Baby, Baby: Second time motherhood after postnatal depression

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Abstract

Women who experience depression after the birth of their first child are at an increased risk of re-experiencing depression following a subsequent birth. This study builds on the work of feminist scholars who have sought to understand women's experience of depression and recovery within the context of their lives and the social, relational and political systems that affect them as women and mothers. I completed two semi-structured interviews with 22 women who were pregnant with their second child and who identified as having experienced depression after their first child was born. The first interview focussed on their experiences of and recovery from postnatal depression and their preparation for the birth of their second child. The second interview three to four months after the birth focussed on the birth and early motherhood with two children. A thematic analysis of time 1 interviews provides a contextual understanding of the women's expectations of motherhood and babies, and the profound contrast between these expectations and their actual experience. Four general circumstances appeared to make motherhood more difficult: traumatic or difficult birth, women's physical health problems, child's health and feeding problems and lack of support. These last two were by far the most common and an understanding was gained of why current strategies by agencies to support new mothers were not effective initially for this group of women. A narrative analysis of both time 1 and time 2 interviews provides a view of each woman's transition from first to second time motherhood within the context of their relationships, the issues they faced, and the positions they took or were assigned. None described experiencing prolonged depressed mood again after their second child was born. Explanations for this were explored. The most common narrative was that of the endurance test whereby over half the women described how they came through by stoically trudging on. However women also identified changes in baby getting "easier" and/or they became the expert on their baby. These attributions as well as the use of seditious talk with friends helped dismantle idealised notions of motherhood and babies. A second narrative was adopted by two women who identified the work they did in dealing with the emotional baggage and relationships related to family of origin and in particular their mothers as key. The impact of a depression diagnosis on women's approach to second time motherhood was explored. Second births and motherhood were narrated as redemptive or even transformational. Key aspects of the women enjoying motherhood more second time round related to their dismantling of multiple barriers to practical support and a hardier positioning of baby "the first one survived, the second one will have to".

Dedication

I dedicate this research to my two families:

To my mother Joyce Cowie (7 July 1930-1 July 1977) nurse, mother, singer, sewer, pianist, friend…who gave me a superb path to follow as a woman.

To my father Alec Cowie (15 February 1926-11 December 1989) for his love of words and who gave me a belief in myself, in education and going as far as you can.

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Chapter 1

Introduction

When women become mothers for the first time they enter an alternative universe of social understandings about their identity as women (Nicolson, 1998; Weaver & Ussher, 1997), changes in their intimate relationship that usually involve an unequal distribution of house work and leisure time (Croghan, 1991; Petrassi, 2012; Sevón, 2012) and losses that can include autonomy, time, occupational identity, appearance, femininity and sexuality (Nicolson, 1999). Alongside these changes women can describe mixed emotions; both happiness and more negative feelings (Lupton, 2000; Nicolson, 1999; Oakley, 1979). The ambivalent feelings and disruption that having a baby can cause to a woman's life have in the past not been represented in the media, popular parenting books and magazines and so have failed to interrupt the popular construction of motherhood as a "happy event" (Nicolson, 1999).

For some women the distress they experience during early motherhood is intense and debilitating. In these circumstances their distress may be self-identified or ascribed by others, the label (major) depression or postnatal/postpartum depression (Lafrance, 2007, 2009; Nicolson, 1999, 2003). Paula Nicolson proposed that women turn to a medical paradigm because there are no alternative models for understanding distress in early motherhood. She theorised that admitting to ambivalent feelings about motherhood threatens a women's identity as a "good" mother (Nicolson, 1999). Naming distress after child birth "depression" positions the woman as ill as opposed to deviant and accesses the powerful resources of the biomedical paradigm to validate the reality and severity of the woman's distress (Lafrance & McKenzie-Mohr, 2013).

However when people become "depression sufferers" several socially shared understandings, based on reports from epidemiological studies, come into play. There is a widely held view that women who experience depression after the birth of their first child are at an increased risk of re-experiencing depression following a subsequent birth (Cooper & Murray, 1995; Philipps & O'Hara, 1991). This echoes the pervasive understandings of depression as a chronic and relapsing illness (Segal, Pearson, & Thase, 2003), which affects women twice as often as men (Bebbington, 1996; Maier et al., 1999) and women with young

children are considered to be particularly at risk of succumbing. For instance the prevalence of postnatal depression has been widely researched and the conclusion reached following a meta-analysis of studies (O'Hara & Swain, 1996) is that on average (depending on method of measurement and the length of the postpartum period under evaluation) 13 percent of women experience depression following the birth of their first baby. A New Zealand study came to the same (13%) prevalence of postnatal depression (McGill, Burrows, Holland, Langer, & Sweet, 1995). How these results from epidemiological studies are taken up by both public/governmental bodies and private people who experience depression can open or restrict options for action. For instance conceptualising postnatal depression as a chronic and relapsing illness may mean women avoid having a second child or alternatively have a second child and take medication.

The purpose of this study is to better understand women's experiences of distress after child birth within the contexts of their lives and the social, relational and political systems that affect them as women and mothers. Following from earlier investigations (Lafrance, 2009; Lafrance & Stoppard, 2006; Scattolon & Stoppard, 1999) I aim to develop in-depth and contextualised understandings of how women come through postnatal depression, and their experiences of either relapse or resilience as they have their second child.

Three bodies of literature inform this study. Firstly, feminist critiques of medical and psychological models of depression will be reviewed and the alternative understandings of women's depression that consider women's experiences within the contexts of their social, political and embodied lives will be outlined. The influences of predominant discourses of femininity are discussed in relation to women's depression. Secondly, the literature on societal constructions of motherhood, and mothering practices will be considered. Writings on the impact of these constructions for women transitioning to motherhood and the inequity experienced within intimate partner relationships will be discussed. Finally, understandings of women's recovery from depression will be reviewed.

Women and Depression

It is generally understood by researchers and mental health professionals that women are twice as likely as men to experience the profound and enduring sadness or misery that gets labeled depression (Stoppard, 2000). The finding of a gender difference in depression is based on a number of sources including large scale epidemiological studies. For instance in New Zealand 1 in 14 women experienced major depression over a 12 month period as

compared to 1 in 23 men, according to a population based mental health survey (Oakley Browne, Wells, & Scott, 2006). That is, according to this study women were 1.6 times more likely than men to suffer from depression in the previous 12 months. This statistic falls somewhere between the 1.2 and 2.7 times women are more likely to suffer depression than men recorded across international studies (Bebbington, 1996).

In attempting to understand the higher rates of depression in women, research beginning in the 1970's alongside the feminist movement connected depression with stressful life events like unemployment, physical illness and the death of a loved one (Brown & Harris, 1978). Social researchers have proposed that women's higher rates of depression are associated with their experience of higher rates of aversive life events and experiences such as poverty (Belle & Doucet, 2003), income inequality (Kahn, Wise, Kennedy, & Kawachi, 2000) and violence, including intimate partner violence (Fanslow & Robinson, 2004; Martin et al., 2006). These studies however appear to hold little sway on the predominant understandings of women's depression which have been and continue to be medical and psychological.

The conception and arrival of the Diagnostic and Statistical Manuel (DSM) 3rd edition (American Psychiatric Association, 1980) marked a sea change away from social (and psychodynamic) understandings of mental health issues, with the medicalisation of psychiatry and mental health. The power of the bio/medical paradigm has ascended exponentially taking previously 'normal' human experiences like birth (Miller & Skinner, 2012), shyness (Scott, 2006), infertility (Becker & Nachtigall, 1992) and misery (Lafrance & McKenzie-Mohr, 2013; Stoppard, 2010; Ussher, 2010) and making them illnesses to be treated. Depression, now a diagnostic category, was previously a common use term for experiences of enduring sadness or misery. Depression moved from something you feel to something you have. DSM and biomedicine acts to locate depression as an illness within the individual (Ussher, 2010).

Narrowly defined symptoms and behaviours were and continue to be used to demarcate the dysfunction. The depression diagnosis directs how individuals are viewed and how they are treated by people in their day to day lives and by mental health professionals. By focusing on the individual, the social, political and relational contexts of a persons lived experience of depression are obscured (Pilgrim & Bentall, 1999). Because my study is concerned with this more complex definition of depression that includes the contexts of

women's lives, I have used the term 'distress' within the project as an encompassing term that does not carry the baggage of the biomedical construct.

The biomedical model has achieved dominant status as a discourse that pervades modern lives. Its dominance is demonstrated by the taken-for-granted way that biomedicine and DSM are perceived to represent the truth of things. Foucault (1977) described the process whereby a framework of knowledge and power becomes a particular discourse that constructs a certain view of reality or truth that supplants alternative views. Thus biomedicine is a social construction that presents depression as an illness and this then shapes the ways in which people interpret their experiences of distress, and as a consequence then seek treatment with antidepressant medication. Dominant discourses usually represent the interests of the powerful. Michelle Lafrance summarised the basis of the dominance and influence of the biomedical discourse and DSM as 'not through overwhelming evidence as the pharmaceutical industry would suggest, but because of the economic, political and institutional power of medicine to shape our view of the world' (Lafrance, 2007, p. 128).

Biomedical discourses have influenced the kinds of questions asked about women's experiences of depression and in particular there has been a preponderance of research focused on perceived biological vulnerabilities like women's reproductive hormones. This has steered researchers down blind alleys that have been at best unhelpful and at worst damaging to women. For instance the framing of natural hormonal changes as medical problems provides a platform for regulating and treating other supposed hormonal problems like premenstrual symptomatology (Ussher, 2003a, 2003b). Biomedical researchers have proposed that women's reproductive hormones are the reason for the hypothetical increases in rates of depression in girls and women at puberty, during child birth and menopause. Jane Ussher (2010) disputes biomedical arguments for a hormonal cause of women's depression and provides convincing counter argument that shows their evidence to be overstated, ignores alternative conceptualisations and is inaccurate. For instance studies of menopausal women show them "to be happy and satisfied with their lives rather than depressed" (Ussher, 2010, p. 13).

Portraying women's bodies and hormones as problematic perpetuates Western discourses of femininity which construct the female body as weak, and defective (Dykes, 2005). The effect of this construction is pervasive in women's lives but not often exposed for social comment. However, a prominent example in the New Zealand media in recent years

presented the attitudes that arise from the construction of women's bodies as defective and responsible in this case for creating unreliable employees. The head of the Employers and Manufacturers Association, Alasdair Thompson went on morning radio in New Zealand to debate gender inequality and presented his explanation for why women are paid, on average, 12 percent less than men. He said "Look at who takes the most sick leave, because you know, once a month they have sick problem. Not all women, but some do. They have children and they have to take leave off" (Morton, 2011). "Sick problem" was clearly a clumsy expression for menstruation. This man's comments caused a justifiable flood of outraged responses and commentary. It likely, however, reflects a broader societal understanding of women being physically compromised which insidiously disadvantages women in the work force. Women's roles in child care were also credited with creating unreliable employees by Alasdair Thompson. While women end up with the bulk of child care responsibilities in families, even when both parents are in paid work, it hardly seems fair that they should be penalised for taking this "double duty" as it is called. Women's roles form one foci of psychological research into the causes of women's higher rates of depression.

Psychological research has provided an alternative conceptualisation to the predominant medical frameworks and has focused on women's roles and women's cognitions as the cause of their higher rates of depression compared to men. In considering women's roles, first it is apparent that women take on the primary responsibility for caregiving in relationships generally and particularly in families where women provide the bulk of caregiving to children, intimate partners, and parents (see for instance Archbold, 1983; Burgard, 2011). Overwork and little reward clearly take a toll on many women. Within intimate relationships Dana Jack (1991) proposed that women become depressed because they subjugate their own needs in order to maintain the relationship. Jack suggested that women are socialised to desire relationships. In order to achieve and maintain relationships women, supposedly, aspire to the traditional values that form the basis of the "good" women role, that is, to be pleasing, caring and helping. By contrast the "cultural pattern of a man's unresponsive, more distanced interactive style" (p. 40), is what Jack proposes creates women's feelings of insecurity in relationships. Silencing their own "true self" to maintain the relationship results in women becoming depressed. Jack's "silencing the self" theory has provided an understanding of women's depression within the social context of their lives.

Focusing on depressed women's narratives provided an insight into the gendered nature of depression also. The approach however has been critiqued (Lafrance, 2009;

Stoppard, 2000) because of its focus on individual women passively internalising and conforming with harmful gender role beliefs without an explanation for why women do not resist and develop more helpful beliefs and roles. Also, this kind of theory continues to devalue the relational qualities that are considered feminine rather than looking at the damaging things (for instance inequality, violence, overwork) that happen to women in relationships (Stoppard, 2000).

Other psychological theories also locate the vulnerability to depression within the individual. An example of this is the thinking styles theory proposed by Susan Nolen-Hoeksema (1991). According to this theory people who respond to negative moods and material (thoughts, memories, attitudes) by ruminating about them - that is, by focusing their attention on themselves - become more depressed. She reported that women were more likely than men to use this style of coping and thus were more prone to depression. She suggested that men used distraction as a coping strategy and this was a more effective and less depressogenic strategy.

Other studies have not supported this idea of different cognitive coping styles between the genders and, for instance, found that men and women both use distraction and rumination (Strauss, Muday, McNall, & Wong, 1997). Furthermore, a criticism of personological models like thinking style is that they isolate cognition and do not account for environmental factors that may contribute to a person having little confidence in problem solving as a means of alleviating distress (Stoppard, 1999). In a subsequent study Nolen-Hoeksema herself acknowledged that rumination per se was not the key aspect causing women's depression as she had found that "the combination of beliefs about control of emotions, responsibility for the emotional tone of relationships, and mastery over negative events fully mediated the gender difference in rumination" (Nolen-Hoeksema & Jackson, 2001, p. 37).

As noted above, a key criticism of both biomedical and psychological understandings of women's depression is that they ignore or at best minimise the significant body of research that identifies social causes for women's distress (Marecek, 2006; Ussher, 2010). Poverty has been acknowledged as a major risk factor for depression and women are more likely to be in positions of poverty (Belle & Doucet, 2003). Broad and growing social inequality and poverty in many Western countries is maintained by discrimination and policies. In New Zealand this burden is carried by Māori and Pacific People in particular (Marriott & Sim, 2014). Poverty and inequality affect women predominantly because they are more likely to be

in the lowest paying and part time jobs or on benefits while caring for young children (Belle & Doucet, 2003).

In New Zealand violence against women, particularly intimate partner violence, has been associated with health effects including depression and suicidal thoughts (Fanslow & Robinson, 2004). Internationally, women disproportionately suffer the impacts of intimate partner and sexual violence and this is strongly associated with the unequal position of women relative to men and the normative use of violence to resolve conflict (World Health Organisation, 2014). These forms of violence can lead to depression, as well as other mental health problems including post-traumatic stress disorder, sleep difficulties, eating disorders, emotional distress and suicide attempts (World Health Organisation, 2014).

Acknowledging this socio-political context, Janet Stoppard (Stoppard, 1999, 2000) called for studies of depression that maintain a focus on the broader social context of women's experiences but also have a women-centred approach like Dana Jack's (1991) interview study. Stoppard used discursive approaches to achieve this. In so doing the daily lives of women have come into view. The work of Stoppard, Lafrance and their colleagues (Lafrance, 2009; Stoppard, 2000; Stoppard & McMullen, 2003) have highlighted the material realities and the dominant discourses that construct and constrain women's lives. Women's stories of depression were often centred on the everyday grind of caring for children and dependent adults, paid employment and housework. The dominant discourses at play were those of femininity and what it is to be a 'good' woman.

Discourses of femininity (and masculinity) arise from the practices of everyday life. When women engage in "feminine" behaviours (like caring for infants) they are thought to be reproducing femininity, however, any behaviour by a woman could be viewed as producing femininity. Discourses do not reside in individuals but are socially constructed which means that they are continually negotiated, defined and replayed in peoples interactions with all the mediums for social exchange such as advertising, news bulletins, conversations and so forth (Lyons, 2009). Within any society particular discourses will hold more sway and can then act as ways that people are assessed, held accountable or legitimated (West & Zimmerman, 1987). The qualities of ideal femininity in Western societies have been summarised as including characteristics such as being nurturing, dependent, cooperative, weak, passive, submissive, cautious, vulnerable and virtuous (Lyons, 2004). The list can go on as most people can identify the stereotypes ascribed to femininity (Mills, 1992).

Schippers (2007) extended the work on multiple masculinities and suggested that there are also multiple and hierarchical femininities. For instance there can be changes in qualities valued as feminine for certain social groups. One example is the documented shift from the traditional passive depiction and reproduction of femininity within heterosex to a more active articulation of desire and pursuit of heterosex by young women and within depictions of female sexuality (Farvid, 2014). With regard to hierarchies, certain groups of women, for instance, married women, may be positioned as having more status than women who are cohabiting (Baker & Elizabeth, 2012; Elizabeth, 2000) or single women (Stoppard, 2000). Nevertheless, the power hierarchies between men and women dominate and "hegemonic femininity consists of the characteristics defined as womanly that establish and legitimate a hierarchical and complementary relationship to hegemonic masculinity and that, by doing so, guarantee the dominant position of men and the subordination of women" (Schippers, 2007, p. 94). Discourses of femininity define the ideal female body and also construct the ideal feminine identities and positions that women can take up. These identities are usually constructed as dichotomies for instance good/bad woman, Madonna/whore, in the same way that man and woman are constructed as dichotomies.

Stoppard (2000) concluded that it is women's attempts to live up to the impossible ideal of the 'good' woman identity and its requirement that women be selfless in caring for others, that is central to women's depression. In the following section I will focus on the social constructions of 'good' mothers and the influence this has had on the mothering practices of Western women. The connections that have been made between discourses of modern mothering and postnatal depression will be discussed.

Motherhood and distress

Motherhood has been constructed as a critical aspect of femininity (Stoppard, 2000) and a defining aspect of an adult woman's identity (Woollett & Marshall, 2001). Women are constructed as natural mothers, immediately able to care for babies and fulfilled in the role of selfless carer and nurturer (Bobel, 2002; Woollett & Marshall, 2001). Becoming a mother is a taken-for-granted assumption within society and the vast majority of women become mothers. The power of motherhood as an institution becomes apparent when adult women do not become mothers. Infertility and involuntary childlessness has been framed as a tragedy and failure as a woman while choosing to be childfree is considered selfish, deviant, unfeminine and an unhealthy choice for women (Gillespie, 2000). Nevertheless, some

women remain childless by choice and there is a recent trend for more women to remain childfree in New Zealand (Statistics New Zealand Tatauranga Aotearoa, 2015) and in other Western countries (Gillespie, 2003). While Gillespie identified that more women are claiming a childfree feminine identity, the predominance of pronatal discourse, ensures that becoming a mother remains the taken-for-granted assumption for (socially sanctioned) adult women. Constructions of motherhood define the practices and characteristics of 'good' and 'appropriate' mothering and mothers, and designate other mothers and practices 'bad' and 'inappropriate' (Woollett & Marshall, 2001). These judgements are "based on factors such as a women's age, their sexuality and able-bodiedness, whether they are single or partnered, their "race" and ethnicity, social class/economic position, and employment status" (Woollett & Marshall, 2001, p. 170).

Mothers are also measured against their ability to follow the current mandated cultural practices of motherhood in Western countries namely natural/intensive mothering (Bobel, 2004; Hays, 1996). Sharon Hays coined the term intensive mothering to describe the contemporary cultural model of mothering. The central features of this gendered ideology are that, the mother is the indispensable, primary care giver (Arendell, 2000; Choi, Henshaw, Baker, & Tree, 2005; Miller, 2007), the practice is child centered (not mother centered) (Woollett & Marshall, 2001), and the activities are expert guided, emotionally absorbing, labour intensive, and financially expensive (Hays, 1996).

The optimal practices of 'good' mothering are based in part on psychodynamic and developmental psychology theories and studies focused on what is "good" for children without consideration for the diverse contexts within which mothering occurs. From the early part of last century the idea that children are the products of their mother's implementation of behavioural principles regarding routine, separation, control and discipline became embedded (Beekman, 1977), and mothers continue to be constructed within developmental psychology as the major influence on children's development (Woollett & Phoenix, 1997). In particular, the activities currently considered ideal include listening to children, being warm and responsive, setting high standards and monitoring children's behaviour (Woollett & Marshall, 2001). In summary, intensive mothering is so called, because of the time, energy, financial cost and emotional commitment required by women to put their children first, and meet their developmental needs and desires (Hays, 1996). This is not to say that children don't benefit from child focused care relevant to their needs. The

intensive mothering ideology however becomes oppressive because it dictates who can be the care giver to children and limits the multiple ways that raising healthy, happy, children can be achieved (O'Reilly, 2004).

Most dominant discourses act to serve the powerful (Foucault, 1977) and Hays (1996) proposed that the intensive mothering ideology persists in part because it serves the interests not only of men but also of capitalism, the state, the middle class and whites. The intensive mothering ideology however has adverse implications for all mothers. As Michelle Lafrance (2009) summarised, "It serves to erode the confidence, self-worth, and resources of working- and upper-class women and further vilifies mothers who are economically and socially marginalized" (p.33).

The second dominant discourse within motherhood is the biomedical discourse which comes into play even before women become pregnant with prominent media calls for women to restrict alcohol intake and take supplements like folic acid for instance. The medicalisation of pregnancy and childbirth has resulted in increased rates of medical intervention over the past two centuries. Clearly some biomedical practices have benefited birth outcomes for women and babies. However the recent high and variable rates of caesarean have been criticised and related to obstetricians becoming involved in normal births rather than high risk situations requiring operative involvement (see a critical review by Johanson, Newburn, & Macfarlane, 2002). Ann Oakley (1979) completed one of the first women centred studies of motherhood and identified that the level of technology involved in birth played a part in women's negative emotional response to birth. Her work has been followed by a growing body of feminist research focusing on women's first hand reports of their experiences of birth, first time motherhood and experiences of distress associated with motherhood.

Caring for a baby involves regular feeding, nappy changes, sleep disruption, bathing, clothes washing and so on. Even in the ideal situation with the easiest baby this is exhausting. Studies that have interviewed women (without selecting women who identify as being depressed) have documented that women often describe very ambivalent feelings associated with first time motherhood. Happiness, and deep emotional warmth can occur while women also report feelings of loss: of identity in particular the loss of a previous separate, autonomous self (Oakley, 1979; Weaver & Ussher, 1997), loss of employment and occupational identity and the social relationships associated with work (Lewis & Nicolson,

1998; Nicolson, 1999; Oakley, 1979), and loss of time, appearance, femininity and sexuality (Nicolson, 1999).

Changes in heterosexual intimate couple relationships when a baby arrives have been associated with a reduction in satisfaction with the relationship and distress in new mothers (Oakley, 1979; Small, Brown, Lumley, & Astbury, 1994). Compared with earlier generations, men are more involved in the lives of their children with fathers being present at births now commonplace and their involvement with aspects of child care assumed (Woollett & Parr, 1997). However, even relationships which have been nominally egalitarian and reciprocal shift to roles that are more gendered with the birth of a baby (e.g., Doucet, 2001). Issues of equity can arise in the division of household labour and the competition for the scarce resources of access to free time and paid work (Croghan, 1991; Nicolson, 1998, 1999; Sevón, 2012).

Describing the distribution of workload as a competition, however, suggests a level playing field. Powerful discourses constructing mothers' and fathers' roles mean that the common practice is for women to take maternity leave from work and become responsible for household work and child care. These traditional roles can then continue even after a woman returns to paid work (Doucet, 2001). For example, Petrassi (2012) identified four ways that a small group of professional women constructed the roles and competence of themselves and the father to their child: the selfless mother and contrasting shirking father; the father restores [the gendered] order of things in 'sneaky' ways by inviting the mother into care giving roles for instance by asking for "help"; and the high status [in relation to their household role] mother. Each construction acted to perpetuate the status quo of traditional gendered roles and inequality. Fatherhood continues to be positioned as personal and elective while motherhood is considered a societal duty (Vuori, 2009). The practices of each follow the same pattern with women ending up with the lion's share of the child care and running the house.

Despite these more gendered models for mother's and father's roles, more recently a narrative of shared parenting has provided an alternative to intensive mothering models. Shared parenting refers to the practise of parents taking equal responsibility for caring for children with a relationship that stresses companionship, reciprocity and free choice (Sevón, 2012; Vuori, 2009; Woollett & Parr, 1997). Eija Sevón in her study of Finnish first time mothers identified that where both partners "showed a willingness and effort" (p. 60) at shared parenting the woman experienced a smooth transition to motherhood. Where women

(and men) struggled between the contradictory narratives of intensive mothering and shared parenting, Sevón identified a turbulent narrative that usually resolved by women following the more traditional mothering narrative of intensive mothering and accommodating gendered inequities.

A consistent response of mothers to first time motherhood is that the reality of the high demands of childcare and unplanned medical intervention in births, do not match their expectations which can result in feelings of inadequacy, shock, failure, disillusionment (Choi et al., 2005; Miller, 2007; Weaver & Ussher, 1997), and sometimes depression (Mauthner, 1999). In attempting to be the 'good' mother, women in an interview study of the transition to motherhood by Choi et al. (2005) described working harder at child care, as well as domestic tasks and the caring of others. Choi and her colleagues related this "superwoman" effort to ideas of femininity today that represent women as able to cope with many competing demands but ignoring the cost to women (see Slaughter, 2012 for a treatise from a "high performing" woman). Working hard acted to avoid being seen as a failure as a woman (Choi et al., 2005). Another way that women avoid being identified as failing as 'good' mothers is by staying silent about their negative feelings and presenting a coping front (Mauthner, 2002; Weaver & Ussher, 1997). According to Natasha Mauthner, when women silently struggle to meet 'good' mother ideals and discount their own needs and desires, they can become depressed. Mauthner (1999) also suggested that women who reduce their expectations of themselves are those who are less likely to become depressed.

Several researchers have noted that during early motherhood the women in their studies locate their experiences universally in relation to the good/intensive mothering discourses (Choi et al., 2005; Lewis & Nicolson, 1998; Miller, 2007). Choi and her colleagues found no evidence of resistance to the ideology of motherhood. Tina Miller particularly looked at the discursive practices in which women engage as they become first time mothers. She concluded that "challenging the more obdurate strands of these discourses [intensive and good mothering] is only more fully realised as mothering experiences grow and confidence builds" (p. 350). Miller also named "the heightened perceptions of risk" (p. 340) around birth and breastfeeding for instance, create more pronounced ideas of maternal responsibility and moral obligation. She suggests that this both creates a reliance on expert advice and information, while ideas of responsibility and obligation are further reinforced by the proliferation of experts (e.g., obstetricians) and mothering information in diverse media.

The reluctance of popular media to pair motherhood and distress is another way in which the societal discourse of idealised motherhood and mothering responsibility is reinforced and disseminated (Held & Rutherford, 2012). Held and Rutherford identified that popular media in America consistently avoided situating motherhood itself as the cause of mothers' emotional distress and instead focused on how mothers should change and adapt to the role. In Australia, mental health education discourses are promoting "depression literacy". Associated advice columns, resource links and celebrity stories, were found to privilege medical and psychological expertise in explaining depression and promoting help seeking behaviour (Gattuso, Fullagar, & Young, 2005). Within articles in popular women's magazines in Australia, an individualising discourse of women's depression as a problem of self-management was foregrounded similar to that found by Held and Rutherford in American magazine stories. The Australian articles also included references to biomedical expertise. However, in both cases the social and gendered context of women's depression is patently missing.

In summary, depression in the post-natal period has been conceptualized as an understandable reaction to the strains and demands of early motherhood (Nicolson, 1998), associated with women being required to meet the high and unrealistic standards associated with being a 'good' mother/woman, in difficult circumstances with little practical help or emotional validation. Ironically, the 'good' mother ideal also requires that women do this "in a calm, pleasant and effective way" (Mauthner, 1999). The same adverse circumstances that affect women at other times in their lives such as intimate partner violence, poverty, and discrimination compound the difficulty for women coping with a new baby (e.g., Abrams & Curran, 2009; Lafrance, 2009).

Recovery from Depression

Understandings of recovery from depression are firmly attached to understandings of the causes of depression (Lafrance, 2009). For instance the current popular biomedical (e.g., genetic, hormonal and neurochemical) and psychosocial (cognitive attributional or coping style, or relational and life events stressors) theories of depression and its recurrence have given rise to therapies. Thus, the focus of quantitative research on recovery over the past 30 years has been on identifying effective treatments, mainly psychopharmacological and psychological. More recently the focus has turned to preventing relapse from depression because despite the regular introduction of newer antidepressant medication, significant numbers of people experience a recurrence of depression particularly on withdrawal from

antidepressant medication (Segal et al., 2003). Moreover, when people have experienced depression, studies suggest that they are at increased risk of experiencing depression again and with each episode the risk increases further (Segal et al., 2003). Consequently, over the past 5-10 years the focus of treatment studies has shifted from comparing which treatments are most (cost) effective, to attempting to find treatments that prevent relapse.

These findings regarding the perceived chronicity of depression have led to significant changes in the management of depression by medical practitioners. For instance the British Association for Psychopharmacology (BAP) (Anderson, Nutt, & Deakin, 2000) revised the guidelines for treating Major Depression and recommended continuation of antidepressant drug treatment at the same acute treatment dose for a minimum of 6 months after remission of depression (12 months in the elderly) in all cases. For people with three or more episodes of major depression over a five year period or more than five episodes altogether the BAP recommend maintaining drug treatment at acute drug treatment dose "for at least 5 years and possibly indefinitely". This guideline clearly is not concerned with recovery from depression but focused on supposedly preventing relapse.

In New Zealand, guidelines from 2008, that are still current (Ministry of Health, 2008) for management of depression, recommend a stepped-care approach with medication or psychological treatment for moderate depression and both for severe depression. Continuation of antidepressant medication after remission is recommended for at least 6 months after remission of a first episode of depression as a strategy to reduce the risk of relapse. After a second or subsequent episode, the recommendation is that antidepressants are continued for at least 2 years and that adjunctive psychological therapy should be considered.

Clearly these recommendations reflect the profoundly medicalised approach to depression and the economic force of drug companies in shaping what is researched, marketed and finally conceptualised as appropriate treatment (Healey, 1997; Horowitz & Wakefield, 2007). Most research on recovery has accordingly focused mostly on outcome and comparative efficacy of therapies without fully investigating or understanding the process of recovery (Anthony, 1993). Instead, recovery is conceptualised as 'treatment outcome' or 'treatment effectiveness' expressed as a number or percentage (McKenzie-Mohr & Lafrance, 2011). It is difficult to translate from numerical data the actual lived experience of participants and their process of moving out of/on from the intense and prolonged sadness associated with depression. Viewing depression as medical illness or dysfunctional attitudes

are very narrow conceptualisations and so theories of recovery from these positions are similarly contracted and decontextualised (Lafrance, 2009).

Lafrance (Lafrance, 2009; McKenzie-Mohr & Lafrance, 2011) noted another difficulty for research on recovery, being that the term "recovery" does not necessarily reflect the experiences of those who have experienced depression. For instance people in her studies of coming out of depression did not necessarily feel that they had "returned to a previous state", but instead described being fundamentally altered by the experience. When first-time mothers experience depression they are clearly in a life transition that complicates the possibility of returning altogether to a previous state. The view of depression as a chronic and relapsing disorder (Segal et al., 2003) can also mean that investigations of recovery are viewed as redundant (Lafrance, 2009; McKenzie-Mohr & Lafrance, 2011).

Despite these barriers to conceptualising recovery, a small body of qualitative studies has developed based on women's experiences of coming out of depression and postnatal depression. These have mostly taken phenomenological and Grounded Theory approaches to understanding women's recovery from depression (e.g., Schreiber, 1996, 1998) and postnatal depression (e.g., Beck, 1993, 2011; Lawler & Sinclair, 2003). Notably, Cheryl Beck developed what she termed the Teetering on the Edge theory of postnatal depression. Beck's four stages, including those concerned with coming out of postnatal depression are: *encountering terror* which involves severe anxiety, feelings of fogginess and obsessive thinking; *dying of self* which is defined by feelings of unrealness, isolation and unwanted feelings of harm for self or baby; *struggling to survive* which includes women having a difficult time participating in life, having difficulty accessing treatment but ultimately finding solace in support groups and prayer; and in the last stage, *regaining control*, in which the women begins an up and down transition towards feeling better, feeling that they have missed out on things during their depression and fearing that depression will reoccur.

Cheryl Beck's two updates on her Teetering on the Edge theory of postnatal depression incorporated the findings from 27 transnational qualitative studies. Her essential model however, has not shifted significantly with the inclusion of new data and gives the impression of a universal model. While there has been extensive research on experiences of postnatal depression, there are only a few focused on recovery that Beck has used to inform the recovery stages of her model and the studies have diverse foci that she has drawn on. For instance, Lawler and Sinclair (2003) in their phenomenological study proposed that coming

out of postnatal distress involved women grieving for their lost self before being able to accept their new self and new role as mother. By contrast McCarthy and McMahon (2008) in a study based in a small rural town in New Zealand, were interested in the "acceptance and experience of treatment" of women who had experienced PND and had received antidepressant and psychological therapies at a community mental health service. Qualitative methods have been used on the one hand to theorise PND and recovery from a phenomenological stance and on the other, have been focused on treatment access and efficacy.

Studies of recovery from depression will usually involve women who have made use of professional services and likely antidepressant medication within this context. However, many women do not seek professional involvement in their recovery. It has been suggested that, without treatment, most women 'recover' from PND within 3-6 months (Cooper & Murray, 1995). Many women seek non-professional help and recommend this to other women coping with depression following childbirth (Small et al., 1994). Similarly, a study of rural Canadian women who described themselves as stressed, found that the women did not seek professional help because of the financial cost of getting to services (Scattolon & Stoppard, 1999). Several of the women had young children and understood the stress to be part of their lives, to be endured and coped with. The women in Lawler and Sinclair's (2003) study also viewed their experiences of PND as a normal part of motherhood.

Studies of women's accounts of recovery from depression that take a discursive approach and consider the social, political and economic realities of women's lives are still few and Michelle Lafrance (2009) has provided the most comprehensive investigations to date. Lafrance from her two studies of recovery and living well after depression identified that while women are silenced by depression the process of recovery involved women "talking back". Their accounts of becoming well, centred on having their distress validated, relinquishing exclusive other-centeredness, and beginning to attend to their own needs and desires. Lafrance identified two patterns of accounting that women appropriated to support these aims. The first involved talk of recovery as a personal transformation through which women resisted or rejected the confines of the "good" woman identity. This involved resisting self-sacrifice and exclusively focusing on others' needs, though still maintaining relationship and care-work. In the second form of accounting, women reasserted the legitimacy of depression within a medical model, which served to frame their distress as

"real" and not a personal failing. Both ways of accounting, according to Lafrance allowed women to take up self-care.

Legitimising distress by having it named/diagnosed as "depression" was described as a relief and validating to women (Lafrance, 2007). This effect of diagnosis has also been identified in other studies including a study of PND by McCarthy and McMahon (2008). Diagnosis acted to externalise the depression and defend against being blamed for being depressed by others or blaming themselves. Women in Lafrance's study constructed depression as being comparable with a biomedical (not mental) illness like diabetes, cancer or heart disease. In so doing, depression gains the status and legitimacy afforded by medical science. This level of work to deflect blame attests to the power of "dominant assumptions that so readily result in disregarding [people who suffer's] pain or blaming them for their own distress." (Lafrance & McKenzie-Mohr, 2013, p. 127).

More recently, several authors including Lafrance (Lafrance & McKenzie-Mohr, 2013; Pilgrim & Bentall, 1999; Ussher, 2010) have identified several problems that arise for women (and men) in locating their pain and distress within a biomedical paradigm. Four main problems are summarised by Lafrance and McKenzie-Mohr. Firstly, there are findings that the expectation of legitimacy is erroneous in that, for instance, women in her studies (Lafrance, 2007, 2009) experienced rejection by people of their diagnosis of depression and the diagnosis of depression held little credibility generally. This relegation of depression and other mental health problems, to the side lines of biomedicine has been related to problems with confusion and a lack of consistency in the concept of 'depression'. Also the diagnosis is largely based on the sufferer's self-report rather than 'hard, scientific, observable data'. Thus the reality of depression is questioned (Lafrance & McKenzie-Mohr, 2013; Pilgrim & Bentall, 1999). A second problem with diagnosis of mental health problems is that locating the problem within the individual, but out of their control, can lead to presumptions about people. For instance the dangerousness of people with the label schizophrenia (Read, Haslam, Sayce, & Davies, 2006) or the unstable and irrational nature of women labelled with premenstrual syndrome (Mooney-Somers, Perz, & Ussher, 2008). The awareness of negative social attitudes to emotional problems was apparent in the accounts of some women in McCarthy and McMahon's (2008) study. Women described avoiding seeking professional involvement and rejected a diagnosis of PND because of the stigma of being labelled as not coping and a 'bad mother'. A third potential problem for people arising from having a mental health diagnosis was also identified within a study of naming premenstrual syndrome

(PMS) within an intimate couple relationship (Mooney-Somers et al., 2008). PMS was named by some women's partners as the only explanation for distress. This would act to invalidate women with legitimate reasons for annoyance, for example having insufficient support from their partner in house care duties. The final issue, raised earlier, is that of diagnosis placing blinkers on the impacts of serious social or economic problems like poverty. This can mean that therapy (antidepressant medication) is mistargeted, invalidating, unhelpful and individually focused, overlooking any opportunity for social change.

Thus, locating depression within a medical framework by gaining a diagnosis and antidepressant medication can legitimise some women's distress and provide relief through its explanatory power and access to assistance, thus facilitating recovery. However, it may also be a construction that is not accepted by the people women come in contact with, thus having a negative impact on recovery. Furthermore, there may be other downsides of naming depression, such as depression ending up being the default explanation for all expressions of negative emotion. Lewis and Nicolson (1998) interviewed first time mothers and found that the reason women turn to a medical construct such as PND is that there are few alternative discourses for understanding experiences of grief and loss as a new mother.

Lafrance (2009), however, did identify two broad patterns that did not incorporate a biomedical paradigm, which women used to account for becoming well after depression. In both cases as Lafrance asserts, "the importance of self-care (as opposed to self-negation) for women's well-being came to the fore" (p. 176). The first pattern of accounting did not disrupt idealised discourses of femininity, whereby women are assumed to take the bulk of care giving and domestic work, alongside sanctions against women acting with self-interest. Instead the women's accounts endorsed or accommodated feminine ideals. Three discursive devices were used to defend the women's need to adopt leisure and self-care: Self-care through crisis whereby women described reaching a crisis point where they were forced to take care of themselves; the adoption of a tomboy/male identity; and use of the oxygen-mask metaphor whereby in order to take care of others (like a 'good' woman should) you need to take care of yourself.

In their accounts of becoming well, Lafrance (2009) identified a second overarching, potentially more emancipatory, pattern. In this case women resisted or rejected the confines of the "good" woman identity. Jane Ussher (2006) also highlighted the need to interrupt and resist discourses of femininity to gain healing and well-being for women. Lafrance identified

three ways of accounting: firstly, women talked about recovery as a personal transformation and how they came to stand up and assert their right to self-care by resisting the 'good' woman identity; secondly, women attributed being in more equitable relationships where partners were described as supporting the woman's self-interests which were viewed by them as important to maintaining self-care; thirdly, some women narrated their practise of self-care as related to "an expression of deep-seated spiritual need" (Lafrance, 2009, p. 169).

Each of these ways of framing self-care assisted women to circumvent the discursive bind of needing to take care of themselves in order to overcome distress, while avoiding being positioned as bad, selfish and uncaring in the process. McKenzie-Mohr and Lafrance (2011) have titled this 'tightrope talk' because of the precarious nature of the discursive position.

I began this section with the statement that understandings of recovery from depression are firmly attached to understandings of the causes of depression (Lafrance, 2009). Feminist understandings thus conceptualise recovery as, in the first instance, relief from the gendered adverse circumstances that affect women such as intimate partner violence, poverty, and discrimination. Secondly, recovery is related to the emancipation of women from the practices that create depression which are imbedded in discourses of femininity and motherhood. Lafrance (2009) identified several discursive practices that assisted women to take on activities of self-care while positioning the women as blameless for their distress. Some women achieved this by resisting and rejecting dominant discourses and creating alternative ways of practicing femininity. Others used discursive practices that justified their need for self-care but did not disrupt dominant discourses of femininity to do this. In both cases women developed the self-care (as opposed to self-negation) practises that assisted them to come out of distress and live well. Many women seek a medical diagnosis and treatment for distress. Having their distress labelled depression and validated within a medical framework can be experienced as a relief and validating and can assist women to gain acceptance of their need for self-care. Several authors (Lafrance & McKenzie-Mohr, 2013; Pilgrim & Bentall, 1999; Ussher, 2010) identified down sides to such a solution. A more broad reaching consequence of a biomedical solution to women's distress is that it subverts any possibility for changing the circumstances or discourses that created the distress in the first place.

The current study

In this study I hoped to extend on the feminist research on women and their experiences as mothers which has to date focused mainly on first time motherhood (e.g., Choi et al., 2005; Miller, 2007; Sevón, 2012). In particular I was interested in women's experiences of first and then second time motherhood within the context of their relationships (with baby, husband/partner, family, friends, maternity caregivers and other health professionals) and the challenges they faced. I wanted to focus on the stories of women who had experienced prolonged and intense distress after the birth of their first child, and how they came out of this distress, that became labelled depression or postnatal depression. To extend on feminist studies of how women recover from depression and how they then negotiated second time motherhood. In undertaking this work I wanted to investigate the societal discourses that the women located their experiences within. For instance I was interested in how New Zealand women take up or resist intensive mothering discourses and how this might influence or be influenced by experiences of distress and coming out of distress. Also, I was interested in how biomedical understandings about the chronicity of depression, relapse and recurrence might be taken up and acted on by women preparing for second time motherhood after "postnatal depression".

In line with the recommendations of Lafrance and McKenzie-Mohr (2013) and Ussher (2010) I have taken a feminist critical realist approach to achieve this focus on both the discursive and material contexts of motherhood, depression and recovery. In taking a feminist stance I hope to explore the operation of gender within the institutions surrounding pregnancy, motherhood (and fatherhood), and the heterosexual couple relationships for women who have experienced postnatal distress. In particular, I am interested in how women wrestle with the distribution of paid work, house work and child care within the context of the couple and family relationships.

Chapter 2

Methodological Issues and Analytic Frameworks

Brief Overview

In this research I took a feminist critical realist approach and used a longitudinal narrative interview methodology. I completed two semi-structured interviews with 22 women who were pregnant with their second child and who identified as having experienced depression after their first child was born. The first interview focussed on their experiences of and recovery from postnatal depression and their preparation for the birth of their second child. The second interview three to four months after the birth focussed on the birth and early motherhood with two children. The research was designed to generate in-depth and contextualized understandings of the women's experiences of depression, recovery, and then relapse or resilience.

Analytic Overview

I took a critical realist position (Willig, 1999) that allowed the embodied, material and power influences on motherhood to be investigated and acknowledged alongside and in relation to the socially constructed discourses predominating women, depression and motherhood.

Social constructionist approaches have allowed researchers to move away from individualistic medical and psychological understandings of women's depression and develop understandings that take into account the broader societal context of women's lives (Lafrance & Stoppard, 2006). Social constructionists hold that all knowledge is socially created. That is, the world we experience and the people we find ourselves to be are the artefacts of social processes occurring in the particular time and place in history in which we exist (Burr, 1995). Language is understood to construct knowledge and also to shape the kinds of action that are or are not possible. For instance, understanding that women should always be caring and pleasing to others requires particular actions by women (e.g., look after others before themselves) and precludes alternative actions (e.g., playing golf all weekend). Understanding that women should be caring and pleasing to others, when grouped with other predominant ways of constructing women combine to form a discourse (system of meaning or way of understanding) the 'good' woman.

The approach to analysis in this study draws on the work of Foucault (1977). He identified a set of strategies (for instance patterns of statements, sets of metaphors and regulated practises) by which a discourse constructs a particular view of an object and obscures alternative, competing, and potentially contradictory views. Dominant discourses are those that appear natural and taken-for-granted in any place and time. The particular dominant discourses that have been identified by researchers on women and depression are the biomedical discourse and discourses of femininity and motherhood (Lafrance, 2009; Stoppard, 2000). The influence of neoliberal and (medical) risk discourses on experiences of motherhood, have also been explored (Lee, 2008; Murphy, 2000; Thomas, 1997) .

Discourses offer particular "subject positions" for individuals to take up or be assigned into by others (Weeden, 1987). Subject positions have been described as "possibilities" for constituting subjectivity (Davies & Harrē, 1990; Weeden, 1987). Subjectivity encompasses a person's sense of self, identities, thoughts, emotions, behaviours and understandings of the world (Gavey, 1997). Dominant discourses provide subject positions that are taken up, often unconsciously, as the 'usual practice' by most people within a particular place and time. People can however "choose" to conform to multiple or alternative subject positions within less dominant discourses, and this may require an act of resistance, rejection, or defence to achieve (Gavey, 1997). The current analysis explored the ways in which societal discourses and the subject positions available around depression and motherhood were appropriated, modified and challenged by the women. The analysis was completed however within a critical realist epistemology and incorporated the material and embodied contexts of the women's lives.

Social constructionist thought and a relativist theoretical position has been empowering as a way of challenging dominant positivist constructs like "mental illness" (Eisenberg, 1988). Social constructionist feminist researchers (e.g., Stoppard, 2000) have shifted the focus from individualistic and pathologising understandings of women's depression to encompass the influence of the dominant societal discourses of femininity that prescribe how 'good' women should behave.

However, constructionist ideas have been challenged as focusing on deconstruction and not being capable of offering explanations for why things are as they are and how things could be better (Willig, 1999). Discursive approaches have also been criticised for ignoring the materiality of women's lives (Ussher, 2004). A critical realist position allows the

researcher to accept the social constructivist view that language constructs our social realities, but also combines it with the understanding that there is an underlying reality of an external world, including the reality of feelings and other bodily experiences, which exist independent to our representation of them (Nightingale & Cromby, 2002). This is particularly relevant for the study of the embodied experiences of depression (for instance see Cromby, 2004; Lafrance, 2009) and motherhood (for instance see Sims-Schouten, Riley, & Willig, 2007). Recently, feminist researchers have called for more studies that use a critical realist epistemology as a way to bridge the biomedical positivist and social constructionist relativist positions and privilege *both* the discursive and material aspects of human experience (Lafrance & McKenzie-Mohr, 2013; Ussher, 2010).

This study followed the recommendations of Carla Willig (1999) who described the two aspects of a non-relativist approach to social construction research. Firstly, she suggested that when gathering participants' accounts and subjective experiences, a critical realist or non-relativist approach "needs to provide detailed and comprehensive descriptions of the discourses available to groups and individuals and the various ways these discourses are deployed and with what consequence" (p. 38). The second aspect of the research according to Willig (1999) involves the exploration of the historical, social and economic conditions "that gave rise to and/or made possible these documented subjective accounts and the discourses which constitute them" (p 38-9). In the study of women's depression, feminists have incorporated women's bodies as a significant material context alongside the cultural contexts of women's lived experience (Stoppard, 2000). Jane Ussher (2004) also recommends incorporating the intra-psychic into understandings of women's biology and depression. Ussher (2010) states that "a critical-realist analysis, allows us to acknowledge the 'real' of women's psychological and somatic distress" (p. 23).

Gender is an organising principle within all social systems (Sprague, 2005). This study takes a feminist stance in attempting to understand the operation of gender within the institutions surrounding pregnancy, motherhood (and fatherhood), and heterosexual couple relationships for women who have experienced postnatal distress. In particular, I am interested in how women wrestle with the distribution of paid work, house work and child care within the context of the couple and family relationships.

Reflexivity/subjectivity of the interviewer

Making explicit my personal interests and values in participating in the co-construction of this research is consistent with the feminist goals of the research (Wilkinson, 1988). The various identities and positions that I take as a feminist, a woman, a mother, a researcher and a clinical psychologist for instance all required careful reflection within the process of planning the research and then in the contacts I had with participants and the way I approached the analysis. As a New Zealand European, tertiary educated woman who had two children, I needed to take care not to assume that I shared the same understandings as the participants even though we shared many similar demographic characteristics. My life experiences also impacted on how I conducted the research.

For instance, at a very basic level, I was and continue to be learning the process of qualitative research. As a novice qualitative researcher but experienced clinical interviewer I had to adjust my approach over the first interviews particularly. A simple problem was my overuse of verbal minimal encouragers (e.g., yeah, mmm. okay). After reviewing my first transcript it appeared they disrupted the flow of transcriptions and also, possibly, the flow of participant narratives. Once these were minimised, participant narratives were interrupted less in transcripts but also I think, within the interviews. Non-verbal encouragers provided less "feedback" which I think allowed the participant to focus on their own account without adjusting to my response so much.

I also reviewed the research questions and responses of early interviews to identify ways (better questions, areas to follow up on more) to get more in-depth accounts and check for any important clues or obscured narratives that I was not following up in the interviews and could listen for in future interviews.

A second consideration is the assumptions participants might have had of me as a psychologist. I identified myself as a clinical psychologist within the participant information sheet, in order to provide some description of my background and interest in postnatal depression. Also it was hoped that my being knowledgeable about depression would reassure potential participants or people referring participants to the study, that I had the experience to manage their information and the interview sensitively. My identity as a psychologist likely influenced the research in several ways. Firstly, some women may have decided not to participate because of my position within the "helping professions" while others may have volunteered because they thought participating would be a helpful process for getting through

their second pregnancy. For instance I asked people about the reasons for volunteering to participate and the most common rationale given for participating was that it could help other women. However some women indicated in their accounts that they thought talking about their experiences of postnatal distress might help them prepare for the second birth and the potential that they might experience postnatal distress again. One woman described the timing of the first interview as "useful" and that it coincided with her already reflecting on her experiences of first time motherhood. This suggested that the interviews were timed in the women's lives to coincide with a time they were likely to be reflecting on the very issues that are the topics under investigation. This was helpful for recruitment however also likely created multiple functions of the research for participants beyond telling their story. Also the impact of the Time 1 interview on the women likely influenced, to some extent, their later experiences and the narratives they provided at Time 2 interview.

Knowing that I was a clinical psychologist meant that participants may have assumed I was knowledgeable about depression and so may have modified their narrative to accommodate that. For myself, being a clinical psychologist was tricky and there was a tension between attempting to encourage participants to provide a narrative account while resisting the temptation to provide feedback, for instance affirmation of strategies they were planning. This was particularly difficult when I was aware that women may experience high degrees of distress following the birth of their second baby. I certainly did not give advice but nodded, and gave non-verbal encouragers which may have been seen as encouragement and affirmation.

Longitudinal Research

Longitudinal methods have been used in qualitative studies of motherhood to investigate the transition to motherhood (Miller, 2000; Sevón, 2012; Smith, 1992). The longitudinal method allows the analysis of accounts across participants in order to identify the discourses engaged around depression, recovery and second time pregnancy and motherhood. At the same time, the longitudinal approach, using in-depth interviews, gave a view of the women's experiences over time and events. In particular, I was interested in how they came through first-time motherhood and depression and how this influenced their experiences of second time pregnancy and motherhood.

A strength of the longitudinal approach is that the research relationship is more developed over the two interviews and this can mean that participants develop more trust and

provide more enriched accounts than they would with a one-off meeting. Reviewing transcripts of the first interview prior to the second interview allowed me to ask questions and follow up on topics that the participant may not have raised themselves. Also, my recall of particulars (e.g., birth interventions) likely increased rapport and potentially increased the depth of what was revealed.

However, a key issue in longitudinal research is the concern that the interview becomes an intervention that influences the "phenomena" being investigated. One way to address this is to adopt a "distal-formal" research relationship (McLeod & Yates, 1997). This stance would not have been appropriate considering the more personal and sometimes emotionally-laden content disclosed in this research. I did not seek to make an intervention or influence the participants. However, I accept that this may have occurred. Firstly, narratives or "stories shape identity, guide action, and constitute our mode of being" (Smith & Sparkes, 2006 p. 170). For example, within this research a few participants explicitly described coming to new understandings or having an "epiphany" (Lisa) during the interview process. This could also occur in single-interview research, though possibly to a lesser extent. Secondly, the temporal flow of the narrative, which usually began with birth and first time motherhood before any explanation regarding their approach to second time motherhood, likely created an expectation, or at least the resources, to create plans if they had not already done so. Thirdly, the interview is considered a joint construction of meaning and narrative by interviewer and participant (Mishler, 1986). While it was not my intention to influence the participants the questions I asked and what I followed up on all influence the participant. For instance they are likely to form ideas about what I am interested in or not and may alter their account accordingly. The approach to the subjectivity of the researcher will be discussed later in this chapter.

The longitudinal method, with its cross-sectional and longitudinal perspectives, thus leant itself to two analytic approaches: thematic analysis, following Braun and Clarke (2006), in order to identify the experiences, understandings and discourses that were predominant across participants; and a narrative approach, guided by Riessman (2008), that identified development and change over time of individual women's experiences, understandings and the discourses they drew on and noting the consistencies and contradictions across women's narratives (Thomson & Holland, 2003).

Participants

Criteria for inclusion in the study included that women self-identified as having experienced depression after the birth of their first child and were currently pregnant with their second child. While participants needed to be able to read and speak English in order to speak in depth about their experiences, no potential participants were excluded on this basis. All the women who responded to the recruitment information (see Procedure) were included in the study. Twenty four women completed the Time 1 interview. Twenty two of these women completed the Time 2 interview 3-4 months after their baby was born.

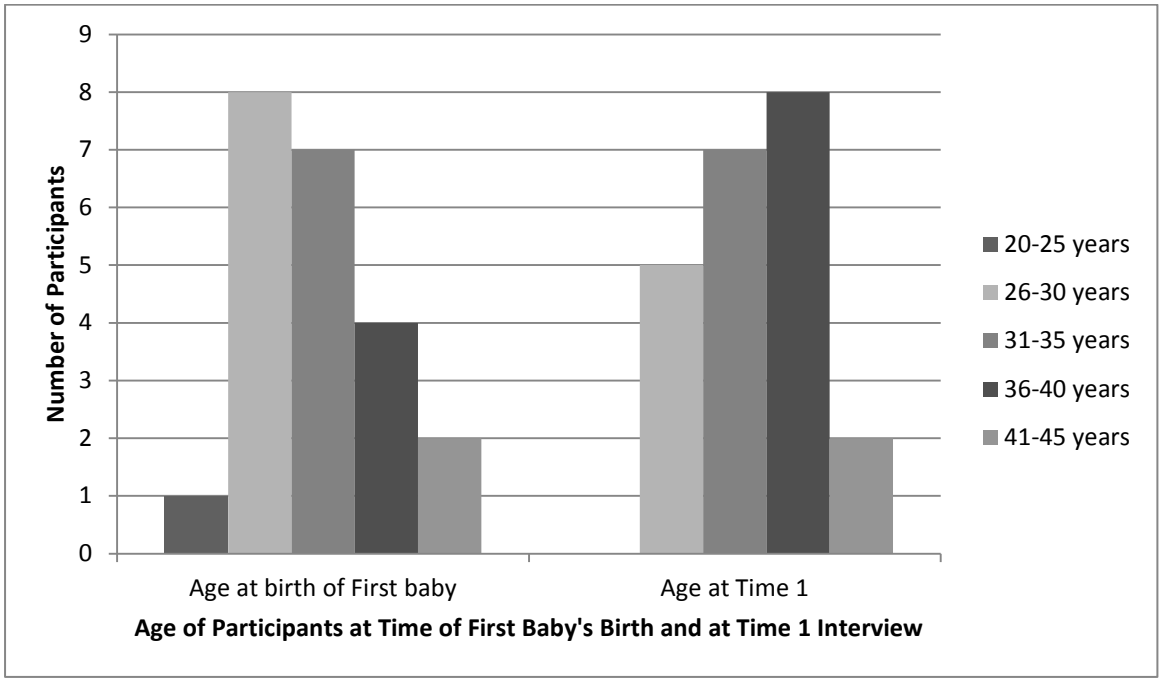
Two women did not complete the Time 2 interview, though gave their consent for the initial interview to be used in the study. Their Time 1 interviews were transcribed and reviewed, however the decision was made to exclude their data from the analyses for the purposes of this study. One of these women declined to be interviewed. The second woman was willing to be interviewed but had returned to work and we were unable to coordinate a time for the interview.

The women's first babies were born between 2001 and 2007 (most in 2005-6). At Time 1 they were aged between 13 months and 7 years with most children (15) aged 2-3 years. Four children were younger and three children were of early school age (5-7 years).

To protect the anonymity of participants individualized summaries of demographic and other information are not included. Detailed descriptions of the women and their lives and relationships are included in the analysis where relevant. Thus measures have been taken to disguise the women's identities by distorting details and not giving their age or the gender of their children. Changes have been made that do not compromise the integrity of the women's stories and circumstances. A condensed summary gives a description of the group of women who participated in this study.

When interviewed at Time 1 the women were aged between 24 and 45 years with a mean age of 36 years. At the time of their first child's birth the women were aged between 25 and 41 years with a mean age of 32 years. The distribution of the ages is shown in Figure 1 below.

Figure 1: Number of participants in each age band at time of the birth of their first child and at Time 1 Interview.



Seventeen of the twenty two women interviewed identified as Pakeha, NZ European or European. One woman identified as Māori/ Pakeha and named her iwi (tribal affiliation), two identified as English, one as USA European and another as South African European. Twenty of the women were married to the father of both their children. One woman was in a defacto relationship with the father of both her children. One woman was in a defacto relationship with her second child's father at Time 1 and was married to him at Time 2. All the first babies were born in Auckland except one, who was born in Australia prior to the participant returning to her home town, Auckland. All bar one woman described having post-high school training and qualifications including four in health fields, seven with business and human resources qualifications, five with Master's or Bachelor's degrees leading to teaching or librarian work, two with law, two in more creative outdoor or arts qualifications and one with an industrial qualification. The participant with high school qualifications described her work as a quality and training specialist.

Six participants had undergone fertility procedures, they described as In Vitro Fertilisation (IVF) treatment in order to have their first child. Of these women one went on to naturally conceive her second child. The five other couples once again used IVF to have their second child. Two other participants who had conceived naturally the first time, used fertility treatment to conceive the second child; one used a donor egg. The over-representation of

participants who had used IVF very likely related to an advertisement placed on the notice board of a large obstetrics practise. While it was not my intention to focus the study on this sub-group of women, the relatively large uptake on the invitation to participate from that site likely reflects the extra challenges for women requiring fertility treatment.

Interview Schedule

I conducted two in-depth interviews individually with each participant. The women were interviewed firstly when they were pregnant with their second child (Time 1) and then once again, three to four months after their baby was born (Time 2).

For both interviews I used semi-structured interview schedules (see Appendix G and H) to provide a guide for the conversation-style interviews. However, in order to gain more detailed narratives, open questions were used to encourage the women to tell their story in their own words and follow-up questions were used to clarify or probe for more detail (Riessman, 2008). The order of the questions in the interview schedule was not prescriptive and the questions served as a guide for areas to cover, with potential follow-up questions.

The Time 1 interview (see Appendix G) focused on the woman's experiences of first-time pregnancy, birth and motherhood. It centred on their expectations, their relationships (for instance with baby, father, family, friends, maternity caregivers and other professionals and agencies), and their experiences of and recovery from depression. The time 1 interview also focused on the participants current experience of second time pregnancy and how they were preparing for the birth and motherhood with two children. Some questions invited women to give a narrative of particular events. For instance "Can you tell me about your pregnancy and birth with your first child?" Other questions focused on finding out more about the material challenges and alternatively, the circumstances that were straight forward for women. For example "What level of care did your baby require?" and "How did your partner (used his name) adjust to the changes? What role did he (all couples were heterosexual) play?" Other questions invited women to describe their understanding or the meaning to them of particular identities, or experiences. For instance "What do you think lead to the "depression" (used participant's term)?" and "What would you tell other women who are depressed after their first baby?"

The Time 2 interviews (see appendix H) focused on the woman's experience of birth and motherhood with two children and centred once again on their relationships with significant people in their lives, any experiences of depression or distress, and their

understanding of the place of depression in their life now or in the future. All interviews were conducted by the author.

A noted above, the order of the questions in the interview schedule was not prescriptive and the questions served as a guide for areas to cover, with potential follow-up questions. Because the focus of the interviews was women's experiences of distress I had to keep in mind the potential that women would be feeling depressed/distressed when I interviewed them. One focus of the interview was thus how their current pregnancy was going and how they were coping currently. I also needed to make a judgement about how the interview was impacting on the participant. Several women did get tearful and upset recounting their experiences however participants did not wish to stop the interview when asked questions such as "Do you want to take a break?" or "Are you Ok to talk about this?" At the end of interviews participants were asked how they found the interview and no participants described feeling worse or distressed.

Procedure

This research was granted ethics approval in 2007 and adhered, in every respect, to the requirements outlined by the Northern X Regional Ethics Committee, for research with human participants. Locality approvals were gained for the three Auckland District Health Boards.

Recruitment

Women who volunteered for the study were residents within the wider Auckland area encompassed by the three Auckland Health Districts. Participants were recruited into the study through an advertisement (see Appendix A) and participant information brochures (see Appendix B) posted in public places such as maternity, obstetric and early childhood services, and through articles in local newspapers (New Zealand Herald, Papakura Courier and Western Leader). The advertisements invited women who were pregnant with their second child and had experienced depression after the birth of their first child to contact the primary investigator (myself) either by phone or email. They were informed that the study involved two interviews: firstly while they were pregnant (Time 1) and then about 3 months after their baby was born (Time 2). Information brochures (see Appendix B) were posted to participants who responded to the advertisements or who had heard about the research by word of mouth.

Ensuring that Māori who met the inclusion criteria would be given the same opportunity to participate as New Zealand non-Māori is an obligation associated with the Treaty of Waitangi. Good governance (Article One of the Treaty of Waitangi) carries a guarantee, not only of upholding the crown's treaty obligations, but also of providing governance that does not disadvantage Māori (Te Puni Kokiri, 1998). As a non-Māori researcher consultation with a Māori researcher (Erana Cooper (Ngapuhi, Ngati Hine), and mental health practitioner Moira Rapana, (Ngati Paoa me Ngati Pikiao), was important to developing the project and participant information sheets. It was also hoped that several characteristics of the study would improve access for Māori to participate. For instance, I used diverse modes for advertising the study and semi-structured interviews that focused on the individual context and social experience of women. By locating interviews at their own home or a place the participant chose, Māori (and others) would be able to have whanau (family) or support people present if they wished.

All women who self-identified as having experienced depression after the birth of their first child and who were currently pregnant with their second child were included in the study. While participants needed to be able to read and speak English in order to speak in depth about their experiences, no potential participants were excluded on this basis. When women contacted me as the primary investigator, a usually brief conversation was used to check that they had read and understood the information in the participant information brochure and, if not, issues were clarified and arrangements were made to supply them with the participant information brochure.

The conversation also allowed me to check that the potential participant met the criteria for the study. Of the women who contacted me and who were then not included in the study, one woman decided herself that she was not appropriate as her low mood after the birth of her first baby was related to the death of her brother rather than birth of her child. Another woman was scheduled to be interviewed and then sadly experienced a miscarriage. Several women had more than one child already or were not currently pregnant so were not included. There were also three women who contacted me after I had concluded recruitment. Although I had sent out letters to agencies thanking them for their help in recruitment, advising them that I had completed recruitment and asking them to take the information down, some agencies had not removed flyers.

The time 1 interviews took place between September 2007 and January 2009. The Time 2 interviews occurred between March 2008 and August 2009. The women were between 16 and 39 weeks pregnant at Time 1 with the average being 28 weeks pregnant. This meant there was broad variability in time between Time 1 and 2 interviews amongst participants. Time 2 interviews occurred when the second babies were between two-and-a-half and four-and-a-half months old for all but one participant, who was interviewed nine-and-a-half months after her baby was born. The reason for the delay in the second interview for this woman was that she had moved towns so we scheduled the interview the next time she was in Auckland.

The participants were given the option of being interviewed at home, at a venue organised by the investigator, or participants could nominate another interview setting. I interviewed all women in their own home except for one woman, who was interviewed at Time 1 in a private room at her workplace. I audiotape-recorded the interviews in their entirety, except for the period prior to beginning the interview, when I would once again give an explanation of the research. This period was an opportunity to build rapport and to answer any questions the participant might have. I also gave the participant time to review the consent form (see Appendix C and D), and at Time 1, I reminded them that it involved two interviews. At both interviews I reiterated key issues including: how confidentiality would be maintained and what would happen with their information; that they could withdraw themselves or any information provided from the study at any time during the interview or up to one month after each interview without having to give any reasons; that I would be contacting them in the week following the interviews to see if they would like the opportunity to talk about any issues or feelings that may have arisen in the interview; and that they could add further thoughts or comment on the interview during that follow-up phone call. At Time 1 I offered the participants a brief summary (up to one page) of the research results via email at the end of the study and an email or other address was noted for this purpose. At Time 2 I checked that their contact details for sending the results remained the same or updated them. They then signed the consent form (see Appendix C and D).

At the beginning of Time 1 interviews women were asked a set of demographic questions (see Appendix F) that included the woman's current age, age of their child, how many weeks pregnant she was, the due date of the second baby, her relationship situation, whether she was in paid employment, what job, how many hours per week and their educational qualifications. I also noted administrative details including participant code, date

of interview, that consent had been gained for both interviews, and the date and time of our second interview. The participant was also asked if she would like a summary of the research and how she would like to receive with contact details recorded. This information and the signed consent forms were kept in a secure place separate from all other research data. Following from this we would arrange a time when I would contact the woman, about two months after the birth, to organise a time for the second interview ideally about a month after the call.

At this point recording would begin. The interviews extended for 80 to 150 minutes for Time 1 and 60 to 114 minutes for Time 2.

I initially started the interview with a question about the participant's family however adjusted my way of beginning the interview with a question about how the participant found out about the study and what had prompted them to volunteer to participate which oriented the interview more closely to the study area. Also, family and social contexts arose within the women's stories of pregnancy, birth and motherhood so were followed up at those points. I would then ask them an open question such as "So how did things go the first time round, how was your pregnancy?"

Confidentiality

Participants were assured that the information given would be treated as confidential and would only be used for research purposes. Confidentiality was maintained by keeping participant contact information filed and locked separately from interview data. All participants were assigned a number and then subsequently a pseudonym. Pseudonyms were chosen to ensure they did not match the name of any other participant and by using on-line lists of the most common names for females born between 1967 and 1983. The names of children were changed to generic terms: [Baby], [First baby], [Second baby], for children up to 1 year old; and then [Child], [First Child], [Second child] for children over 1 year old. The name of the participant's cohabiting male partner and father of the baby was changed to [Husband]. This term was chosen as it seemed to match the status accredited to the men in the narrative. Most couples were married at Time 1 and all were married to that partner at Time 2. Several measures were taken to ensure that any writing, presentation or extracts taken from the interviews would not identify the participant and her family. Identifying details such as profession and residential locality were made more generic or distorted. A tension existed in the narrative analysis as contextual details are important for in-depth understanding. To avoid

identifying the participants I distorted aspects of their narrative that were identifying and I have not included in this thesis the detailed participant summaries used for facilitating analyses.

Only one participant identified as being Māori which raised a complicated issues regarding how to manage confidentiality while not ignoring culture. Article Two of the Treaty of Waitangi specifies the retention of Māori control over Māori resources. It was important to consult with Māori researchers and mental health professionals knowledgeable in the area to avoid misunderstanding or misrepresenting Māori participant accounts. Also the focus of this study was on the in depth understanding of the experiences of a small number of women. Therefore, it was not appropriate to make generalised statements from the data. This provided some protection to Māori in that statements cannot be made about particular cultural groups beyond the experiences of the individual women who told their stories. It was and will continue to be particularly important for me to emphasise this point in any forum that I present the study findings. In particularly, it was important that any findings that related to Māori people be offered to Māori workers in agencies that support women with young children such as Whanau centres and Māori Mental Health services. In this case I would have offered to come and discuss the study with a focus on a shared review of the relevance and implications of the study. Because the study involved very small numbers making generalisations about culture is inappropriate. Due caution and consultation with Māori was important to ensure that I didn't make generalisations while also not being "culture blind".

As only one participant identified as Māori it was impossible to make references to her culture in the analysis because it was so identifying. Within the interview I did ask about her identity and listened for ways she might conceptualise or tell her story that might relate to her being Māori. Her story shared many common themes to those of other non-Māori participants and so the aspects of her experience (such as whanau relationships) were captured but not named as cultural aspects of her experience.

Transcription

Transcription was completed by a professional service employed for this purpose and confidentiality agreements (see Appendix C) were signed by the transcribers involved. The interviews were transcribed verbatim in their entirety by professional transcribers employed for this purpose. While Riessman (2008) has suggested that transcription is a useful first stage for interpreting interview data, she also recommends that the investigator serves as

interviewer, “because the interpretive process begins during conversation” (p. 26). Because the interviews were long, I decided that professional transcription would be expedient. As I had completed all the interviewing of participants the interpretive process had begun during the dialogue and I continued to familiarise myself to the data when I listened once again to the audio-recordings to check the typed transcriptions for accuracy. There are many conventions for transcribing speech (Lapadat & Lindsay, 1999). In this case, all utterances were transcribed as well as pauses, laughter, the trailing off and/or “picking back up” of a sentence, and an indication that a word has been cut-off midway through speech (for transcription conventions see Appendix I). Because thematic and narrative analyses were used, transcription conventions were applied that maintained overall readability as opposed to the more finely detailed transcription necessary for conversation analysis or structural analysis with small samples for instance (Braun & Clarke, 2006; Riessman, 2008). The transcribed interviews were then uploaded to Nvivo8 qualitative data analysis software; Version 8 (QSR International Pty Ltd, 2008) to assist with analysis.

Thematic analysis of participants experiences of pregnancy, birth and motherhood first time.

The thematic analysis of Time 1 interview data began at the first interview. Familiarity with the data was developed by completing all the interviews and then listening to the recordings alongside the transcripts to check for accuracy. Each contact with the data was approached as an opportunity to develop an in-depth understanding of the individual case. Right from the first interview I formed notes and ideas relevant to the research questions. In particular I was interested in the women’s understandings of and the meaning they were making of particular life events including relational, bodily and emotional experiences as well as the material challenges or assistance (what helped or didn’t help) they experienced. I was also keeping an ear for the social discourses in which women were locating their experiences. The interviews focused on broad topic areas namely: Lifestyle before pregnancy, Pregnancy and preparing for first baby, Beliefs about motherhood, Birth experiences, Family, Immediate post-birth experiences, Paid work, Caring for babies, Experiences of postnatal distress, Naming postnatal depression (PND), Recovery and Coping, and Pregnancy and preparing for second baby. As cases accumulated, I began to identify repeated patterns (that became codes) both within and between accounts that related to the research questions. Each transcript was reread and coded according to the initial codes identified, as well as forming the evidence for new codes. The entire data set (both across participants and within each account) and coding were then reviewed to search for higher

order themes that related to the research questions and that usually combined a number of codes. Themes that did not have sufficient or less convincing data to support them were put aside. In this process the links between themes were identified and the influence of latent societal discourses was investigated. Three key overarching themes were identified and formed the basis for the analytic Section 1: Experiences of distress within the context of first time Motherhood and Mothering.

Narrative Analysis of social discourses and positioning of women, depression and recovery

Time 2 interviews were being completed even as I was continuing to interview new participants for Time 1. Consequently, I was immersed in stories of second time births and motherhood alongside those of pregnant women who were reflecting on their first birth and motherhood. This provided a strong sense of the consistent and contrasting aspects of the narratives that could then be analysed in more detail by reading each woman's two transcripts consecutively. In order to maintain the contextual richness of the data, the analysis focused on extended accounts and topic-centred segments from several participants. I coded the transcripts according to narrative plot, genre, tone, imagery, and use of metaphors. I also coded accounts that drew on or resisted dominant societal discourses (e.g., biomedical, intensive mothering, natural, neoliberal, risk discourses) and analysed the gendered context and consequences of these discursive actions. Accounts that identified the way the women were positioned or took up positions within the context of these discourses were also coded, and the consequences of this were explored. This analysis informs Section 2: Adjustment, Sedition and Recovery from Depression.

Section 1: Experiences of distress within the context of first time Motherhood and Mothering

Chapter 3

Brief Introduction

> ***My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do.*** (Foucault, 1983)

Put simply, motherhood is difficult. Taking on the task of caring for a baby has huge significance in our society. It can be conceived as the crucial resource for continuation of the species, and yet it is largely a project that is hidden within the infant's home. However, society dictates what happens in the home. Western society has developed and reinforced a regime whereby women are responsible for the primary, if not sole, caregiving to their infant children, and has dictated how this should be done. The dominant ideology of mothering in Western society is that of natural/intensive mothering (Arendell, 2000; Bobel, 2002; Choi et al., 2005; Miller, 2007; Sevón, 2012). The key aspects of mothering practice within intensive mothering are that women place the child's needs first and take on a deep emotional commitment as well as the time and energy to meet the child's needs and desires at every developmental stage (Hays, 1996). This sounds like demanding work, however within the ideology of natural mothering, women are positioned as natural caregivers with the instinctual ability to bond with and selflessly nurture their babies (Woollett & Marshall, 2001). Also, within this ideology, women are expected to find motherhood both rewarding and satisfying (Elvin-Nowak, 1999; Woollett & Marshall, 2001). In this way the difficulty of caring for babies is obscured. Following Foucault's (1983) argument, it is not that these ideologies of mothering are necessarily bad. On the contrary, they are likely to be good for children. It is that they are dangerous to women in a number of ways, which may account for the intense anxiety many of the women in this study described experiencing.

They are dangerous because, rather than being presented as just an option to aspire to (or not), they define what it is to be a ‘good’ or “bad’ mother. As motherhood continues to be viewed as a defining aspect of femininity, this also equates to being a ‘good’ or ‘bad’ woman (Arendell, 2000; Stoppard, 2000). Acknowledging ambivalent feelings about motherhood may be dangerous because it threatens women’s identities as “good’ mothers (Nicolson, 1998; Weaver & Ussher, 1997). Also, if women deviate from the practices of natural and intensive mothering , they risk social condemnation and moral judgement (Lafrance, 2009). These ideologies are dangerous because they become oppressive, dictating who can be the care giver to children and limiting the multiple ways that raising healthy, happy, children can be achieved (O'Reilly, 2004).

Thus, my project focused on women for whom the ideology of natural/intensive mothering was supposedly framed (Stoppard, 2000) and directed at (O'Reilly, 2004), namely middle- and upper-class women. In New Zealand there is a certain reluctance to define people in class terms. Perhaps this is because of our colonial and Pacific roots we react against the hierarchical system of British society and understand ourselves as more egalitarian. However, social inequities have increased here, as in other Western nations, and the group of participants in this study were remarkably homogenous in being mostly financially stable, living in a home they owned and all in heterosexual relationships, with all but one living with the father of both children (at least at the time I interviewed them).

Understanding their experiences of distress during first time motherhood provided a window into the particular material and relational challenges that this group of women faced and how they managed these within the context of the discourses surrounding pregnancy, birth, and motherhood. As has been found in other studies of motherhood, this group of women described motherhood as more difficult than they expected. They each described experiencing distress during the first months of parenting their young babies, which they had at some point identified as “postnatal depression” or “depression”. In describing their experiences the women generally contextualised their accounts of distress within a sequenced narrative of their experience of the birth, early parenting and their relationships with their baby, husband, family, friends and health professionals. They also talked about the preparations they had made for having their first baby, which had often been significant (e.g., moving countries, fertility treatment). This section provides understandings of the restraints on women that created their feelings of distress as mothers. Section 2 then focuses on the

ways in which women grapple with these restraints to come out of postnatal distress well enough to consider and take on the project of second-time motherhood.

This section, focused on women's experiences of postnatal distress, is divided into three chapters. In Chapter 4, I explore the women's accounts of their experiences of distress as first time mothers. In Chapter 5 the women's expectations of motherhood, themselves and their babies provide an understanding of the discourses in which they located their lived experiences of motherhood. Chapter 6 focuses on the material challenges that dominated the experiences of motherhood and mothering for this group of women.

Thus, in Chapter 4, I first outline the diversity of emotions that formed women's experiences of postnatal distress. I then focus on five issues that predominated their responses to the challenges of first time motherhood: feeling overwhelmed by the responsibilities of first time motherhood (related to several issues including to the primary care giver role, the fragility of the new baby, the breastfeeding mandate, and being faced with the losses they were experiencing); shock associated with managing the demands of motherhood particularly; anxiety and fear associated with "getting motherhood right" and "keeping up appearances" to avoid other people's judgement or critique; and finally feelings of loneliness and isolation. The women narrated their distress within accounts of their changed lives and relationships. Thus understanding their contact with the significant people in their lives (husbands/partners, visiting midwives, and coffee groups) formed a part of the exploration of the women's accounts of distress.

In Chapter 5 I focus on the women's accounts of their expectations of motherhood and parenting young children. These accounts gave an indication of the societal and experiential knowledge that women brought to first time motherhood. While several women described being unprepared for motherhood or, as Mary said: "I don't even think I thought about it", assumptions they had made became apparent as they described their surprise at how unexpected aspects of birth and baby care were. I identified key ideas that the women raised were in line with natural mothering ideology. The women understood motherhood to be easy or 'difficult but not that difficult', themselves to be capable and babies to be idealised or trainable.

It is usual to experience exhaustion, sleep deprivation and disruption to daily life when caring for an infant. In Chapter 6 I explore four key challenging circumstances that compounded the difficulty for the women in managing early motherhood and caring for their

baby. The four challenging contexts were: traumatic and/or difficult births; women's physical health problems; infant health and feeding problems; and a lack of practical assistance and useful information and advice. Advice was not always viewed as acceptable. Instead advice was framed as acceptable when it was respectfully cautious, timely, and from a trusted and respected source (usually an experienced mother). The most striking aspects of these contexts for distress were how challenging they were for women and how hard women worked at motherhood despite them. It would seem that in some instances the discourse of intensive mothering trumped that of biomedicine. Women's physical ill health did not provide an excuse for shirking on motherhood. Thus, while this section focuses predominantly on the discourse of natural/intensive motherhood, I also identified the influence of the biomedical (particularly with respect to birth and breastfeeding), neoliberal and risk ideologies which predominate in Western society today.

Chapter 4

Stories and Symptoms of Distress

Each of the participants described her own individual experience of distress and the feelings named included anger, anxiety, depression, detachment, exhaustion, failure, fear, guilt, hopelessness, isolation, loneliness, being overwhelmed, responsibility, sadness, and shock. Several women described experiencing urges to abandon their child and family, and three described experiencing thoughts of suicide. Several women described fears that they might accidentally harm their child and one voiced thoughts of putting her child in danger (leaving the baby near the edge of the bed). None of the women described acting on these thoughts. These feelings, thoughts and urges cross many diagnostic categories but were consistent with those listed in a screening tool for postnatal depression (The Edinburgh Postnatal Depression Scale (EPDS) Cox, Holden, & Sagovsky, 1987) and experiences described in two phenomenological studies of postnatal depression (Beck, 1992; Wood, Thomas, Droppleman, & Meighan, 1997).

The meaning and intensity of the feelings was more clearly portrayed within the stream of speech that the feelings form the subject of. This is illustrated by these three very different accounts of feelings;

> I was feeling sad, I was feeling overwhelmed, just sort of out of my depth really, and just lonely, anxious, anxious all the time sort of so wound up that I couldn't kind of unwind. Michelle

> Just, on the one hand detached, on the other hand really angry. I, I just, I didn't, it wasn't that I was angry at anything but I was just too tired to, to, to react with anything except sort of, I guess aggression to anything that was, that was pushing me. Pamela

> I just feel, just not the same person...Yeah I just don't like it at all...this might sound a bit cliché but I just get a bit, I get really down. I feel like I'm just...yeah really down and like I'm in a pit and that's, you know it's always going to be like that. Amy

These three women used adjectives and metaphors that emphasised the intensity of their feelings such as "so wound up", "really angry" and "in a pit". They also describe

multiple feelings, even contrasting feelings as with Pamela who compared feeling detached with feeling angry. Another contrast in the women's accounts of distress was that despite the distressing feelings, most, though not all the women also described experiencing positive feelings such as love and attachment to their baby. Some like Donna positively compared their experience to those they had read about, usually referencing Brook Shield's (Shields, 2006) memoir of her experiences postnatal depression that included thoughts of harming her baby.

> I just couldn't stop crying I just couldn't, I couldn't, I just felt like my life was over and the good thing is, and this is where when I've read other people's experiences of postnatal depression that I think I'm lucky, that I just remember cuddling [baby] and actually that making me feel better and more like oh I can, you know like that actually the cuddling him/her kind of did make me feel better. Donna

Here, Donna describes the act of cuddling her baby even while distressed. This is another example of the complexity of emotional responses that did not easily fit diagnostic categories that generally only focus on negative (distressing) symptoms.

There were however, four significant patterns to the women's accounts of distress. These related to; the overwhelming responsibility many women felt associated with motherhood and mothering, the shock and hardship of motherhood, anxiety associated with trying to get it right and finally the loneliness and isolation as women coped alone and kept up the appearance of coping. I will now describe each of these patterns of distress in turn.

Overwhelming Responsibility

Underlying all the responses to first time motherhood was the seriousness with which most participants approached caring for their baby, as Cynthia described how "someone like me late thirties having babies we're so earnest about having to do it, whereas if you're a younger one you just go with the flow. We take it so seriously our role." While Cynthia related this to age, younger participants such as Mary and Amanda, both in their 20's, also took their responsibility very seriously. All three followed the intensive child focused feeding and care regimes currently considered optimal practice for caring for infants across western countries (Hays, 1996; Miller, 2007; Sevón, 2012).

The seriousness with which the primary care giver role is taken by women was demonstrated by 11 women who continued the role despite their own health issues. These health issues were related to pregnancy conditions (e.g., two women experienced a skin rash called pruritic urticarial papules and plaques of pregnancy or PUPPP) and/or post birth complications (e.g., infections in uterus or caesarean wound) or breast infections. For some women like Monica, the health problems caused significant pain but representations of "good, nurturing mother" were prioritised over her own wellbeing.

> I'd done so much reading to prepare myself with what to expect and how to be a good nurturing mother, and I really wanted to be that. So I made sure that [baby] had floor time, and I was down there with him/her, but the pain was, but it wouldn't stop because of the pain and that's, I guess it's sort of the person who I am, I don't, I'd rather push through the pain and do what I know is right, and what feels right.
>
> Monica

Monica indicated that this kind of interaction with her baby was central to her understanding of "good, nurturing" mothering. She followed with the developmental rationale for why she believed this was necessary: "I probably made it much, much worse by doing that, because I didn't want to not give him that time, because the first, well year or two is so important." This understanding draws on discourses regarding the importance of stimulating pre-school children in order to facilitate their intellectual and physical development. Taken from psychological studies of development, these ideas have become part of popular parenting literature and the discourse of good mothering (Hays, 1996; Woollett & Phoenix, 1991; Woollett & Phoenix, 1996). These studies have been criticised for focusing exclusively on the "needs" of children while ignoring the lived context in which these supposed needs might be met and the circumstances and experience of the mothers they portray as responsible for meeting them (Woollett & Phoenix, 1997). The implicit threat operating for Monica is that the learning for her child will be compromised without her input. This provides some indication as to why a woman would compromise her own health or comfort in these endeavours.

Another social pressure on mothers that can have a high cost is the strong cultural imperative for mothers to breastfeed (Blum, 1993; Crossley, 2009; Wall, 2001). In New Zealand, since adopting the World Health Organisation International Code of Marketing of

Breast-milk Substitutes (World Health Organisation, 1981) the increased promotion of breastfeeding has resulted in significant changes of practice within hospital birthing units, focused on encouraging and teaching women the art of breastfeeding. Linda is an exemplar of the endurance required (by several women) to prioritise feeding their infant what is presented as 'nature's perfect food'. Despite having an "abundance of milk" Linda suffered "bad cracked nipples and … mastitis" which made her sick: "so, I was in a full body sweat every time I put [baby] on, it was so sore I was crying…the pain was so bad and so I started expressing, so I ended up expressing until she/he was about nine weeks." However, Linda then experienced a breast abscess which she described as "a shocker so she [medical specialist] aspirated that and then went back a few days later and there was another one and she [medical specialist] said 'right, you've got to stop feeding now.'" Medical recommendation seemed to give the mandate for Linda to stop feeding her child breast milk. This was something she did not initiate on her own despite the pain and cost to her health. As she described "the only good thing about that was that someone told me I had to stop." As we will see in Section 2 on recovery, medical diagnosis and prescription appear to have a power to override strong cultural imperatives regarding women's responsibilities to prioritise their children over themselves.

Another indication of the power and impact of motherly responsibility was the finding that over half the women talked about this feeling and understanding explicitly. As Kimberley described "just the huge, I don't know if I put it on myself, just the feeling of I'm responsible for this little [baby]…..and probably not letting, I probably should have let [Husband] take some of that as well. And he would of." Her statement attests to the strongly gendered nature of child care responsibilities and once again highlights the cultural ideal of the indispensable mother as primary care giver (Miller, 2007). Michelle's experience of a broken tooth was her example of her sense of having to be there for her baby at whatever cost as she recalled thinking at the time "Oh no I can't be away from him/her for more than like, so long, because I've got to feed him/her again" and in retrospect stated that she had, "let it [the responsibility] take over a little bit, I don't know, it ruled your life a little bit too much."

Women described different aspects of their responsibility that were overwhelming including the dependence, neediness and perceived fragility of their baby as Linda said "here's a baby, it's not about me, they're completely dependent, you know I have to be their source of life and care" and related this to how she felt "overwhelmed with responsibility." Dawn similarly viewed her child as dependent and needy: "Yeah just having this, having this

being (laughter) there all the time with being so reliant and so helpless sort of thing yeah was quite mind blowing yeah."

Feelings of responsibility were related by many women to both the difficulty of motherhood and the loss of independence this entailed as Jennifer described:

> that terrified me, I think, that whole ultimate responsibility…I think it's just that, it is such a shock to your system when you have a child and you're used to working and doing your own thing and not being responsible for anyone and then you're like, oh my God, ahhh. Jennifer

Loss of independence and the freedom to go to work each day as their partners continued to do, was raised by several women and was also related to their sense of isolation and loneliness as will be described below. Firstly, I will focus on the "shock to your system" that Jennifer termed the lived experience of motherhood and which many women had described as the "overwhelming responsibility" of the job.

The Shock of Motherhood

The shock many women describe experiencing when they become mothers for the first time has been linked by several authors to the difference between the overly optimistic societal presentation of motherhood and the actual hard work and demanding nature of caring for babies (Miller, 2007; Weaver & Ussher, 1997). Similarly in the present study, many women described the reality of motherhood and caring for an infant as more difficult and less enjoyable than they had expected, as Jennifer described: "I guess a bit disappointing really, to have this thing[motherhood and baby] that you had put all these expectations into turn out to be not fantastic."

The shock that many of the women in this study described experiencing seemed to relate to two main issues: unexpected birth trauma and difficulties in the case of 7 women, (which I will described in Chapter 6: Contexts for Distress) and shock that motherhood and the work of caring for babies was for most participants so much more demanding, more emotional and/or lonelier than they had expected.

The difficult aspect of child care usually related to the demands of infant feeding particularly with children who fed very frequently or had difficulties with feeding and/or weight gain. Learning the art of breast feeding was something many women found more difficult and technical than they expected. As Lisa described; "I didn't realise that they, that

babies take an hour to feed [and] that breastfeeding would be so painful". New babies generally require more frequent feeding through the night and the practice for increasing weight gain for children of low birth weight or slow weight gain appeared to be more frequent feeding. The combination of a demanding feeding regime with broken and shortened sleep lead thirteen participants to identify tiredness associated with sleep deprivation as one cause of their distress. For instance Linda described her experience of how "the first three weeks I probably cried every day, just would, don't know why, just felt, just sort of I think I felt completely overwhelmed and sleep deprivation definitely doesn't help."

Alongside the demanding requirements of infant feeding, feelings of stress and anxiety were attributed by some women as the cause of problems with sleep. For instance, Julie described experiencing "anxiety induced sleep deprivation" which she termed "that sort of overtired I'm so overtired I can't sleep." Anxiety that affected sleep, often arose as the women attempted to achieve the tasks of motherhood in the way they believed was expected. This will be discussed in the next section where I focus on women's expectations of motherhood.

The combination of demanding work load and sleep disruption, alongside concern for their babies and whether they were able to do the job, lead many of the women to become exhausted, anxious and tearful. Half the women described crying frequently (over many days or weeks) and being surprised at their reaction. Four women (Linda, Kimberley, Michelle and Donna) described this as being very "hormonal", attaching a feminine biological explanation despite having given an account of very stressful circumstances. Amy and Michelle attributed this change in emotions to a sense of "not being themselves". Michelle described her response at the time as:

> I think you just have no appreciation of how you're gonna feel and how crazy your hormones are, and that whole like feeling like you're gonna cry all the time and I laughed a lot in that time too, because it was a bit laugh or cry…I remember that sort of you're 'always, sort of, teetering on the edge emotionally'…and that's that person that I was then I didn't understand and I didn't have any, didn't really feel that that was me and so that was a weird thing. Quite aside from her, it was sort of like I was a person I didn't recognise, and that was a little bit scary. Michelle

Michelle's use of the third person to describe herself in the statement "quite aside from her" reflects her sense of disconnection from herself at the time and her use of the term "weird" gives a sense of her bewilderment about her responses.

Several women described feeling that their lives had changed irrevocably, for instance Lisa who stated that very soon after a very difficult birth "no one really seemed to give a toss you know life was just going on for everyone yet mine was completely over." Lisa, like other women, also had the sense that the hard work was never going to end: "this baby was never ever going to be any different and this was my life for the rest of my life and I'd made a huge fuck up". For many, their sense of time seemed to elongate and the hardship was perceived as all-encompassing and forever. This was particularly the case for the women whose babies experienced low weight gain, colic, reflux, asthma and eczema as Wendy poignantly describes "it was kind of just feeling hopeless and helpless that you know it was just going to carry on like that forever. That my baby was going to carry on screaming, and I was going to carry on not enjoying it"

The unrelenting nature of the work of child care was described as unexpected and distressing by eleven of the participants. For instance Melissa said her child "became known as Miss/Mr Spilly" because s/he vomited "just constantly, in her/his cot, all over you….everywhere." Melissa described how she "just trudged on as best I could". Melissa used humour to manage this difficulty, however, her repetition of how she "trudged on" over the course of the interview highlighted the endurance test she felt she was undertaking.

The unexpected hardship set alongside women's expectation of something very different also had the effect for a number of women of judging themselves as inadequate. At this early stage of motherhood they did not seem to have the confidence, experience or knowledge to question whether the standard was attainable. As Jennifer eloquently describes:

> I remember a conversation with, with [Husband] in which he said, 'Well aren't you happy?' and I said, 'Well some of the time, yeah, when things are going well, I'm in, you know, I'm it's good, but it's not good all the time, and most of it's really, really hard.' And he was kind of, a bit appalled that I should not be happy, having kind of in theory got what I'd wanted for all this time. And I found that difficult, I guess, and was probably some guilt attached with that, because you think, 'Gosh I've, I've we worked so hard to have this baby and I've got this healthy baby, well reasonably,' and, you know, 'I've got a supportive husband I'm not on my own we're not

> destitute,' you know, 'Shouldn't I be happier than this?' And so there is a bit of a, you know, then you do start feeling a bit guilty about it. 'Oh why aren't I enjoying this more?' and it's easy to look at other people and think that they are all having an easier time than you. Jennifer

Jennifer's statement highlights the highly moralistic language ("shouldn't I") that is associated with societal ideas of motherhood including that mothers should find it satisfying and rewarding. This leads women to feel guilty when they do not feel altogether positive about motherhood (Elvin-Nowak, 1999; Hays, 1996; Weaver & Ussher, 1997). Having "worked so hard" is another key aspect of Jennifer's account. It perhaps reflects her disappointment that despite hard work she has not got the positive outcome she expected. Working hard and trying to meet the expectation of having a contented and happy baby and self was a key aspect of many of the women's experience of motherhood as will be discussed next.

Getting it Right

The most common feelings described by the participants as part of postnatal distress were anxiety and fear. These feelings sat alongside the common experiences of overwhelming exhaustion and sleep deprivation. Anxiety and fear were attributed to attempts made by the women to "get it right". That is, manage the tasks of motherhood, caring for babies and maintaining their couple and family relationships.

Getting motherhood right (beyond the experiences of birth) begins with bonding or attaching to your baby with what Jennifer described as having the "feeling that people talk about [of] overwhelming love". As Jennifer's account demonstrated, participants were aware of the societal discourses of the instinctual and natural nature of women's feelings of love and care for their babies right from birth (Bobel, 2002; Hays, 1996). Consequently, ten women described feeling disappointment and guilt at the lack of the expected feelings of 'bonding' for their baby immediately after birth.

The women managed this in different ways. Two women, Lisa and Jennifer, both experienced emergency caesarean births and attributed their feelings of disconnection, for several days after the births, to pethidine medication they had received. Both dealt with the initial feelings of disconnection from their baby and mothering, by passing as much responsibility for infant care to other people as they could without drawing attention. Both described experiencing an unspoken rejection of the primary care giving role. Over time, both

women began to take on the care giving role with practical assistance from family and friends. Lisa also gained intensive home based assistance from maternal mental health services. The 8 other participants initiated and continued to provide the primary cares for their child from birth. Over the course of days for some and up to a year for others, all ten women gave an account of how they developed stronger feelings of connectedness and love for their child. The women, who took longer to develop feelings of love and attachment, described on-going feelings of guilt and regret. They were particularly concerned for any lasting impacts on their child, having likely read on line and in child care literature about the effects of postnatal depression and lack of attachment on children. 'Getting motherhood right' also meant meeting the care needs of their child and seemed to relate to all baby behaviour and in particular, sleep, feeding and crying.

Infant sleep appeared to be a project for many mothers who attempted to rigidly follow advice from parenting books popular at the time. For instance Jennifer described being "really anal about the time s/he'd go to bed and how long, waking him/her up". Cynthia followed advice from "about three books and they'd all be similar stuff but slightly different." According to Cynthia the books specified that you "don't let your baby fall asleep on you cause that will be a habit that you won't be able to break …..They've got to learn to sleep on their own. So I never felt as if I could walk around holding, cuddling [Baby]". This account highlights the anxiety engendered in following these "rules". It also shows the cost to Cynthia who lost opportunities to enjoy early motherhood and the sensual experience of cuddling her first child. She planned to cuddle her second child as much as possible.

In order to get infant feeding right, women are required to breastfeed. As discussed above exclusively breast feeding infants for the first 6 months was and continues to be the strongly sanctioned practice of the time (Crossley, 2009; Ministry of Health, 2009; Wall, 2001). In line with these guidelines, all the participants (except one who had a breast reduction that prevented breast feeding) initiated breast feeding and 8 continued longer than the 6 months recommended. The discourse presenting breastfeeding as an innate, natural response has been diminished by the intervention of hospital midwives and lactation advisors who teach the skills and techniques of breast feeding. Unfortunately, advice and techniques can be presented as or assumed to be inflexible rules. This is illustrated by Cynthia's account of how she conscientiously followed rules around feeding and was shocked by her sister-in-

laws flexible approach; “you can’t split feeds. You know, you can’t, that’s snacking, you can’t do that.”

Crying was presented as the baby indicating some need and “getting it right” seemed to be about the mother deciphering and responding to the need and soothing the baby to stop the crying. Participants described feeling very judged and distressed if their baby cried in public places. Women whose babies cried a lot tended to avoid public places where possible, remaining at home to evade the perceived critical gaze of other people.

The women most commonly responded to the challenges of child care by working harder (using breast pumps in conjunction with breast feeding for instance), and problem solving using written material, advice from health care providers and family members. The women seemed to readily let go of ideas of the instinctual nature of breastfeeding, for instance, and the ready access to midwives and advice early in the process seemed to facilitate this. Concern for their child’s health, the perception that it is possible to “civilise babies” (Dykes, 2005) and the women’s sense that it was their role to facilitate this, meant that many women described feeling anxious when strategies were unsuccessful or, as in the case of breast feeding, were difficult to evaluate.

Consistent with Dykes (2005) study of early breast feeding in maternity units, many women described experiencing a lack of milk supply whilst in the maternity unit before their “milk came in”. Problems with early milk supply and initiating breast feeding was attributed to the mode of birth by the women who experienced caesarean births. For instance, the two women (Lisa and Erin) with the shortest duration of breast feeding (8-14 days) had experienced emergency caesarean births and significant health problems that made breast feeding very uncomfortable. Two of the three women whose children were described as slow to gain weight also had experienced caesarean births. These were very different experiences as Cynthia described a planned caesarean while Pamela experienced a preterm emergency caesarean and significant health problems after a traumatic birth. Of the three other women who had caesarean births, Dawn described problems with her milk supply in hospital that became a stressful focus of her time there, as she was given strategies to stimulate her milk and advice which she starts this account with:

> Yeah a bit you know this is how you hold her and you know and also as far as trying to get your milk to come in they were trying to give me very you know put us on to various sort of health products and things that would try and stimulate you know the

> milk and everything like that. But I mean none of that seemed to actually, actually work so it was getting all way more stressful than anything really yeah which obviously doesn't help the milk coming in. Dawn

Laura was the only woman who experienced a caesarean who did not describe problems with breast feeding initially and continued to breast feed her child for 3 years. The final woman had a breast reduction that precluded feeding.

Over half (12) the women in the current study described being concerned about whether they had insufficient breast milk to meet their child's need after their "milk had come in". This was a significant cause of worry and anxiety. For instance, Mary described how she "used to worry that I wasn't feeding her/him enough" despite the fact that her baby "was a real bonnie [baby] and my aunty would just say to me 'Rebecca you feed her/him all you know[the time] like s/he's absolutely fine.'" Some women described worrying about their supply of milk when their children had slow weight gain and did not seem at the time to be able to let go of this worry even when expressing milk showed adequate quantities. For example, Michelle described being:

> "very anxious and worried … that s/he wasn't putting on weight,…..that there must be something really wrong with her/him, or with me, and maybe I wasn't feeding her/him enough and, and so I was drinking all sorts of revolting herbal concoctions to try and help that situation (laughter). When actually looking back I don't think I [did] cause I didn't really have an issue with expressing or anything." Michelle

Dykes (2005) attributed this mistrust that women have in their capacity to meet the nutritional needs of their infant to the influence of discourses of femininity which "construct the female body as weak, defective and deeply untrustworthy". She also identified how the "techno-medical paradigm" that is predominant within the practices of western pregnancy, labour and birth, undermines women's sense of their own capability. Consequently, Dykes (2005) suggested that the women she interviewed viewed their breasts as "potentially faulty machines" because of these discourses.

Similarly, participants in this study seemed to distrust and question their capacity to provide sufficient sustenance to their infants by breast feeding. Dawn provides an exemplar of the distrust and questions around breast feeding she described experiencing when she left hospital with her new baby.

> "Yeah well I would have liked to have a bit more time particularly from the feeding aspect of it to at least have had one or more sort of full days that you know I was doing the feeding and someone was saying, 'Yes that's right, no that's wrong.' Your know see s/he's doing this and it means s/he's getting I mean obviously you can't see how much they're getting that's the problem with breast feeding where if you've got a bottle you know how much they've had. So you know is my milk flow enough, is it not you know am I starving my child you know you've just got no idea…"
>
> Dawn

This dramatic statement regarding the potential risk of not adequately feeding her child was reflected in many of the women's talk around the tasks of parenting and fuelled the anxiety they described experiencing. As Mary said; "so worrying that I was doing something wrong or something that it was going to affect [baby] psychologically for the rest of her/his life".

Mary's concern about the lasting impact of her behaviour on her child's development may seem extreme; however, it compared almost directly with an extract presented as an example of the pervasive medicalisation and risk construction of infant feeding cited in an Australian study of breast feeding literature, that is "There is growing evidence that infant feeding affects the immune system for life, and affects subsequent generations." (Williams, Kurz, Summers, & Crabb, 2013, p. 345). This focus on risk reflects the neoliberal focus on individual responsibility for health and the dangers of not following health and child development guidelines. The risks are made both explicitly, as above, and are implicit in the messages strongly promoting child-centred parenting and the benefits of breastfeeding (Wall, 2001; Williams et al., 2013). Breastfeeding and child-centred parenting are equated with good mothering (Blum, 1993; Wall, 2001) and an interview study by Murphy (1999) identified ways women who used formula feeding described their own feeding practices to avoid or refute being labelled as deviant because of their "failure to breastfeed".

The women in the current study also described ways in which they avoided being seen as inadequate as a mother. Most commonly they did this by hiding their distressed feelings and continuing to problem solve and work hard alone. This forms the focus of the next section.

Keeping up Appearances

Seventeen participants talked about various ways they tried to manage other people's perceptions of them as mothers. Women subjugating and silencing their needs within the

context of couple relationships and family responsibilities has been hypothesised as a cause of their experiences of depression (Jack, 1991; Jack & Ali, 2010) and premenstrual distress (Ussher, 2003a). It is proposed that women take this action because of societal discourses of what it is to be a 'good woman' and a 'good mother', which position women as the caregivers in relationships. The 'good woman' in the family is conceptualised as one who subjugates her own needs for the sake of her children and couple relationship. The neoliberal focus on personal responsibility for monitoring and managing risk (Petersen, 1996) further isolates women as the arbiters for maintaining their own and their family's security and wellbeing. Murphy (2000) in her study of women's accounts of formula feeding, identified the way in which the ideology of motherhood underpinning the women's accounts was consistent with that of neoliberalism, that is, "they constituted themselves as active, responsible, rational and autonomous with a duty to foster their babies' health" (Murphy, 1996, p. 319). Another potentially silencing aspect of neoliberal ideology is the idea that "mothers should be in control of their emotions" (Williams et al., 2013, p. 350). This was a theme identified in the study of how infant feeding as constructed within child care materials by Williams et al.. The cultural preference for focusing on how mothers can adjust more to the role rather than situating motherhood itself as the problem was identified in a study of popular American magazines and advice books (Held & Rutherford, 2012). Consistent with this, a study of Australian magazines found they foreground an individualising discourse of women's depression as a problem of self-management while also referring to biomedical expertise (Gattuso et al., 2005). To summarise, all these studies identified discourses that identified women and mothers are responsible for controlling their own emotions in general and depression in particular.

These discourses may go some way to account for why many of the women in the current study did not seek assistance in the early stages of new motherhood and went to efforts to hide their distress or as Jennifer puts it, "keep up appearances". Jennifer referenced family values "to never show weakness and … you should always keep up appearances" as her reasons for actively ensuring that no one, other than her husband, was aware of her postnatal distress. Seven women used various descriptors to describe ways they disguised their real feelings. For instance Linda described "putting on this face of everything's okay", while "churning up inside". Other descriptors used were "coping face", "a front", "fake frame", "happy façade" and "the mask". The 17 women who talked about keeping up appearances, described who they would and would not talk to about their own distressing

feelings or their child's difficult health and behaviour problems. They also talked about why they were restrained in this way.

Husbands/Partners

The person most likely to be aware of the women's distress, not surprisingly was the person living with them. Most participants shared their distress, or at least did not try to hide it, from their partners. As Lisa described; "he's the one that I suppose cops it, he's the one that probably sees a lot, my friends wouldn't have a clue." However many other women were more cautious about expressing their negative thoughts and feelings. This was framed by some women as an attempt to shield their husbands from their negative feelings. For instance, Susan "didn't want to tell [Husband] what was going on because I thought 'Oh poor man, he's lost his job, don't want to stress him out anymore.'" In this case Susan prioritised supporting her husband with his distress.

Alternatively several women described more self-protective or strategic reasons for not telling their partner/husband about their feelings of distress. For instance Mary described her concern that telling her partner about her feelings would avert the focus from his problem behaviour. Mary described her fear "that everything would then therefore be related to the postnatal depression rather than anything to do with his behaviour …which was complete disengagement from the family". Mary had voiced her awareness of the "stigma of mental illness". Her action of actively avoiding talking about her distress works to defend against being disenfranchised by being labelled postnatally depressed. It also acts to maintain the focus of her distress (potentially anger and hurt) on her partner's disengagement,

Two women, Linda and Lisa described having thoughts of how they could "escape" from the responsibilities of motherhood, including thoughts of suicide, leaving home alone, or of how to relinquish care of her baby- by giving the baby to husband or leaving the new baby on the edge of the bed so that the baby would fall (unlikely with a largely immobile new baby). Both women said they did not want their partners to be aware of these thoughts or "know the extent of me working out plans to escape" (Linda). The reason they did not talk about these thoughts may relate to the medical and psychological conceptualisations of these thoughts as reflective of the woman as 'at risk' or 'risky' as a mother (Murray & Finn, 2012). Both women may have been weary of potential repercussions of voicing the thoughts.

Clearly women were strategic in whether they did or did not tell their partners about how they were feeling and it may be that for some this was in part to avoid burdening their

husbands. More often, “not talking” about problems with mood or child care acted to prevent negative judgements being made about the women themselves and their abilities as a mother. Melissa describes how her husband was aware that this talk about child care would be distressing for her. She described how he “deferred” child care decisions to her and would not make suggestions for how to manage their baby’s very difficult screaming because “probably [he thought] that I would get upset”. Crossley (2009) conducted an autoethnographic study with her partner of their experience of the first weeks of caring for their first baby and he provided an explanation for his reluctance to take over an aspect of his baby’s care:

> “He was your domain. Your whole identity had been formed around being there for him, and in effect, for me to have done that would have been like saying you’re not to be trusted to do what’s right by him….I had to be very, very careful, criticising because I could see how important it was to you.” (Crossley, p. 80)

In the present study, Cynthia’s experience was an example of how her husband’s advice and monitoring of their baby’s weight gain problems was experienced as undermining. Cynthia described feeling “totally tense and anxious and totally undermined, had no confidence at all” when her husband became concerned and strongly advocated moving from breast feeding to formula because of concerns for their baby’s weight loss. It seems that in the early stages of motherhood women attempt to fulfil the perceived ideal of the strong exclusive mother-infant attachment. As they are just beginning to develop a sense of identity as a good mother, they may not have the confidence to withstand critique or question from the child’s father or anyone else. As Melissa said, letting people know she needed help would be “Admitting I was a failure.”

Midwife

A more surprising finding was that many of the women said they had not and would not discuss problems beyond some child health issues with their visiting midwife or the women in their coffee group despite the fact that these two New Zealand initiatives are in place to support first time mothers in the early weeks of caring for their baby. After birth the lead maternity carer (LMC) (usually midwives, though some doctors and obstetricians also carry out the role and the role can be shared with other health practitioners), according to guidelines, will continue “to provide maternity care which includes monitoring you and your baby’s health and providing you with the information you need to make decisions about your health and early child health care for 4-6 weeks after birth” (Ministry of Health, 2011). The

LMC is expected to visit the woman at least 7 times after birth including 5-10 home visits before transferring care to a "Well Child Provider", usually Plunket, who describe themselves as "the largest provider of free support services for the development, health and wellbeing of children under five in New Zealand" (Plunket, 2012).

Many of the women did not become distressed until after their midwife had completed the visits; however, of those who did feel distress during the early stages, six described having difficulty telling their midwife how they were feeling, but for three different reasons. The first two wanted to live up to the good patient they thought they were expected to be, the second two experienced their midwives as actively unsupportive and the third two found their midwives just didn't have time.

Firstly, Lisa and Donna described how they tried to be 'good patients' because they liked and respected their midwives. Lisa's midwife was also a friend "which was really nice having someone so personal but it was also really hard because I was I'd heard all her thoughts and feelings about natural labour, natural births, breastfeeding um and what a good patient is and so I was determined to….be a good patient and not be too much hassle". Donna described how "I liked her kind of like she was sort of staunch and cool I kind of tried to put on, I remember once breaking up and starting to cry and then you know go 'oh I'm sorry, I'm sorry, I'm sorry I'm just' you know I like I tried to put on a front of like 'everything's going well' and 'look how I'm coping.'"

Ethicists have critiqued the prevailing principle advocating that 'patients' be allowed autonomy in decisions around their care because it does not account for the relational restraints that may undermine informed consent and choice (Entwistle, Carter, Cribb, & McCaffery, 2010). Within midwifery it has been proposed that in her journey to motherhood a woman has relationships with many practitioners (including midwives) that influence and inform her sense of self and her experience of birth and new motherhood (Thachuk, 2007). Advocacy of empowerment may inadvertently deter usually capable and competent women from admitting to vulnerability and difficulty coping.

Both Donna and Lisa described trying to be stronger and cope better so as not to let their midwife down. Donna consequently was not able to show the extent of her distress around her midwife but was able to speak to her sister who referred her to a medical specialist. By contrast, Lisa's midwife/friend was the only person she talked to about her intense feelings of distress (described in the previous section) attesting to her trust and

confidence in the relationship and her midwife's skills. Her midwife provided practical help and arranged prompt specialist home based medical care. Even so Lisa chose a new midwife who was not her friend for her second birth because she had found the mix of friendship and midwife demanding to manage.

When the relationship with the LMC has not gone well, women described feeling little confidence in gaining support for their postnatal difficulties. This was the case for Susan who described her birth experience as traumatic and related her distress to her midwife not giving information and not gaining informed consent for procedures. Susan also made sense of her lack of voice during the birth as being related to a counterintuitive aspect of having a birth plan (a process designed to increase empowerment) because "it lulls you into a false sense of security, you stop asking questions." As Susan said, "We just needed to be involved".

Melissa described her disappointment when the midwife whom she had got to know over antenatal visits unexpectedly resigned from the profession almost immediately after baby was born and transferred her care to a new midwife. She indicated that she was not able to talk about her difficulties with the new midwife because of her loss of confidence and also because the relationship was new. Several women who had obstetric care for antenatal visits and the birth had similar comments to Melissa regarding their difficulty talking about their feelings and concerns with the visiting midwife with whom they had no previous relationship. Continuity of care through antenatal, birth and postnatal visits was viewed as more conducive to a genuine relationship where women could talk about their vulnerabilities if at all.

Dawn and Kimberley described not discussing distressed feelings because they didn't think the midwife had time. As Dawn said:

> "I didn't find her particularly supportive at all really, you know she'd just breeze in for her ten minute visit every sort of couple of days and breeze out again and it was it was never, never at the time you needed her sort of thing." Dawn

Kimberley made the point: "I don't think they see you enough to register how you're coping because you can put a front on for the half an hour or so that they're there." The primary health focus of the midwife may impede her openness to hearing stories of emotional turmoil for women even potentially serious problems such as suicidal thoughts. Several women described that they were never asked about how they were coping and that if they were going

to tell the midwife or obstetrician the LMC would need to ask specifically about particular symptoms. As Linda described:

> "In that six week check-up. I didn't go to a GP, I went to the obstetrician, so that was one thing that [Obstetric Service] weren't particularly good at, I don't think they asked enough questions about…Well if someone said to me are you having suicidal thoughts…You know, they would have got, it'd be pretty hard to say no, if you were, if you went through a medical professional." Linda

Linda compared her experience of never being asked to her friend who had been given a postnatal depression questionnaire when she went to her doctor and then received medical and psychological help, which Linda said she would have liked. Linda provided a contradictory insight however, regarding her willingness to expose herself to scrutiny at the time when she was feeling distressed; "I don't think anybody really asked me those questions and I was, you know, I'd be the last person to admit that it was postnatal depression, I was happy to put it down to baby blues as well." There are two aspects to Linda's statement. Firstly, Linda describes being the last person "to admit" to postnatal depression. This frames it as a confession to a crime. Women who are distressed are unlikely to expose themselves to judgement. One way to defend against this is to cautiously raise an issue to gauge the listener's response. Linda did not take the option to talk about her feelings of distress till much later and with a friend who described similar problems.

Susan however did attempt to tell her midwife about her symptoms, later diagnosed as PTSD in a cautious way:

> I remember once making a comment to her when she came to visit 'Oh I'm having trouble sleeping', you know, 'I'm tired but I'm having trouble sleeping.' And she said 'Oh, why's that?' I said 'Oh, lots to think about', never mind, you know, these flashbacks keeping me awake at night, I said 'Oh it's lots to think about.' She goes 'Yeah, that's true.' (laughter) I thought 'I'm trying to tell you something's wrong' and she didn't bite, so I thought 'Mmm, okay.' Susan

Both Susan and Linda's level of restraint further highlights the risk women feel they are taking in disclosing negative emotional experiences as new mothers.

A second aspect of Linda's account is her preference for labelling her distress "baby blues". By doing so, Linda places her distress in the realm of 'normal' or common

experiences and similarly some women described the difficulty they had deciding whether their own feelings or their babies' behaviour were normal. As Melissa states "also it being first child you sort of think 'Oh this is just normal.'" When women's reference point for motherhood and babies is idealised any diversion from that becomes difficult to evaluate and once again places a restraint on women expressing concern. In the early weeks of motherhood, when most women in this study had little or no contact with other mothers and children, there was no opportunity for gaining an alternative reference point. Unfortunately, when they did, women once again seemed to be exposed to idealised visions of mothers and babies.

Coffee Groups

Coffee or mothers' groups in New Zealand are usually promoted and supported by Parents Centre, who provide pregnancy, birth and postnatal information (Parents Centre, 2012) and Plunket (Plunket, 2012). Almost universally, participants who attended a group, often formed from the women in their antenatal class, described being unable to express any real (negative) feelings to other mothers in the group during the early months of motherhood. They cited many clear reasons.

Firstly, women referenced the fact that they had "only just met them" (Amy). Making genuine and trusting friendships can take time. Usually meetings are at most, weekly and in a group format that can preclude intimate conversation about vulnerabilities. Also, women who had children with health or feeding issues were less likely to attend regularly so took even longer to develop closer friendships. Melissa said, "the coffee group which has been really good, but not people to talk to". Putting a group together just on the basis that they live close together and have babies at the same time can be a lottery in terms of compatibility of values, interests and personality. As Melissa implies, a coffee group can be a place where you get together for coffee but not have enough sense of connection and trust for instance to talk genuinely.

The second common reason for not talking about problems at coffee group was that everyone else "seemed to be coping and happy and you know their babies were all sleeping and it was all going sort of text book for them and I was sitting there thinking 'ohhhh am I the only one suffering here'" (Wendy). Inherent in Wendy's statement is the comparison and benchmarking that being in a group of other babies and parents provided. Women, new to babies were unsure of whether their child's progress and behaviour were 'normal'. For the

many women in this study who had babies that had health and growth problems, this then provided a negative comparison. Also women compared their own internal feelings of inadequacy and distress with the outwardly "coping and happy" women in their group which provided further perceived evidence of their inadequacy. Ironically, the women themselves described how they also maintained a façade that they were coping and happy, which was based on the third reason for not talking about their distress. As Kimberley said "you don't want people to know that you can't cope".

In early motherhood, the women appeared to act in ways that conformed to the idealised view of motherhood. As Julie described "Everyone's so there's such a thing around, you know, the positivity around motherhood and, you know, 'isn't it fabulous', and they think you've got this wonderful child and so on, that sometimes the honesty gets, gets lost and gets very hidden." With no alternative view of motherhood to challenge these notions, no openings for honest dialogue occur. As Julie continues; "I call them Pollyanna mothers you know the Pollyanna mothers who for everything is always fabulous and rosy….I actually I don't want to talk to them in some ways."

Eleven women's stories of their distress included comparing themselves and their situation unfavourably to others; as Dawn described: "Yeah, yeah everybody else seems okay, why can't I do it?" When women experienced motherhood as more difficult and distressing than the ideal, they seem to be silenced by the potential risk of critique or judgement. Strong self-blame, guilt and shame accompanied these negative comparisons as Wendy poignantly describes: "I just felt embarrassed I guess that I would you know that I would yeah. I sort of felt like I should be coping and I wasn't and that was my fault and (laughter) I just I don't know I just felt I was ashamed I guess yeah."

Being a Professional Woman

Several women described the particular difficulty for professional women, of not feeling entitled to talk about their problems because of their privilege. There was a sense that because their lives were "so easy" they had no right to complain. As Donna states "I would have felt like it was a bit indulgent for me to sort of bang on".

Other women felt they were unentitled to expect others to take care of them while in hospital for instance. This may reflect their experience of themselves as fully autonomous and self-regulating in adult life in line with neoliberal citizenship (Petersen, 1996). For instance, Dawn described her disbelief that she would "be allowed" to "call them [hospital

staff] if I need". Her lack of belief in her entitlement to care also extended to discrediting and minimising her feelings of distress as she described how it "seemed logical to me at the time that oh I'm just, I'm making this up you know this isn't really as bad as it you know as it is I'm making it up". Dawn described maintaining a "very good mask" perhaps because she did not think that others would take her distress seriously in the same way she minimised it.

Jennifer's experience highlighted how having been a professional, independent woman meant she expected to continue to work things out independently:

> "It's a pride thing. And, and I guess 'cause I figure that I've got enough of a nous to work through it and enough of an understanding of psychology in, in my background to, and I guess maybe because of my background I feel more pressure that I should be able to recognise the signs and then work through, work through it rather than not be able to, yeah." Jennifer

This understanding likely assisted her to persevere in finding solutions, though may have meant she didn't seek assistance if indeed it had been available.

Minimising

Several women talked about how their attempts to tell others about their distress were met with minimising responses that were unhelpful and silencing. Firstly Lisa became more distressed because professionals gave her no acknowledgement of the emotional cost of the pregnancy related rash she experienced:

> "None of it was recognised. You know if, if one of the midwives had sat down and said 'I can understand how this rash would be making you feel like that and then how we're getting no sleep either why don't we try…' but there was none of that no one." Lisa

Other women described experiencing unhelpful platitudes and reassurance like "they all do this and you know you wait till six weeks and then they're fine and then twelve weeks and oh they all get better and it's like you just don't need to hear that stuff. I really hate hearing people say 'everything will be okay'" (Linda). Many of the women had children with health issues that extended long after the 6 or 12 week markers that seem to be prevalent in the women's accounts of the expected easing of the intensity of child care required by mothers as children grow and develop. Some women like Monica talked about reassurance that was minimising. Monica described her mother's advice which did not turn out to be true

as her own and her child's health issues continued over months; "'Oh, that's normal, you'll get through. We all go through that.' It's like, that's good, 'cause you kind of wait to see if you can get through it and then the, it, nothing changes."

Loneliness and isolation

Loneliness and isolation were key experiences described by 15 of the women as they moved from paid work outside the home to being at home alone with a baby. As Karen described, "I've never been on my own in my life like I've always had friends around". Karen did not have a partner or a relationship with the father of her child and described "the hospital experience as quite lonely" as her mother and friend left. Karen described how she had "never been so isolated in my life" managing her child largely alone after moving from a shared living arrangement to a home on her own. All other participants had partners who generally took leave from work for the first 1-3 weeks after the baby was born. They did not describe feeling alone until their partner went back to work or, in Donna's case, went overseas for work. In anticipating and then coping with his absence, Donna described how she "just couldn't stop crying" and described how at the time she feared that this was a recurrence of how "miserable" she had felt in her earlier life when she was alone overseas and experienced "that similar sort of thing feeling out of my comfort zone and feeling really like I was on my own." At the time Donna experienced anxiety about what her distress might mean about her, the security of her couple relationship, and her future. Donna described how she later came to the realisation that crying was "a reasonable reaction" to her husband being away and living in a community she had no connection with socially or economically. She "started to realise this is not just me". Her comments highlight the changing nature of the women's understanding of their situation and reactions over time; Donna was not alone in developing a more compassionate and understanding view of her initial distress. Donna's relational situation with her husband and his work is further discussed in Section 2.

I will describe in more depth two ways of experiencing and responding, sometimes concurrent, that were apparent from the women's accounts of being at home once their partners had returned to paid work. One way of responding related to the practice of some women who took steps to avoid social contact (which I will discuss later) and the other related to women feeling trapped. Women described long days when, often for the first time in their adult lives, they were at home with no adult company for extended periods of time. The long day and sense of being trapped in the home is emphasised in Susan's account of how her "[Husband], you know, had to go to work early in the morning so it would get left

there all day and I'd be, was stuck in the house". Susan's statement of "getting left there all day" frames her as not just alone but left alone by her husband and bereft. Despite having apparently agreed to the arrangement, some women described feeling resentful of their partner's ability to leave and go to work each day, as Melissa describes experiencing "a bit of resentment there and there was also the 'I'm stuck in this everyday again and you get to go off to work, you travel, you go and have holidays.'" Five women talked about their husband's ability to leave for work each day and/or his continuation of social activities. This was presented as heightening their sense of being "stuck in the house" and the implicit message was the unfairness of this gendered division of labour. Sevón (2012), interviewed 7 Finnish women who also described the cost or loss they experienced in the way parenting roles are gendered. The participants in Sevón's study used surprisingly similar expressions to describe this experience: "My life has changed, but his life hasn't".

While most comparisons were made by women of their loss of freedom compared to their partner, some women compared themselves to their colleagues, who were continuing life as before. As Michelle described "it's quite lonely as well to be stuck at home and not really know very many people and just, kind of, and everyone who you do know is working during the day." It was apparent that many women felt the loss of their social network when they left paid work, and most did not have a group of friends who were also parenting young children to replace it with. As was noted above, many women did join new mothers groups; however, the newness of these relationships precluded the sharing of personal vulnerabilities in the early stages of motherhood. Also, work was viewed as something that offered more freedom than motherhood. For instance, Linda candidly described work as "if somebody pisses me off I'll, you know, you can sort it out or, as I said, you can resign, you can always choose to leave your job, you know, you've got choices." Whereas motherhood was described by Linda as "you are sort of stuck in the house and you can't go out and your husband still goes off to work and his life hasn't changed really that much and yours has dramatically."

Linda's talk about choice and the option to leave a paid job, when set alongside the comparison she makes with motherhood, refers by implication to the fact that for women there is no socially acceptable way to resign from motherhood. Some women related their 'stuckness' very much to their responsibility to their babies. Julie described feeling "hostage" to her baby, as well as, "very vulnerable 'cause I felt I'm absolutely being controlled by this tiny thing as to how I feel, which, you know, is not a nice position to be in." Melissa also

described how she "wouldn't go down to the shops because s/he might spill [vomit] everywhere, s/he might start screaming and I can't make her/him stop. And people are going to look at me." This highlighted the particular problem for women with babies with health and feeding problems who felt social judgement particularly in public places, when their babies were crying, screaming or vomiting. Several women described this as the reason they, like Melissa avoided going out whenever possible.

The second way that women described managing the first weeks was to deter visitors. While loneliness was a problem for some women, others found the pressure of appearing competent in front of friends and extended family members challenging and exhausting. Meeting the usual societal expectations of a host was described as beyond their already stretched capacity to cope. Wendy described not wanting to see visitors as she managed her babies reflux "because I just wasn't coping and I just didn't want to see them (laughter)…and I just sort of felt like any time that [baby] was asleep I wanted to be trying to get some sleep…So no I just I wasn't really encouraging visitors…And I was sort of you know in tears a lot at that stage, so I don't sort of I don't recall feeling like I wanted to have [visitors]." Andrea described "cottonwooling" herself as she was adjusting to caring for her child with potentially severe health issues. Andrea also described how being "not very good at asking" meant that "social isolation is, is an issue for me when I'm depressed cause that's what I'll do is I'll just shut down and I won't I don't communicate."

Thus within the present structure of families and motherhood within western society, for many women, like those in this study, isolation as a mother seems almost inevitable. As the person assigned primary responsibility for the day to day care of infants, women are more likely to be the one taking time from paid work to care for infants. With the expectations that mothers will provide care consistent with the natural, attachment and/or intensive mothering paradigms predominant in western middle class parenting, women are likely to expend more time and energy meeting these ideals. Public spaces have improved as mother and child friendly places by providing infant change facilities, for instance. However, many of the women described avoiding public spaces because they expected judgement from a public they viewed as intolerant of the less than ideal realities of baby and child behaviour. Many of the women described having less contact with and access to practical help from family members and their own mothers in particular. This will be further discussed in Chapter 6 that focuses on the particular contexts for postnatal distress.

Discussion

The five aspects of the accounts of distress highlighted in this chapter are not independent of each other. For some women the overwhelming responsibility associated with their understanding that they should be the primary care giver to their child, began when their new baby was placed in their arms. At this point the distress seemed to be associated with the realisation of the daunting permanence of their responsibility and their accounts indicated that this was because this new position compared so dramatically with their life before motherhood where they had experienced more choice and autonomy in the paid work force. This highlights the first issue for understanding women's distress, namely the loss of income, autonomy and options when women become mothers.

Overwhelming responsibility then became apparent as women described finding the tasks of what they perceived to be responsible motherhood so unexpectedly demanding and difficult. What women expected of motherhood and babies forms the focus of the next chapter. What became apparent in looking at accounts of distress was that many women in the current study found life at home with a new infant lonely and isolated. Their response to the disjoint between their expectations and experience acted to silence the women about their distress in these early months when they had no experience of infant care. Unfortunately for many women, the services (visiting midwife) and initiatives (coffee groups) that would be expected to provide a bridge to information about what babies and motherhood is really like, were initially not effective in doing this. The anxiety that women described in attempting to meet the idea they had of good mothering and the care with which they avoided being seen as not coping, attest to the power of the discourses of womanhood and motherhood the women were aspiring to. The following chapter focuses on the expectations that this group of relatively financially resourced women in Auckland, New Zealand in the late 1990s-2000s, expected of motherhood and babies, in an attempt to further identify the discourses of motherhood that started to become apparent in this focus on the women's distress.

Chapter 5

Expectations of Motherhood

So what did the women expect? For the most part the women I interviewed described a sense that they were expecting motherhood and caring for a baby to be difficult but not as difficult as it turned out to be. Their voiced understanding that motherhood is difficult indicated that the women were aware of stories of the usual hardship associated with sleepless nights and regular infant feeding, for instance. Also, most women said that they had heard about postnatal depression but that this was "brushed over" in antenatal classes which focused more on managing the birth process. Consistent with many other studies of the transition to motherhood (e.g., Choi et al., 2005; Mauthner, 1999; Weaver & Ussher, 1997) the women described a mismatch between their expectations and their lived experience of motherhood. It is this disjuncture between the reality of motherhood and the idealised construction of motherhood that has been suggested as a cause for women experiencing distress postnatally (Mauthner, 2002). Described as the "myth of motherhood", the motherhood ideal has cultural currency and acts as a powerful standard by which "good mothers" are measured, and so aspire to (Ussher, 1989).

Choi et al. (2005), in an interview study of 24 women's expectations and experience of new motherhood, identified that the women were unprepared for motherhood, having based their expectations on various myths of motherhood including that they should be able to cope with the new baby, domestic tasks and caring for others. The women experienced feelings of inadequacy when they struggled to live up to the demands of these "superwomen" myths. Choi and her colleagues proposed that these myths of motherhood represent the ways femininity is performed and so women in her study worked hard to avoid being seen to have failed as this would "threaten their sense of self and their identity as women" (p.117).

In this chapter I will note several parallels and points of difference with the findings of previous studies, as I also attempt to understand the expectations and "myths" that the women in the current study drew on when they became new mothers. There were three aspects to women's expectations. Firstly, there were expectations that motherhood would be not that difficult, natural, instinctual and a woman's responsibility. Secondly, I will focus on the accounts women gave of the personal resources they expected would help them as

mothers, namely being experienced in motherhood skills, being a capable and competent problem solver, and/or having skills passed down from their own mother. Finally I will describe the women's idealised expectations or "myths" about how their baby would be including how trainable their baby would be.

Ideas of motherhood as not that difficult, natural, instinctual and a woman's responsibility

More than half the women described expecting the tasks of motherhood to be "easy" or at least easier than they turned out to be:

> I thought it would be totally nice and easy and s/he'd be a beautiful baby and s/he would, I would be having coffee with him/her and breast feeding him/her and taking him/her out and, you know, it'll be morning coffee groups but it's not, you're at home. Cynthia

Not only does Cynthia describe having expected motherhood to be easy, she, like many women, also described an idealised picture of motherhood. Similarly, Susan gave an account of how she had looked forward to leaving work and gave a glowing description of her expectations of life at home with a baby: "Oh I'll be at home with the baby it's just gonna be wonderful."

Ideas that motherhood is easy sit alongside cultural discourses that trivialise women's domestic work. For instance the work of full time motherhood continues to sit outside the demand and reward structure of the paid workplace and it has been disregarded by theories of career development (Schultheiss, 2009). Also, the perception of motherhood as a universal aspect of womanhood (Arendell, 2000) infers that the practices of mothering must be easy because they are supposedly achievable by all women. Also more directly derogatory attitudes that exist in cultural discourse concerning the activities of mothers were named by Donna, who described her own "quite sneery" attitudes with regards to mothers prior to having her own child: "What do they do all day?" as Donna stated, was at the more disdainful end of ideas that portrayed motherhood as easy.

The added pressure to try and perform motherhood according to idealised constructions was present in this account by Julie:

> Another thing that puts pressure on mothers is feeling that they need to conform with the images of it being, you know, all fantastic, and all rewarding and you know a beautiful experience. Julie

Julie's statement highlights the dual challenge she faced of managing the challenges of her own material experiences of motherhood while also "conforming" or appearing to conform with what she understood were "images" or a portrayal of ideal motherhood. The portrayal Julie gave of how motherhood should be contrasted starkly with the description she gave of her experiences of terrible days as a mother:

> I would sleep really badly because of the stress and anxiety worrying about everything, and then I'd have like a terrible day, or I'd just have a terrible day because [Baby] refused to sleep, or wouldn't feed well or you know there was some or the eczema was playing up, or you know there was some really difficult things going on. Julie

Only one woman, Donna, described motherhood as better than the drudgery she expected: "everybody always tells you about how it's such a drudgery and all that but it's actually no one tells you that it's actually amazing and fabulous and, you know, how happy it makes you." She gave an account that actively rejected idealised constructions like the "yummy mummy" and described her struggle to accommodate her loving feelings for her child with her previous identity and those available within society at the time:

So you were asking what a mother would be? I mean I think it's more what a mother was not you know like glamorous, sexy, dangerous, intellectual, stroppy, you know, interesting, you know, all those things that kind of I guess, I quite aspired to be or liked it's like then you've become all kind of drippy, sentimental, you know, just all fluffy and eggy weggy and kind of pink and, you know, and all that sort of thing. And I kind of felt like, 'Oh my God I'm going to turn into that' you know and I mean, I know these days that there's kind of role models but it seemed like the role model was kind of like be a yummy mummy which is kind of like revolting as well. And I kind of couldn't see my, you know like dieting to get back into tight jeans or something, you know, it's so not I was not that either. Donna

It appeared that other women had somehow minimised or discounted talk that they had heard about how difficult being at home and caring for babies can be. Amy provides a narrative that provides examples of the ways in which the women accounted for why they do

not give up the hope that their experience of motherhood will match the socially constructed ideal that is portrayed in popular press (Held & Rutherford, 2012). Amy initially gave an account that suggested the difficulties of motherhood were minimised, in this case at her antenatal class where "Nobody like, you know I, I did my Antenatal Class, we did an Antenatal Class together and nobody sort of tells you about the really hard, hard times." Amy then went on in the same passage to describe how she herself avoided telling her sister about the hardship:

> And my sister's just had a baby and I remember thinking like she's just had one three months ago, and I remember thinking should I tell her this, this or this? I thought no, I can't, I can't tell her, you know. Amy

As was described in the previous section, many women avoided talking about their own distress; however, Amy gave a reason that was not about managing other people's opinion of her. When I asked Amy "So what kind of restrains you from telling?", she then went on to explain her reluctance to provide an alternative more negative narrative of motherhood essentially maintaining the positive constructions of motherhood despite her knowledge that it could be very different.

> Well I thought, I don't what to ruin her perception of what it might be like cause she's all you know, excited (laughter) and I don't want to put a negative you know...you don't want to be negative about it and also it might, that might not happen to her or you know she might have a baby that sleeps really well or she might....And she has, she's coped really well, you know, does that..? Amy

Amy described her own hope that her sister's experience of her baby would be easier and ended with a revision of her statement that "no one really tells you" by summarising how she had herself disregarded other people's talk of the difficulties because of her own hope or expectation that problems of mothering wouldn't be that difficult to manage.

> No one really tells you, oh actually I do remember people at work saying 'oh I can remember, you know, there's no sleep' and that sort of thing, but you kind of think, oh yeah whatever, you know, it can't be that bad or...that sleep deprivation's only for, you know I remember thinking it's only for a short time at the beginning type thing. Amy

This account suggests that women may hold both ideas but emphasise the positive idealised view as is illustrated in Stephanie's account:

> It was kind of mixed because my logical self thought, 'well it will be hard' you know but my emotional self was like 'I'm going to cry. I'm going to be full of love for this child and you know when it's born I'm just going to be so overwhelmed with emotion and yeah it's going to be fantastic.' Stephanie

Stephanie's description also referenced the idea that loving feelings will arise without question. Cynthia's description of herself as a "baby whisperer" with her friend's children, presented her as having a natural affinity with children. Many (8) of the women referred to their or other people's view that the tasks of motherhood, particularly breastfeeding and bonding, would be natural, instinctual processes that women's bodies are innately prepared for. For instance, Stephanie, who described expecting "just this instant love" for her baby, also expected that feeding "would be more natural". Cynthia also described expecting an instinctual relationship with her baby that would assist with feeding "I was kind of had this view that oh I'll know when I need to feed him/her, it'll be instinctive I'll know when I need to feed him/her. S/he'll wake up and tell me".

Karen described her mother's advice: "'You're a mother. It comes naturally and your sister did it when she was 15' and you know that kind've thing she, she just did it naturally. I was just like still reading the books trying to work out". Karen, like many of the women, did not just rely on instinct but used research (reading parenting and baby care books mainly) and problem solving skills once they became mothers and faced situations where instinct did not seem to be working. Only one woman, Jennifer, who finished work early in her pregnancy, described reading about child care prior to her baby being born: she had "done all the reading, cause I had months, nine months to prepare, so I'd read every possible book and strategies to getting the child to sleep and, and do all the rest of it". The fact that most women did not research baby behaviour and parenting techniques may reflect their expectation that it would be easy and instinctual or just that they were so focused on finishing work, their pregnancy and the hurdle of the birth that this was not considered a priority.

Ideas of motherhood as natural and instinctual sit alongside expectations in most societies that women will become mothers (Phoenix, Woollett, & Lloyd, 1991), that this is the natural order of things. Feminism promoted choice for women as to whether to work in the paid employment or work at home as care givers to their children. While more women are

choosing to remain childless or delay having children (Statistics New Zealand, 2012), for the most part within western culture, women continue to be the primary caregivers for infants alongside other caregiving roles (Burgard, 2011). The expectation that the mother is the person primarily responsible for the infant was not explicitly stated as an expectation of motherhood by the women (all but one in couple relationships) perhaps because it is such an assumed position. The presumption of this role within the structure of these families was illustrated by the fact that, in accordance with tradition, at least for the first 3 months, all the women remained at home full time while their male partners continued in paid employment.

Also, despite women saying that they had chosen to be the full time care giver to their babies, about half the women described being burdened by the overwhelming responsibility of caring for their child. Linda, for instance, described how she "got overwhelmed with responsibility" and related it to "here's a baby, it's not about me, they're completely dependent, you know I have to be their source of life and care." Lisa described how she became very tearful very soon after the birth of her baby and said she felt as if "no one really seemed to give a toss you know. Life was just going on for everyone yet mine was completely over." Both women infer that they took it for granted that they held primary, if not sole, responsibility for their baby. Kimberley also identified her sense of her responsibility for her baby and suggested that in doing this she did not allow her partner to take a more active role:

> It was a lot of more emotional than I thought it was going to be. And just the huge, I don't know if I put it on myself, just the feeling of I'm responsible for this little guy.....And probably not letting, I probably should have let [Husband] take some of that as well. And he would've. Kimberley

While Kimberley in this statement suggests that she prevented her partner from taking more of a care giving role, in another part of her narrative she also described her husband as saying he did not "do nappies". Studies of the relative contribution of men to domestic duties compared to women show that men in general (Croghan, 1991; Sevón, 2012) take less of the burden of domestic work even when women are also in full time work. So while women are likely conforming to cultural expectations that they take the primary role, men equally may be supporting this configuration. Linda also described how she is the primary parent:

> And you know like [Husband] worries and is anxious about Baby as well but he can still walk out of the door in the morning and go to work and, you know, if we go out

> for dinner at night, he's not the one who texts the nanny to make sure everything is alright. But that's you know probably my fault, I'm the default and I've taken the primary role. Linda

Both women's statements imply that, when a woman takes the primary role in parenting it is a free choice; however this ignores the complexity of society's expectations of women and the clearly defined roles allowed for women as mothers and men as fathers.

As part of the tasks of mothering, the women generally took responsibility for the decisions regarding the model of parenting (e.g., attachment or routine focused, breast or formula feeding, and so on). Alternatively, some women described jointly problem solving child care issues with their partner and being more confident when they had agreement, as Linda described with her couple relationship "we're quite good at, you know, the two of us as a unit are absolutely perfectly comfortable with how we've chosen to parent [baby]."

By contrast, the women who described having disputes with their partner or other family members about child care found the undermining of their position as primary care giver disempowering and distressing. Being unable to assert the societally mandated role as primarily responsible for their child likely undermined their developing identity as a good mother. For instance, both Cynthia's mother and partner had strong and conflicting views on the ideal method for feeding babies, which Cynthia said served to "really undermine" her. Cynthia described how their conflict was an intrusion on her wish that "the breast feeding was going to be my thing."

It appeared that being the person primarily responsible for child care decisions was important for women's sense of identity as mothers and that this idea was clearly entrenched for most women before they became mothers and the fact that they did not list it as an identified expectation further reinforces the "taken for granted" nature of this understanding.

Ideas of self as capable

Previous experience

When applying for a new job a likely question will be "what experience do you bring to the position". Having some knowledge or experience would generally be seen as an asset to taking on any new role. Eight women described having previous experience with caring for babies and children that they expected would be helpful to managing the adjustment to

parenthood. Six women, for instance, described previous positive experiences with babies of friends or family. As Cynthia, described:

> When [Child] was a baby that totally wasn't what I, cause I was expecting, I thought that I was the baby whisperer that it'll all be just lovely and s/he would be this accessory. And I mean, I am a baby whisperer cause I, like my friend's children they love me, other babies love me but it wasn't like that with my own. Cynthia

With this statement Cynthia suggested that she had personal qualities that were attractive to children and experience of children and babies. She raised this in the context of explaining why her lived experience of a fractious baby who was difficult to feed, was "totally" unexpected.

Two women worked in child care prior to having their own baby and expected that this experience would be helpful to caring for their own child. Amanda bluntly stated "I guess being a child care worker I just kind of thought that everything would go smoothly and kind of thought I knew everything." Kimberley described how "everyone was going oh you'll be fine, you know what to do, you know what to expect, and I was like yeah, I know," and while she acknowledged that it would be different she thought it would be better with her own child, in that "I'd have more time to do stuff because when you're working you have to go and get ready for work and everything before you get there and then you do, I don't know, I just thought I'd have all the time in the world and I just didn't."

So while most women in this study described not having previous experience of caring for babies, those that did, described an expectation that their experience would relate directly to their skill and knowledge for caring for their own child. For one woman, Laura, this was indeed the case as she confidently took on the care of her baby with support from her mother and sisters, having described previous experience of child care: "I was eleven or twelve when my little sister was born. So, you know, I was like a second mum." For Laura, the postnatal distress that she experienced related to disagreements with her husband's family about the level of involvement they wanted to have with Laura's baby. This challenged the role she wanted to take as primary, attachment focused mother. In this circumstance her confidence in her ability as a mother was not undermined.

By contrast, Kimberley, Amanda and Cynthia, did lose confidence despite having very relevant child care experience. This likely related to three aspects of their experiences of

early motherhood which they described as unexpected; caring for their child was more difficult, they were more emotional and the difficulties were not easily resolved. Having previous experience may have meant these three women judged themselves on an even higher standard and when problems arose, they were more disappointed and critical of themselves. As Kimberley said "Umm (long pause) yeah that was sort of it, that it was that I couldn't do it and that I was sort of telling myself off that you should be able to do it."

Amanda's account of the distress she experienced on the third day after her baby was born presents her problem and risk focused prediction of the consequences of her and her baby's breastfeeding difficulties. Referencing her expectations as a child care worker serves to both give credibility to her analysis of the problems while simultaneously undermining her sense of her capability to resolve the problems.

> Well I know day three I definitely got the baby blues cause I know that was when my mum arrived, and I looked at my mum and just burst out crying. I think the breastfeeding really didn't help like because I knew when I was pregnant that if the breastfeeding was sorted then s/he'd sleep and then you know it was this circle and s/he just never fed properly and s/he never slept properly. And I guess being a [child care worker] I just kind of thought that everything would go smoothly and kind of thought I knew everything and it was like taking a step backwards and feeling out of control. Amanda

The double edged problem of having more knowledge but being unable to resolve difficulties appears to be the ingredients in Amanda's sense of "taking a step back and feeling out of control". Kimberley gave a summary of the connection between her experience of postnatal depression and her work. Her reluctance to talk about her experience may have related to a sense of shame at not meeting her own and others (see above) expectations.

> Probably the fact that I did get diagnosed with postnatal depression and because I've been a [child care worker] and that, I was one of the last people… who sort of thought, oh yeah I can cope! (laughs) And I didn't and um the fact that I've only, even though I had it, I've only just started saying to people, well when I was pregnant, when I had [baby] I got postnatal depression. I didn't really tell anybody at the time. Kimberley

Thus, for women who have child care experience, their identity as an expert can make it more distressing when they experience unexpected challenges in motherhood that are not easily resolved. This is because both their professional identity and their identity as a mother are undermined.

Transferable skills

Kimberley and Amanda were not the only women who had an expectation that their work skills would be relevant to the job of mothering. The participants all worked in full time in professional positions prior to becoming pregnant and most continued working until the birth of their baby. Many (15 women) made statements suggesting that they were expecting their work strategies, knowledge and skills such as planning, people management, problem solving, common sense or 'nous', intelligence, and so on would be helpful in caring for their new baby.

For instance Jennifer, who worked in management said "I figure that I've got enough of a nous to work through it and enough of an understanding of psychology in, in my background...that I should be able to recognise the signs and then work through, work through it..." Monica a marketer said "I should've known, 'cause I'm an intelligent person." Michelle a project manager, described many work strategies she thought would be useful:

> I like to be able to plan things...organise things, I'm a big list person...I had wonderful autonomy...control over everything...it was up to me to schedule everything and reorganise...I think I tried initially to be a little bit like that, that was my approach to motherhood. And really I don't think it works like that at all because they just don't do what they are supposed to do when they're supposed to do it. Michelle

It would appear from these accounts that the women had a sense of themselves as intelligent and capable and that they had a confidence that their general approach to work could be usefully applied to parenting. The descriptions, however, do not give a clear indication or sense of the women being aware of how they would be applied or 'work' in relation to baby behaviour. By contrast, Stephanie, a health professional, like Amanda and Kimberley the child care workers, gave an account of how her work experience would assist her to cope with specific aspects of motherhood:

> I kind of felt quite set up for it cause I do you know all sorts of horrible hours and I've worked through nights before and you know I thought if I can function helping to do a

trauma and saving lives then I can get up in my own home and be sleep deprived and still function. Stephanie

Learnt From Own Mother

Along with work experience women's expectations about motherhood are inevitably going to be influenced by their own experience of having been mothered and observing their own mothers (Jack, 1991). However most participants did not reference their mothers as their models for parenting and those that did related it to their mothers commitment to specific parenting strategies such as breastfeeding; for example, Kimberley described her mother being "really involved in La Leche ….I didn't consider that I would do anything else, you know, mum fed everybody so you'll be fine."

Others described following the general philosophy of parenting from their mothers and older siblings, like Pamela and Laura who developed firm beliefs in child focused parenting "I've got like three sisters and a brother and my two oldest sisters, you know, they've sort of been like my role models with babies."

By contrast, four women described how they would parent in a different way from their mothers and fathers, as Stephanie stated bluntly: "To be the opposite from mine, how harsh does that sound?" when asked how she gained her parenting ideas. Mary described how her mother put her work ahead of mothering: "my mum was like that very much family was second", which, as a child, she had found hard. Consequently, despite still aspiring to achieve in her work life she practised a very child focused model of parenting. When she returned to work she found the lack of support from employers and struggle to balance work and home eventually lead her to the decision to prioritise her parenting role and compromise her career.

These stories highlight how women can be influenced by their own mothers in very obvious and conscious ways. It is also likely, however, that the women were influenced by their mothers in less obvious and conscious ways regarding maternal warmth and physical affection for instance that are part of the unremarked assumption of how a mother should be and therefore were not described by women except when it was not the case. Also, in a practical sense, if women did not have younger siblings it is unlikely they gained a model of how to manage the practises of caring for babies. With smaller families in recent times (Statistics New Zealand, 2012) this is more likely to be the case.

Babies as either idealised or trainable

When women were asked what they had expected motherhood to be like before they had their baby, not surprisingly, their ideas about babies were often described. The women's expectations about babies were also identified by listening to the accounts they gave of caring for their young babies. As with motherhood in general, the lived reality of caring for babies was often described as being much more difficult than they had expected. Two main expectations that many women described having had about babies before they were born were identified. Firstly, babies were idealised: "happy and content and cute and adorable...fun" as Wendy put it. Secondly, babies were viewed as trainable, reflecting a societal discourse which Dykes (2005) described as the ideology of babies being 'civilised'.

The 12 women, who described having idealised images of babies as altogether lovely, also gave accounts that indicated they expected their babies to have some sort of predictable pattern to their behaviour. This is illustrated by Wendy's account of learning at antenatal class "the baby would get up at you know two or three or four times a night and you'll feed it and it'll go back to sleep and you'll go back to sleep". This statement indicates an expectation of a pattern with some potential for variation indicated by the up "two or three or four times". By her comments, Wendy also presented the idea that the mother can respond to this pattern in order to meet the baby's needs. Susan perhaps made this second point more overtly with her statement "I know that they cry a lot. And I thought that it's fine, you know, lots of cuddles and he'll stop crying." Her account referenced the presumption that babies can be soothed and comforted when distressed.

Most women expected that their babies, if not immediately, would develop a predictable or helpful pattern of sleeping, feeding and crying. Many women spoke of expecting that they could have some agency in facilitating this with techniques such as soothing. Books they had read seemed to give some women the impression that babies are "supposed to have" routines. As Michelle described "I'd read far too many of those stupid books... that...tell you all about these wonderful routines that children are supposed to have". Michelle's statement doesn't make clear whether these "wonderful routines" will need her help to implement. However, the fact that she, like most women, went to books after her baby was born to find strategies for managing her baby's behaviour indicates she believed the books would help her effect positive changes to her baby's behaviour.

Jennifer was unusual in this group in that she had prepared more for the tasks of caring for her new baby before her baby was born. She began reading about child management while she was pregnant when she had a long period off paid work before the birth. Jennifer described explicitly "I wanted to put her/him in a routine, so ... I'd read every possible book and strategies to getting the child to sleep and, and do all the rest of it." By her statement "I wanted to put her/him into a routine" Jennifer makes clear her agenda to train her baby into more predictable routines of behaviour. Jennifer's approach suggests that she was not putting her faith in her baby developing helpful patterns without parental intervention. Alternatively she might have wanted to speed this developmental process. Jennifer and Michelle's approach of reading parenting literature indicates that they (and the other women who also sought advice and information from parenting books) had a belief that they could effect changes in their baby's behaviour.

Thus expectations about babies form two aspects. Firstly the idealised expectations of what their baby's temperament and behavioural patterns (for instance of sleeping, eating, waking) will be like and secondly, the expectation that the baby would be amenable to having their behaviour modified by their mother (for instance by soothing, feeding, wrapping tightly). The idealisation of babies arises because the current dominant view of children is that they are "sacred and should be cherished for their innocence, purity and inherently loving and trusting nature" (Hays, 1996, p. 64; Lupton, 2014). These ideas were promulgated in the popular parenting books that Sharon Hays (1996) examined and are consistent with the overwhelmingly positive images of babies in media presentations of mothers and babies (Held & Rutherford, 2012).

Jennifer, Michelle and the other women's expectations that their babies could be trained and that it was part of their job to train them, is consistent with views of child development and mother-baby relationships perpetuated by psychological research (Woollett & Phoenix, 1997). Woollett and Marshall (2001) summarised the current constructions of 'good mothering' of children. It appears that right from birth the women were attempting to meet the standards of the 'good mother' construction with respect to their practices of monitoring their baby's behaviour, being warm and responsive and setting high standards for their baby's and their own behaviour. The women's reliance on parenting books was consistent with this intensive mothering ideology (Hays, 1996) in that the books were a resource when babies did not respond in the idealised ways that were expected. While the books provided information and advice, many women described them as perpetuating the

idea that all problems can be resolved by the mother. The idea the women had that they should be able to resolve their problems with infant care, is consistent with Fiona Dykes (2005) finding that the women in her study, experienced motherhood as a project to produce a 'good baby' in line with "notions in western society around civilising babies". Consequently it was very undermining of women's confidence when they did not find ready solutions as they expected. Many of the women struggled with infant feeding, weight gain and health issues and this is discussed in more detail in Chapter 7.

Discussion

The women experienced a complex load of expectations about themselves and the personal qualities, skills and knowledge they brought to motherhood; about motherhood being their responsibility and not that difficult and about babies being "cute and adorable" and trainable by said capable mothers. Consistent with many studies of the transition to motherhood (see for instance Lupton, 2000; Miller, 2007; Nicolson, 1999) the lived experience of motherhood was a profound contrast with the expectations the women had of themselves as women, and as mothers, of what mothering would involve and of how their babies would be. The next chapter highlights four of the main challenges that the women in this study described. I propose that even the fact of having the challenges was distressing, as they ran counter to the women's idealised views of motherhood and babies. Consequently women experienced further distress related to a sense of loss and a lack of certainty in the new, less ideal territory of motherhood as they experienced it. I also propose that, as Dana Jack describes, many of the women's distress was also associated with their isolation, related in part to their understanding of motherhood as women's work, that is, <u>their</u> work. The reluctance many of the women had for allowing others to take over parts of the role, attests to the power of this discourse of mothering responsibility. The discourse of mothering responsibility would potentially position women who relinquished the role as failures, unfit or mentally unwell (Woollett & Marshall, 2001) . Also the women's sense of themselves as capable problem solvers may have also given them persistence in attempting to resolve problems themselves rather than seeking advice or assistance in the early period of caring for their babies.

Chapter 6

Contexts for Distress

For the most part the women were able to give a narrative of the events surrounding pregnancy, birth and early parenthood and described their own understanding of the unexpected and significant difficulties they believed had contributed to their distress. In hearing these stories it became apparent to me that no participants experienced the idealised experience of motherhood that they had expected and that their distress arose in the context of diverse and significantly stressful events or circumstances. There were four general circumstances that appeared to make motherhood more difficult; traumatic or difficult birth, women's physical health problems, child's health and feeding problems, and lack of practical advice and assistance. In this chapter I will explore each context in turn and then provide a brief discussion.

Traumatic or difficult birth

It is useful, firstly, to give some context with regard to birth experiences within this group of 22 first time mothers who gave birth to their first baby between 2001 and 2007 (with the most frequent year (mode) being 2006) . All were hospital births except one woman who birthed at home. One other woman who had also planned a home birth was taken by ambulance to hospital because of foetal distress ending up birthing vaginally with no complications. A third woman planning a home birth experienced a preterm emergency caesarean.

Only 6 women did not have some form of birth intervention beyond pain relief.

- Two women had what are labelled assisted births in that their baby was born vaginally assisted by use of forceps and/or ventouse suction.
- Ten women had their labour induced, including 6/7 women who used IVF treatment (the 7th woman using IVF had a planned caesarean).
- Of those ten women whose labour was induced four went on to have caesarean births. Two other women had emergency caesareans without induction, and one other woman, referred to above, had a planned caesarean. This gives in total, seven caesarean births. This rate of caesarean births (31.8%) is higher than the 24.6 rate of caesarean sections performed in New Zealand in 2006 (Ministry of Health, 2010). In Waitemata and

Auckland District Health Boards where most of the women in this study gave birth, the recorded number of Caesarean births were 27.2 and 28.4 per 100 births respectively in 2006 which were higher than the national mean but not as high as the rate for women in this study.

The women in this study are not a representative sample of the population demographically nor with respect to the higher proportion of participants who had experienced fertility treatment. It is likely that these factors are linked with the fact that many of the women experienced interventions in the birth process. For instance, of the 13 participants who were over 30 years at the time of the first baby's birth, only two women were not induced and/or had a caesarean. By contrast only two of the 9 women 30 years and younger were induced/had a caesarean. This interaction of age and intervention is also noted in Ministry of Health (2010) national reports and is likely a function of clinical practice where induction was recommended to all participants who were over thirty.

However the question arises as to the cost to women, when birth interventions are implemented that prioritise the safe birth of the child. A review of empirical studies concluded that "a link between caesarean section and postpartum depression has not been found" (Carter, Frampton, & Mulder, 2006). There were diverse accounts of the impact of caesarean births by the women in the current study. Three women described their caesarean birth positively with terms such as "it was all great and lovely and ...excellent" (Cynthia); "that was great and ... phew ...she's arrived" (Erin); "good I was just so glad to have the hospital team there." (Laura). Each described being fully in agreement with the decision to have the caesarean, in that Cynthia had planned the caesarean, Erin was concerned for her baby's welfare and Laura had experienced a very long and tiring labour and "just wanted a caesarean". However, the four other women who experienced caesarean births described aspects of the experience as "a shock" (Pamela), "hideous" and "scary" (Lisa), "going hideously wrong", "freaky" and "bizarre" (Dawn) and "a blur" (Jennifer).

For these four women and 7 others in the study (half the 22 women) the birth experience was described as difficult and a number of key issues seemed to be important. The women described difficulties including the experiences of fear and anxiety related to concerns for the safety of their baby or themselves, feelings of disconnection from the birth experience and their baby during and after the birth due to shock, exhaustion or drug reactions, feeling unsupported by maternity care givers during the birth and for some women

feeling ill informed about events and procedures during the birth. Within this section I will take a more narrative approach in order to make more contextualised connections from the women's accounts regarding the material challenges they faced and their responses.

Pamela's description of her baby's birth included most of these aspects except that she remained emotionally connected with her child during and after the experience where both her and her baby's lives were acutely at risk. Her birth experience contrasted dramatically from her plan for a home birth. At 37 weeks, following a scan, Pamela discovered that her baby was at risk and that she would require an urgent caesarean. She described intense fear for the safety of her child and herself "practically hysterical...I just didn't ...know what was gonna happen and I was really scared."

Several incidents occurred in the course of the caesarean which increased her distress. These are not detailed to preserve anonymity; however, to summarise, Pamela described feeling unsupported and found the health professionals involved in her care lacked sympathy for her feelings of fear and loss of control. Her birth was narrated as a series of catastrophes that started with sitting in the waiting room and overhearing her radiologist talking to the receptionist about scan results that showed serious complications with her baby and the need for urgent referral. Pamela described several medical procedures which were "extremely painful" and gave an account of her lack of confidence in the competence of the staff who she said "did not know what they were doing". She gave a sense of her intense shock when she described the point that she "really did think ... that they just...lost it, they'd lose me". Pamela's account of the on-going impact of the birth experience and her own near death included feelings of intense hyper-alertness, anger, particularly at health professionals, self-blame for not picking up on issues earlier and reviewing over and over what she or the midwife could have done. She identified these problems as associated with post-traumatic stress disorder (PTSD) and her experiences and symptoms would be consistent with some of the criteria for such a diagnosis (American Psychiatric Association, 1994).

Acute fear was also the prominent feature of Susan's birth where she described being "petrified" to the point where she "shut down". Her labour was induced and after a long labour her baby was born with assistance from a ventouse (vacuum suction device). Susan related her fear to the fact her lead maternity care giver did not tell her she had been induced and she made several other decisions without discussion or explanation with Susan or her husband. Susan attributed her fear during the birth to her primary maternity caregiver being

remiss with “Not giving the information. [Having] a condescending attitude” and being “unsupportive”. Susan described feeling “in shock” and “detached” for weeks after the birth and several months later was diagnosed as having PTSD symptoms that she related as “not bonding” with her baby, “being hyper-vigilant” in a “constant state of arousal”, “flashbacks...to the birth” and feeling “tired...angry ...upset.”

Both Pamela and Susan experienced intense fear combined with a lack of support, confidence and information from maternity care givers. Both described experiencing PTSD symptoms which they related to these experiences despite the acuity and method of ‘delivery’ of their babies being very different.

Lisa also experienced a difficult birth where labour was induced at 42 weeks but because of meconium in the waters she was then taken for a caesarean section. Unlike Pamela, Lisa was able to have her own midwife throughout the process whom she trusted and she was quickly accepting of the need for a caesarean section and believed she was “well informed” throughout. However, she gave an account of “starting to panic thinking the pain’s coming” as she vividly described the sensations of the operation when she “felt them cutting me open and the cold air and everything I started screaming” and heard “the sound of chicken skin ripping you know when you rip a chicken leg”. Afterwards Lisa described feeling disconnected generally; “I was quite doo lally and not really present”. She also described not being “the least bit interested in” her new baby. Unfortunately her first experiences of her child were negative; breast feeding was initially painful and she also experienced pain from the operation and extreme discomfort at the return of a pregnancy related skin condition. Lisa described continued feelings of disconnection, being “useless” to her baby, “so unhappy”, “on edge” and “angry no one could see what was going on inside me.”

While it may seem intuitively likely that Lisa’s experiences of shock and horror during the birth would impact on her coping and sense of unreality after the birth, Lisa along with two other participants attributed her feelings of being disconnected generally, and particularly from her baby, to the pethidine and tramadol medication she had been given. Lisa referenced “great big dilated pupils” and being “quite incoherent” as evidence for this conclusion. Similarly Jennifer, was also given pethidine medication during the birth involving induction and caesarean section, “which I ended up having a bit of a reaction to and ended up completely stoning me out for three days”. She described that the birth “wasn’t a good experience” as she felt “completely out of control” and that it was “all a blur...I don’t

even remember having him or him coming out or anything". Her narrative was focused on explaining the crux of the matter for her which was that after the birth she "did not want to have anything to do with" her baby, describing similar feelings of disconnection to Lisa as well as being "terrified...at the whole ultimate responsibility". Side effects of pethidine given to women during birth have been summarised as nausea, vomiting and sedation in a review of studies by Bricker and Lavender (2002). These authors made no comment on postnatal effects for women. They did however describe findings that suggest use of parental opioids (of which pethidine is most commonly used) for labour pain relief can be associated with problems for new babies including respiratory depression, decreased alertness, inhibition of suckling, lower neurobehavioral scores, and a delay in effective feeding (p.105). Several quantitative studies (see for instance Astbury, Brown, Lumley, & Small, 1994; Boyce & Todd, 1992; Green, Coupland, & Kitzinger, 1990) that have looked at birth events and their relation to postnatal depression have described finding a connection between increased obstetric intervention (including pethidine analgesic) and postnatal depression. By contrast, Astbury et al. (1994) found that birth complications such as low birth weight were not associated with postnatal depression. These findings give further acknowledgment of the distressing nature of births that involve obstetric interventions, including emergency caesarean, and pethidine pain relief. The potential effects on their infant's responsiveness and feeding are also likely to impact on the women's confidence and stress in early mother hood.

Births experienced as traumatic or difficult caused a mix of responses including but not always-fear, shock, anger, exhaustion and disconnection from self and others including the woman's baby. Feelings of disconnection from their baby were described by 9 participants. This feeling of disconnection lasted for a short time following exhausting births for some women, for instance, Stephanie, who was in labour for two and a half days and described how she responded to seeing her baby with little emotional reaction:

> 'oh here you are' there was nothing, nothing else…I just thought 'what's wrong with me like I should be, I should be overwhelmed and happy that s/he's here' but it just didn't feel, I was just so tired and just like 'well here you are now what do I do with you' kind of thing…and it made me feel really guilty like does this mean I'm going to have problems, a problem dealing with her/him…and I just felt the most awful mother on the planet. Stephanie

While later, Stephanie was able to acknowledge the impact of exhaustion, her expectation of how to be a mother turned disappointment into judgement. By the end of her first week, Stephanie had overcome the challenge to breastfeed which had also "not come naturally" as she expected. Stephanie then came to a decision to "just take it day by day and just deal with it." In this way she then began to "kind of kiss her/him more and cuddle her/him more… and relax with her/him a bit more and just appreciate the time yeah a lot more."

Other women described feelings of rejection of the role they were expected to play very soon after birth where the practice described by women at the time they had their first baby ranged from (for some women) just showing them the baby and offering for them to hold it if they wished. This was the usual practice after a caesarean birth. Some women were helped to breast feed their baby soon after birth. Others, like Mary, were given skin to skin contact and breast fed their infant very soon after birth. The recommended practise today as summarised by a Cochrane review (Moore, Anderson, Bergman, & Dowswell, 2014) is to introduce babies to the mother's breast and have skin to skin contact between mother and baby as soon as possible after the birth to facilitate bonding and breastfeeding. Lisa, who had difficulty with bonding and feeding her first child, showed that she had become aware of the reported benefits of skin to skin contact and after her second child was born by caesarean, she asked for this to happen to avoid the problems arising again.

Dawn, who experienced a difficult birth including induction and emergency caesarean, described how when her husband brought over the baby "I just like 'get him/her away from me I'm just yeah not interested.'" Dawn related her reaction in more detail

> I just wanted the whole thing just to be, just to be over and I didn't, wasn't in any I was, I guess I was more concerned I mean 'is s/he okay yes, okay then that's all I need to know I can't deal with, with her/him right now I need to yeah all I can cope with is what's happening to my body it's yeah it's all just crazy yeah.' Dawn

This experience combined with her baby's significant subsequent problems with reflux and colic meant that Dawn felt she "didn't feel bonded to her/him. I felt like I was enduring the time with her/him." Dawn did however report having a sympathy and commitment to care for her baby. Dawn, like 4 other participants, described starting to feel bonded or connected emotionally to her baby when he/she was 9 months to 1 year old and all described feeling disappointed and/or guilty about this. For some, like Dawn, the lack of bonding may be attributed to the challenges of caring for a baby with health or feeding issues that make them

difficult. These problems of caring for and attaching to babies with health or feeding problems will be discussed later in this chapter. For other women who had relatively 'easy babies' who slept, fed and could be soothed easily for instance, other stressors made child care more difficult. For instance, Erin and Laura experienced difficulties in their couple relationship that disrupted their ability to be the mothers they wanted to be for their children. Still other women, like Monica and Amy for instance, experienced severe health issues making child care painful. Which leads us to the focus of the next section, namely, the impact of women's health issues, which often, though not always, began during the birth process.

Women's physical health

Physical health problems associated with pregnancy, birth and post birth were described by just over half (12) the women. Many of the problems caused intense discomfort. For instance two women described experiencing PUPP (Pruritic urticarial papules and plaques of pregnancy) a pregnancy related eczema, which they described as being "covered in a really itchy rash" (Mary) and finding no relief as Lisa described "big red and purple welts just all on my arms over my chest stomach legs arms everywhere um and I mean I'd just take to myself with the cheese grater and just scratch myself because I couldn't get any relief."

Another pregnancy related health issue experienced by Wendy was "restless legs" that meant her legs twitched and kept her awake "so I wasn't getting to sleep till sort of often two in the morning...So I was I was pretty much exhausted by the time [baby] came along". These issues prevented the women from sleeping well before the birth and all three talked about the impact of tiredness for them in the early parenting phase. For Lisa the itch continued after her baby was born, and made contact with her baby intensely uncomfortable "I was starting to itch and I was on plastic sheets with a stinking hot baby um and yeah it was just hideous". Lisa's experience of PUPP likely made her birth experience, which included an emergency caesarean even harder. Both problems then impacted on her recovery from the operation. The practice is also to have mothers continue with breast feeding and caring for the new infant through this recovery. Emotionally this was overwhelming for Lisa and it is not difficult to conceive that it would stretch the capacity for coping in most people.

Eight women described post birth physical complications. I will not name the women to protect their anonymity as some problems are quite uncommon experiences. Three women experienced blood loss and either high or low blood pressure problems, one women

experienced a haematoma after a forceps birth, two women were unable to sit for several weeks after birth as one experienced a bad vaginal tear and the other described how "I broke my tail bone and I had really bad hips as well...during labour...Yeah. And I, my pubic ligament was, yeah, a bit hashed up..." Two women experienced infections, in one case this was due to a retained placenta while the other woman experienced an infected caesarean wound. Both required readmission to hospital for treatment.

These health issues, neatly summarised, fail to describe the way these problems affected the women and seemed to cause further disruptions to their ability and confidence as mothers. Firstly, several women described feeling physically very unwell and some described being in pain. Despite their health challenges, the women gave accounts that demonstrated that they had put many of their own needs aside in their determination to be the mother they believed they should be. For instance, all the women who experienced post birth health problems described breast feeding their babies, even though for some this was very difficult. For instance, Julie, who had surgery after the birth, gives an account of the difficulties this caused in initiating breast feeding:

> Whole first few days in hospital were very, very difficult and the breastfeeding was difficult because my milk supply was affected by the anaemia and I couldn't sit up to breastfeed...because of the pain...cause trying to breastfeed lying down which then made that even harder, so I got really cracked nipples. Julie

Other aspects of mothering were affected by health problems. Monica described her motivation for "pushing through the pain" as she cared for her baby:

> To be a good nurturing mother, and I really wanted to be that. So I made sure that s/he had floor time, and I was down there with her/him, but the pain was, but it wouldn't stop because of the pain and that's, I guess it's sort of the person who I am, I don't, I'd rather push through the pain and do what I know is right, and what feels right. And then just keep, and I probably made it much, much worse by doing that. Monica

Monica's account of her activities in providing "floor time" and goal to be a "good nurturing mother" are consistent with aspects of intensive mothering doctrine (Hays, 1996). In following the ideal of the attentive mother who provides stimulating experiences for her baby, Monica sustained activities that appeared very aversive to her and were likely a factor

in her disclosure that she was not able to tell her child that she loved her/him for the first year of her/his life.

A final point to note, is that Monica, Julie and Lisa's stories all illustrate how one difficult experience or problem leads on to others. As will have become apparent throughout this chapter, the women generally experienced multiple contexts for distress often related and compounding.

Child's Health and Feeding Problems

By far the most common context for distress involved infant feeding difficulties and health problems, with 17 of the women describing some form of distress related to such problems. Feeding problems included poor infant weight gain, baby colic, and spilling or reflux. Baby colic is defined by Plunket (2015) in an on line information site for New Zealand mothers of preschool children, as "when a baby cries for several hours a day and there is no obvious cause for the crying. Your baby may draw their knees up and be hard to comfort". Barr (2006) summarised recent findings that indicate that colic is at the more difficult end of a continuum of increased inconsolable crying occurring in most infants in their first three to five months of life. This framing of colic as a normal (but nevertheless difficult for parents and caregivers) part of infant development, is a shift from previous medicalised understandings of colic as an illness. Spilling or reflux is where babies bring up (regurgitate or vomit) milk. Reflux or spilling is attributed to the valve at the top of baby's stomach still developing, so that milk sometimes comes back up if the valve doesn't close properly (Plunket, 2015). Martin et al. (2002) state that "spilling in infancy is very common, but the majority of children settle by 13 to 14 months of age". Health problems that were not related to feeding occurred in three babies who experienced serious cases of asthma in one case, another had eczema or one baby experienced developmental problems identified soon after birth.

I will focus firstly on infant feeding problems as they were the most common and were inextricably linked to women's sense of confidence as mothers. Ensuring their infants had sufficient milk to thrive was by no means straightforward for many women and problems with feeding and breast feeding in particular formed the most common reason for distress for women. The distress was associated with a number of aspects of the mother and child dyad, including difficulty for both mother and infant in getting breastfeeding going and then worries and difficulties maintaining breastfeeding in a way that ensured the infant was

growing, mother's health issues that impacted on breastfeeding (like painful birth injuries, mastitis or other infections, discussed in the previous section) and child health issues that increased the work load and made feeding, soothing and comforting the infant very difficult and disrupted the mother's sense of closeness to her child.

These difficulties occurred within the context of most women in the study at least attempting to breast feed. Only one woman in the study did not breast feed at all because previous breast reduction surgery prevented this. The length of time the women breast fed ranged from less than one month (three women) to one woman who breast fed for 3 years. Four women breastfed for 1-3 months, five breastfed for 4-6 months and nine others breastfed their babies for longer than 6 months. This rate of initiating breast feeding was similar to that reported in the New Zealand (NZ) Health Survey completed in 2006/7 (Ministry of Health, 2008b) where 9 out of 10 children aged from birth to 14 years had been breastfed as babies.

Within New Zealand, as with many other countries, government health agencies over the past 20 years have worked to increase the uptake of breastfeeding and have promoted practices in line with the recommendations of the Global Strategy for Infant and Young Child Feeding (World Health Organization UNICEF, 2003):

> Infants be breastfed exclusively from birth to 6 months of age. After that time, appropriate complimentary foods (solids) should be introduced and breastfeeding continued up to two years of age or beyond. (WHO, 2003)

The participants described being exposed to the promotion of breastfeeding, particularly in the birthing units at hospitals, and their accounts demonstrated that most were aware of information that has originated from scientific studies as to the purported benefits of breastfeeding (for a scientific review see Eidelman et al., 2012). Women talked in particular about the benefits for infants receiving breast milk in the first few days after birth in order to better develop immunity to health problems. Erin's account illustrates her commitment to breast feeding for the health of her child, noting the benefits for the immune system:

> I'd read some of the stuff about it saying even if they can get a small amount of breast milk then it helps their immune system and if you can keep some breast milk going for the first three months that's, and with him/her rapid breathing and them not knowing what it was I thought, 'god I really need to try to do that.' Erin

Difficulties feeding infants often began while the women were still in the birthing unit. As outlined in the previous section, women described having had an expectation that breastfeeding would be a natural, instinctual process of loving bonding between them and their baby as Stephanie described: "I really thought that would be more natural and it was a lot more hard, harder to do technically than I thought". What Stephanie and other women found was that feeding was more of a skill to be developed and more "technical" than they had expected. This is also illustrated in Donna's account of how she had "managed, you know, all of the actual logistics of the breastfeeding… like putting together a kitset you know, chest of drawers."

For some women developing their breastfeeding was made more difficult because of a lack of milk supply while they were in the birthing unit. This raised two issues. The first was that some women did not have enough opportunity to practice breast feeding their baby because of the lack of milk supply. They then did not feel they got sufficient guidance from hospital staff to gain confidence in breast feeding before being discharged. A second consequence of having a milk supply that took time to develop was that women became very focused on their milk supply and concerned about whether they could provide sufficient milk for their babies. Dawn's account describes her lack of confidence and the intense worries she experienced at the time related to feeding:

> Yeah well I would have liked to have a bit more time particularly from the feeding aspect of it to at least have had one or more sort of full days that you know I was doing the feeding and someone was saying, 'Yes that's right, no that's wrong'. You know see s/he's doing this and it means s/he's getting I mean obviously you can't see how much they're getting that's the problem with breast feeding where if you've got a bottle you know how much they've had. So you know is my milk flow enough, is it not you know am I starving my child you know you've just got no idea… Dawn

Dawn's fear that she may be starving her baby may sound extreme however the level of oversight of baby weight gain in hospital and by visiting health visitors elevates the importance of women providing sufficient milk for the baby to thrive. Within the accounts it was common for women who breastfed to question the adequacy of their milk supply even when their infants were growing. However, this was particularly concerning for women who had children who did not gain weight as expected. In trying to meet their babies' nutrition needs, the majority of women described following the child-led demand feeding protocols

which were the recommended practice of the time and currently (Ministry of Health, 2008a) Dawn defined demand feeding as "Oh, you know, you just do it when they need it and you know whatever they need you know, you do it sort of style". Following these protocols added to some women's difficulties as they assumed that a baby will demand to be fed.

Eight babies were described in ways that indicated they were not showing strong feeding behaviours in that they did not cry to signal hunger, were poor at sucking and/or were very sleepy. Problems arose in two ways. Firstly, the babies did not ingest sufficient milk at each feed to gain the energy to feed more strongly and gain weight. Without getting sufficient milk the babies were then in a pattern that potentially got worse as the baby got weaker. Alongside the anxiety that women (and their partners) experienced, the women then had to consider the alternatives to breastfeeding 'on demand' because their babies were not adequately signalling a need for food and required special strategies to enhance their weight. Strategies to increase their child's weight gain were described as emotionally and physically demanding on the mother and included increasing frequency of feeds, breast feeding then expressing breast milk that was then fed to baby from a spoon or bottle, giving adjunctive bottles of formula or transferring completely to formula feeding.

In these circumstances a terrible bind arose for the women. Do they breast feed their fragile baby in line with the 'breast is best' endorsements arising from the powerful lobbies of scientific, medical and psychological developmental and attachment research (Eidelman et al., 2012; Woollett & Phoenix, 1991)? When these discourses are combined with support from the natural mothering movement (Beckett & Hoffman, 2005; Bobel, 2002) breast feeding is elevated to a moral imperative and equated with good mothering. Moral language was used by women in their discussion of breast feeding even when it went well as Mary said, "Thank God I could breast feed."

Alternatively women could move to "dirty bottles" as Cynthia described her mother calling them. If breast is best then bottle or formula feeding are positioned as second rate at best. The counter story to the promotion of breast feeding as the ideal nourishment for babies is that formula and/or bottle feeding are equated with depriving the child of the benefits and exposing them to potential harm. In this way formula and/or bottle feeding are viewed as bad mothering. As Lisa said "I felt quite happy when I put her/him on formula...I felt ashamed that I felt like everyone was thinking I was a bad mum kind of thing... I had absolutely no consideration for [baby] really in that time". Lisa's comments indicate her conflicted feelings

about moving from breast milk to formula and her view of this as "having no consideration" for her baby indicates the moral standing of the "breast is best" mandate. Dawn stated "you get told that breast feeding's the best thing to do …and formula no, no you really shouldn't do that you know it's not really the done thing" which highlights her understanding of formula feeding as immoral particularly as she added how she felt "guilty" about formula feeding.

So in circumstances where hospital staff, visiting midwives and partners encouraged women to shift from breast to formula or bottle feeding, the stakes were high for the women. To follow this advice the women had to accept that they would thus be positioned as having failed as good, breastfeeding mothers, and would be potentially viewed as depriving their needy child of what is represented as the best nourishment.

This invidious position was made more difficult for two women (Cynthia and Kimberley) who both described a strong determination to breast feed which they attributed in part to the influence of their mothers who were described as very supportive of breast feeding. For the most part, male partners deferred feeding decisions to the woman and no participants described partners who disapproved of a shift from breast to formula feeding. However, when there were issues regarding poor weight gain, two men, Cynthia and Kimberley's partners, were critical of their determination to continue breast feeding and not use formula. When advice was contrary to what the woman were doing or wanted to do, both women described becoming very anxious and unsure. Cynthia's baby was failing to gain weight and she was breast feeding and then expressing milk and bottle feeding it to her baby. She received criticism from both her mother, who agreed with breast feeding but did not approve of bottles, and her husband, who wanted her to supplement the breast feeding with formula. Cynthia described her experiences thus:

> Very tense, I was trying to please mum, I was trying to please [Husband]...And at the same time I was having to express all the time so I was getting knackered. And washing all these friggen bottles, you know, nine bottles a day, you know, well we'd have nine feeds a day. So I was getting all those infections under your fingernails, you know, which is kind of fatigue and, you know, when you get poisonous fingers.
>
> Cynthia

Once again, one problem leads to another; her child's physical health problem then became an emotional, moral, social and physical problem for Cynthia. Cynthia's story gives a sense

of the anxiety and sheer hard work that all the women with children with weight gain problems felt.

A second distressing aspect for two women who had babies who were sleepy and placid after birth, is that in following the guide of the child-led parenting paradigm they allowed their baby to sleep. They did not get instruction or guidance in the immediate hours after birth to feed their baby from hospital staff and the babies themselves were not "demanding" to be fed. Monica described the context of a difficult birth and then little staff assistance immediately afterwards as the context of her not feeding her baby.

> Didn't really give me anything to eat afterwards and didn't say that I needed to breast feed. So I had no idea that baby's out in the world and no nutrition… it wasn't until one of the Midwives there mentioned, 'When was the last time you breast feed?' And I, I hadn't. So that was probably a good five hour, six hours by that stage. And of course that was a really difficult process to start off with. But then you feel more detached, because you don't feel like you're nurturing your child from the word go. 'Cause you feel like you've done something wrong already, by not having that breast feeding experience within the first couple of hours. And when you know it's necessary but, you know after you've been told it's necessary. So that was difficult.
>
> Monica

Monica's account presents the cost to her confidence of being positioned as failing or "doing something wrong" because she did not meet one of the perceived best practice guidelines related to breast feeding, namely breast feeding as soon as possible after birth. She equates breast feeding with "nurturing" and attributes her lack of emotional closeness with her baby to the delay in feeding. Cynthia described having her baby placed on her breast immediately after her caesarean birth but then did not feed the baby for the next 24 hours because she and family around her thought her tired baby needed sleep.

When babies have feeding problems that mean they are not providing behavioural signals that they are hungry, the child led parenting paradigm is problematic and can misdirect women in deciding what the best approach is for their children. Also, the myopic privileging of breast feeding does not take into account the complex physical, social, political and cultural contexts of women and their babies. This acted to limit the options that women could take in providing the best care for their child while still being positioned good mothers.

Seven women described their babies as having colic, reflux and/or spilling. The descriptions of the lived experience of these problems gave a sense of the aversiveness of some of the "symptoms". A key problem was the length of time and intensity of the babies crying. Melissa described her baby crying "from eight till eleven every night s/he'd scream non-stop" and Dawn gave an account of her baby's timing: "s/he'd just be screaming you could set your clock by four o'clock s/he'd start and seven o'clock s/he'd finish of an evening so you literally could set your clock by her/him. (laughter)". Another difficulty was the discomfort that children experienced while feeding which made feeding aversive for the mother. Dawn described how her baby would:

> fight me when s/he was going to be fed because it would hurt her/him but I didn't you know and so s/he'd be like sort of pulling her/his head away and I'd be like trying to, trying to hold her/him on trying to sort of force her/him on sort of style and you know s/he'd end up screaming and I'd end up crying and it'd just be a bloody disaster.
>
> Dawn

This account of infant feeding is a distinct contrast to the warm and loving interactions that can occur when a woman feeds her child. When a baby does not respond to feeding positively, not only does the woman have an aversive experience as she attempts to meet her child's nutritional needs, she also loses the potential for warm and loving moments of connection between mother and child that can come from a baby's positive responses to being fed and close to their mother. Reflux and spilling for Michelle were terms that were used to described constant regurgitated milk and the fact her baby would "power chuck at least once every couple of days".

These problems were described by the women as "horrible" and "terrible" and something that had to be endured. As Dawn said "I don't like it, oh well suck it up" and Melissa described how she "just trudged on, as best I could". These accounts describe the fortitude required by the women to continue performing their mothering tasks. It impacted, however, on the closeness women experienced with their child. For instance, Dawn and Susan, whose babies screamed and cried for long periods, both described finding it hard to bond with their babies during this time. Another significant effect of the infant colic, spilling and reflux was that it isolated women in the home. The women all talked about the difficulty of taking their child out of the house and the difficulty getting breaks from child care. Some women got innovative. Melissa for instance described being initially resentful however with

humour described how she "invested in ear muffs... you know, when you've got a child right here next to your ear having a big old scream fest it, it really grates you. Really gets on your nerves. So, yeah, we just put ear muffs on."

The third set of child related issues that impacted on mothers were relatively severe health issues experienced by three children. One baby required admission to hospital for asthma on several occasions, another baby had severe allergies and eczema that required dietary restrictions and a third baby had developmental issues identified early after birth. Each woman described experiencing a point where they consciously adjusted their view of their role as mothers to meet the special needs of their child. Each shouldered more of the responsibility of care for their child because they did not feel that alternative care givers (family or paid child care) could meet their child's special needs adequately. The emotional cost to women in these circumstances related firstly to the increased work load associated with managing their child's health needs, the concern for their children and the loss of options with respect to going back to work, for instance. This account by Julie gives a sense of the lived experience of a child with allergies and eczema. Firstly she described the emotional cost associated with the difficulty and hard work of managing the health problem:

> But it was incredibly hard work we had I was told to give her/him two twenty minute baths a day, and this was a baby who absolutely hated the bath and screamed the whole way through and would scratch her/himself stupid whilst in the bath. I was supposed to put cream over her/his entire body eight times a day…And again this is a wriggly infant who hates…being naked and got rashes over her/his body… Julie

Julie then goes on to highlight the extended nature of the hardship which she underlines with repetition. The continued adjustment to new challenges associated with the child health issues is highlighted by her comment about his mobility and the changes she made in her work plans to accommodate her child's special needs:

> That was starting when s/he was about eleven weeks I think…when the eczema first started… just at the stage when everybody says, 'Oh yeah three months things get easier' actually it all went to custard…For us and got really, really hard…And didn't really get easier for a lot longer. So that was I guess a major factor in not going back to work, because [Baby] needed so much extra care I really felt that I couldn't leave her/him with anybody else, and by and then getting on to, I guess, when s/he was

mobile at nine months I've got all the issues about picking food up off the floor.

Julie

Summary

The accounts of 17 women, presented a picture of motherhood as "incredibly hard work" (Julie) both emotionally and physically when infants have feeding and health problems. The problems were generally difficult to resolve which undermined new mothers confidence in their own abilities to care for their child. Some problems like colic, reflux, spilling, asthma and eczema did not have ready solutions though women searched for and tried strategies to improve their baby's wellbeing. Providing the names of these problems in a list minimises how aversive some feeding and health difficulties were to live with. Women also described intense anxiety and uncertainty as they tried to find solutions to improve the comfort of their infants and for some, to ensure their baby's growth and survival. Michelle described her response to caring for a baby with reflux thus: "an anxiety issue just being sort of constantly worried about her/him and worried about what to do next and just not sure and just feeling like it was just all just too, more, much more than I signed on for". Managing problems that went on for months became test of endurance and some women described times of feeling very hopeless.

When children had problems that meant they had discomfort while feeding, or cried, screamed or spilled a lot, several mothers described their feelings for their child being affected. Michelle described not feeling detached from her child but her account shows her conflicted feelings related to her child's problems with pain while feeding and long periods of crying each day:

> I certainly remember not liking him/her very much and I never felt, I sort of thought, oh you know, I didn't feel that I didn't love him/her but I do remember thinking, 'I don't like him/her very much.' And every now and then I'd s/he'd do something and then you think, 'Oh that's so lovely,' and then you think 'Oh that's so cute' and then s/he'd be horrible again and you went, 'Oh.' (laughter) Michelle

Having a child with feeding and health problems generally also meant that women became more isolated and trapped in their homes. Women whose children had more enduring problems found that they were required to continue with full time mothering beyond when they expected to, creating further adjustment at the point they were planning to return to work

for instance. These compromises and adjustments will be discussed in more detail in Section 2 of the thesis focusing on women's paths to recovery.

When deciding how to manage child feeding problems the women faced a discursive bind. Women described being advised to supplement with or switch to formula and/or bottle feeding both in hospital by staff and on returning home by the visiting midwife or other health professionals and family. The dilemma for women was that in following this advice they were put in the position of failing to meet the recommendations of powerful lobbies promoting exclusive breast feeding for new born infants up to 6 months (for instance Eidelman et al., 2012; Ministry of Health, 2009). Within breast feeding promotion material benefits are at times reworded as risks. For instance, The American Academy of Paediatricians, in their policy document on breast feeding (Eidelman et al., 2012), has a recommendation that paediatricians should warn women about the "health risks of not breast feeding". This wording repositions the findings of health benefits to a risk focused message. Deborah Lupton (1993) investigated the political and moral function of risk discourse in public health and concluded that it is often used to blame the victim. In the case of breast feeding the blame is on the mother, which may explain the guilt, anxiety and uncertainty women described in making decisions to change to formula, in particular when their child was slow to grow.

This created conflict for two women in their couple relationship when their husband voiced the fact that they did not support the women's persistence with exclusive breast feeding. The men did not face the same exposure to blame and so faced no societal judgement for their choice of child nutrition. There was a cost to their couple relationship, however, of not supporting their partner's decisions. The following section focuses further on relationship and social issues that impacted on the women's wellbeing.

Lack of Social Support

One of the most common problems raised by women (21/22) was that they did not have enough assistance from people they could trust during the early months of motherhood. The lack of assistance they related to an absence of or deficiencies in practical assistance, guidance on mother care tasks like breast feeding, encouragement and affirmation that they were doing the right thing, and/or companionship during the day. For instance most (19) women described experiencing some form of difficulty within their couple, family or friendship relationships when their first baby was born. Of these women half (10) described

difficulty with having no family or friends living nearby, 5 women described their male partners/husbands as either unavailable or unhelpful in ways that were distressing to them and 5 described how members of their extended family were unhelpful and added to their difficulties.

Interestingly, four women moved countries during their pregnancy, three returning to New Zealand while one went initially to Australia before returning to New Zealand a few weeks after the birth. All stated that they returned to New Zealand to be closer to family, as Erin said "we'd come back so I could have family and support around" and Amanda stated "I wanted to be surrounded by my family so we came back". However, shifting sometimes created problems with employment and finances. For instance, Michelle's husband took time to find a job that he liked and Erin's partner started a small business, which caused financial and work stress for them both and took them to live in another town, away from family and with no established social network.

Susan had immigrated with her husband to New Zealand some years before her pregnancy. They had not developed a network of friends, preferring to spend their time together as a couple, and Susan described how this had not been a problem to her until she became a mother with her family living overseas. She indicated that she would have liked "friends with young kids it would really have helped us, but we didn't imagine that that was going to be a problem."

Many of the women described taking maternity leave or resigning from work and not having an established group of friends who were also at home with young children. Donna also lived in an area where she did not have family or friends and felt socially disconnected.

> I didn't know anybody out there and so, you know, the whole thing of being left on your own with a two week old baby when you're living out in a place where. And it's not like, it's not like I mean this is going to sound so sort of smug middle class completely but …like even in terms of like neighbours or whatever you know there was the woman across the road I used to hear her, you know, 'I'm going to give you a hiding' to her kids and so you know it's not like you'd kind of go, 'let's get together and have a nice coffee group or something.' Donna

Donna was also in the same position as a number of participants whose cohort of friends did not have children and were continuing with full time work. As Michelle said "I think it's

quite lonely as well to be stuck at home and not really know very many people and just, kind of, and everyone who you do know is working during the day." Indeed, fifteen of the women described experiencing feelings of loneliness, isolation and/or having "cabin fever" at being at home for an extended time for the first time in their lives with no adult company.

When women discussed not having close family support they were almost always referring to not having their mother available. They gave a number of reasons for this. Firstly, was the simple fact of living in different countries or New Zealand localities, and for half the women this was the case. Movement of people in New Zealand, for instance from rural to urban centres for employment reasons, was identified as a factor that disrupted the quality of social networks such as family connectedness (Romans-Clarkson, Walton, Herbison, & Mullin, 1990). Several women whose parents lived away from them described how they came and stayed for a week or longer soon after the birth but that they received little practical assistance beyond that initial time because of the distance.

However, the mothers of some women lived close by but were unavailable to assist them during the early stages of parenting for other reasons. For instance, because they were viewed as too frail or old as Donna described her mother "came to stay one night and I felt like I was looking after her as well as the baby…they're quite old". Others were described as too busy with their career or paid work as Mary recounted her mother being "amazing and knowledgeable and has got an amazing job" and consequently they "don't actually get to see her very often she's quite busy". Some mothers were described as unavailable because they were busy with other responsibilities. This was the account given of Kimberley's mother who was living with and raising other grandchildren.

The importance that women in this study placed on assistance from their mothers is consistent with the reports from two British studies (McGlone, Roberts, & Park, 1997; Mitchell & Green, 2002). These studies identified that female kinship relationships continue to be generally valued, particularly the relationships between women and their mothers. The relationships between women and their mothers were found to be strengthened when they in turn became mothers, for the 14 working class women interviewed in the study by Mitchell and Green (2002). From their population based study, McGlone et al. (1997) concluded that while kinship relationships were valued, women's increased participation in the paid work force had decreased the time and way that women were able to participate in the work of kinship relationships. This certainly seemed to be the case for some women in this study

whose mothers were in full time paid employment and had less time to provide practical assistance and emotional support. Another interaction of paid work and level of support was the effect for women and men who had remained in the paid work force for longer and had their babies in their late thirties and forties. In their case there was more chance that their parents would be less physically able, as was apparent from Donna, Wendy and Julie's accounts.

Another group of women found their mothers or family unhelpful. One problem was related to parents who gave the new family 'space'. Monica, who usually had daily contact with her sister, described how "my Mum, I don't know where she gets these ideas from, but basically said to my two sisters that, 'Monica and [Husband] need time to bond and get used to the baby, so no contact for the first two weeks.' So I had nothing." Wendy's mother "was very sort of hands off she didn't want to intrude." Lisa described her mother as "really caring and thoughtful….But she's got this thing she doesn't like to interfere". There are two aspects of these accounts. Firstly it appeared that the women's mothers were prioritising the nuclear family relationships over a more extended family engagement. Secondly, they seemed to be attempting to preserve their daughter's autonomy. However, for the three women above, this was at odds with what they wanted. Women who were happy with their mother's involvement gave a sense of what the women may have wanted. For instance, Michelle, who had a baby with colic, described her mother as fantastic:

> But my mum was fantastic and spent a lot of time coming over and visiting, and coming for the day, and bringing dinner, and hanging out washing, and taking [baby] away…very practical help, help which was great actually, and she would take [baby] for a walk and it didn't matter that [baby] would scream at her. Michelle

Practical assistance with housework, preparing meals and, for some women, caring for their baby were the main sources of support women described as helpful. When asked about whether her mother gave Michelle advice, she described appreciating the way her mother went about giving advice as optional rather than a directive:

> Mum's quite a, 'we'll just try this and see what happens and we'll...' she wasn't very pushy about oh we you know baby's need to do this, or whatever…but quite sort of, 'oh well,' you know, 'let's give this a go'. My mum's had five children but, you know, she said it's a long time ago I can't really remember when it was all odd

> (laughter) and she's the first grandchild so there hasn't been any sort of practice cousins or anything so it was a bit of an experience for both of us, really. Michelle

As with Michelle, other women described appreciating advice presented as ideas rather than dictums about how they should do things. Michelle's reference to her mother's experience also reflected that of other women who appreciated ideas from people they thought had experience at mothering. For Lisa this was an older woman nurse who came into her home and provided practical assistance, and guidance on baby care and managing her home.

It was unclear whether Monica, Wendy and Lisa voiced their wishes. Asking for what you need is not uncomplicated. For instance, Lisa's wish for more practical assistance and advice from her mother was complicated by her concern that she would be seen as inadequate and would be judged if she asked for help, "I didn't really want mum around very much cause I felt like I'd let her down quite a bit by not coping too well with [Baby]." This expectation of judgement was also implicit in Andrea's description of a "dialogue going on in my head about it's all you know if only I could have the place neat and tidy and clean then I could have visitors".

Three women described their mothers as actively unhelpful and all described ways in which their relationship had been difficult throughout their lives. Cynthia described her mother as "very dominating" and how she "was always the good daughter". This caused difficulty in two ways-worrying and feeling guilty when she did not follow her mother's advice on feeding her child and dealing with the conflict between her mother and husband who she described also as "definitely in control".

Stephanie and Jennifer described ways in which their mothers had been abusive or negligent when they were growing up and related this to difficulties they experienced as new mothers. The discussion of these two women's experiences as new mothers and how they got through is the focus of Chapter 10. One aspect for Jennifer was that her mother had died several years before her baby was born and the birth raised her feelings of grief for her which were unexpected. "Like she was a huge part of our lives and huge personality and, I mean we're very similar in lots of ways but also had a terrible relationship so I guess a lot, I think a lot of what happened was a lot my grief came back and maybe I wasn't ready for that." Jennifer described difficulties bonding with her baby, that she related to the loss, in that it "totally preoccupied my whole being and [baby] just got left behind".

Similarly, grief was also the primary issue for Amy, whose mother became ill just after she got pregnant and then died before her baby was born. As she said "And yeah so yeah I don't know how much I need to say about how horrible that is, that was. It was a really, really hard time and I think that being pregnant, you know..." In contrast with Jennifer's difficulty bonding with her baby, Amy described no problems bonding with her baby "in fact looking back I wonder whether I, not bonded too well but like I really, I clung on to her/him." This highlighted the very individual way women respond, in this instance to grief, and how whatever way they cope can be criticised, in this case of having too much or too little "bonding". Hope Edelman (1994) in her seminal book on motherless daughters highlighted some effects for women becoming mothers when they had experienced early maternal loss, including fear at not having a support system, and a retriggering of the cycle of mourning. These were prominent aspects of both Jennifer and Amy's accounts of early mothering. In her interview study of young women who had experienced maternal loss in adolescence, Schultz (2006) suggested that the experience of maternal loss caused a disruption in identity development during early adulthood. Extending from these findings (and a possible focus of future research), is the possibility that maternal loss disrupted Amy and Jennifer's identity development as mothers adding to their uncertainty and distress.

Two women, Laura and Mary described members of their partner's families (father-in-law and mother-in-law respectively) who held very different views about parenting to them and who were very dominating with their views, causing distress as both women asserted their model of parenting. The women's distress seemed to be associated with having to defend their position as the primary care giver and decision maker around their child's care. Focusing on Laura's experience shines a light on how culturally bound the paradigm of mother as primary attachment figure is and how distressing it is for women when they are not able to perform this culturally mandated role. Laura identified herself as a Pakeha/European New Zealander who came from a "quite reserved independent family, who never tells, you know, we never tell each other what to do". Laura's accounts of her mothering practices indicated that she favoured an attachment focused, intensive mothering regime prioritising the mother/baby dyad as the primary attachment relationship and the nuclear family as the context. Her male partner's father and mother were both from different collectivist cultures and Laura described finding the involvement of her partners extended family "dominating", and "full-on". Laura described how she "freaked out about, sort of, my loss of independence". She described conflict with her father-in-law that related to his wanting to be

the primary person in the baby's life. This was Laura's perspective on her father-in-law's behaviour:

> He was just, it was his child, you know, and he couldn't, and I was in the way. And I just felt that so strongly, and he'd just come in and take the baby off me and like want to take it away, and take over, and take charge, and [he would say] 'give me my baby' and 'My baby and I are doing this' and blah, blah, blah and just wanting to come over all the time and, you know, and it just really, really made me just see red, you know. That he couldn't step back and couldn't respect my role, but he just didn't and he still doesn't really. Laura

Laura's account presents a power struggle over proprietary claim to the child and who was in charge. The anger she described feeling with her statement "really made me just see red", reflects her sense that her father-in-law was violating, and "couldn't respect" what she believed was her rightful role. The extent of the conflict reflects how strongly these values about family and role are held in society and how personally people are invested in taking up the roles their culture defines for them. The clash of cultural beliefs had a profound impact on Laura, her husband and both their extended families. Laura and her husband separated when their baby was about one year old because of the disjuncture in their values and the distress it caused. They maintained contact however, and reunited when their child was about four years old.

The primacy of the mother's role as care giver in European/New Zealander couples was also reflected in the structure and roles partners/husbands took in the care of their babies. For instance, only one woman in the group of 22 participants returned to paid work when her child was three months old while her partner remained at home as full time caregiver. While generally the women reported gaining support from their partners, the form of this support varied. Most commonly men were described as taking the role of 'helping when asked' as Pamela described her partner doing: "he's great at helping especially, I mean he, unlike a lot of other people, he's very good at doing what he's told." More rarely, men took more independent responsibility for child care as Jennifer describes how her partner gets up "at seven o'clock when [baby] wakes up and gives him/her breakfast and plays with him/her for an hour and then I take over and then when he walks in the doors he takes over."

By contrast, six other women, who described partners/husbands as unhelpful in the early stages of parenting, were generally referring to their lack of involvement with child care and household responsibilities or more generally being unavailable. The division of labour in almost all cases prioritised the man's sleep and paid work was referenced as the reason for this prioritising. As Kimberley said "he's got to work all day and earn the money so we'd let him have his sleep at night and it's still like that now". This prioritising was generally not questioned by women even when poor sleep was named as a factor causing postnatal depression. Kimberley, for instance, described herself as "liking her sleep". However, her sleep was completely disrupted because she experienced a post birth infection and their baby required 2 hourly feeding, day and night. Kimberley achieved this regime alone by breast feeding and using a breast pump but became very run down, exhausted, forgetful and tearful which she described as being "hormonal". Despite this, her husband did not complete any night time feeding. By positioning the "symptoms" as hormonal, the inequity of the workload between her and her husband and social causes remained obscured and unchallenged.

Three women gave accounts of how their partners had assigned particular child care tasks as not part of their role. For instance, Kimberley's partner clearly defined what he would and would not do in a way that would be very difficult for a mother to state overtly; "he'd quite happily give [baby] a bottle and give him/her a cuddle but he's never done nappies and he's always said he'd never do nappies". Donna described her partner separating himself from child care when he said he didn't want to "take part in everything that was happening about you and the baby" and politely deferred all parenting to her: "Whatever you think darling".

When asked what role her husband took when their baby was born, Lisa said "Um he went out and put up a clothes line". Lisa provided an account of how her husband positioned himself as the care taker of the family but then during the three weeks he took off work when baby was born he did not partake in household duties of cooking or washing for instance, roles which he had never taken. From Lisa's report, he had also taken steps that prevented Lisa getting the practical assistance from her mother.

> [Husband] felt like it was his job to be looking after me and um felt like he was palming me off by having, expecting my mum to come down um and because mum didn't offer then it was really hard to ask her to take time off work. Lisa

In asserting his role as head of the nuclear family and dissuading Lisa from seeking assistance from her mother Lisa was effectively isolated and faced with a heavy workload and little knowledge of child care.

Another barrier to gaining support from her mother, Lisa called the "Dad dynamic". This she described as "not wanting to put her mother in an awkward position if I did ask her….he's quite controlling so I don't know what he's sort of putting in her ear" and also her discomfort of her father seeing her not coping: "I still don't feel comfortable talking to him and you know falling apart in front of him".

Donna described a similar situation where her mother wasn't able to leave her father to his own resources to come and help her. Lisa and Donna's accounts highlight how the prioritising of the nuclear family and (grand) parental couple relationship placed a barrier between mothers and daughters at a time when the transfer of support, care and knowledge from experience is invaluable (Mitchell & Green, 2002).

The following summary of Lisa's reaction to the birth of her baby may give a sense of the impact of this lack of practical assistance. Lisa's acute fear during the birth by emergency caesarean left her with what she called a "panicky anxious" feeling. She experienced fearful thinking focused on her lack of knowledge of how to care for her child and how the responsibility of motherhood and caring for her child was overwhelming. Her response in this overwhelmed state was to reject her child and role as mother. These responses become more understandable when considered within the context of her situation of having no expectation of practical assistance or guidance from her family or husband. Lisa's husband named her distress her "penchant for drama" essentially minimising her concerns and confirming her expectation that he would not provide the emotional or practical support she needed. This is consistent with Lisa's own analysis of his comment that "it's really disappointing. I feel like I can't rely on him".

Thus while most women stated that practical help was often what they most needed, these partners in different ways ruled themselves out of many of the duties of caring for babies or household that are clearly not biologically gendered in the way breast feeding is and significantly increasing the emotional and physical workload of women.

Three partners were unavailable in a physical sense. Lisa's husband continued their social life without her. Mary's husband took on another job on top of shift work and "was

never here...and when he was he wasn't particularly helpful either" to the extent that she described his behaviour as "complete disengagement from the family". A major stressor for Donna was that her partner travelled for work and had a planned 3-4 week trip away from home when her child was 2 weeks old. Living in an area where she had no social contacts and a long way from family made this loss "almost a visceral kind of animal thing of like needing someone" and how she "cried so much I mean I've never forgotten that fear that sort of water logged feeling you get when you've just cried so much". Mary and Lisa's accounts indicated their feelings of hurt and anger at what was experienced as the men's abandonment of them. Donna's account indicates her distress but by contrast she does not seem to feel anger which would suggest she did not question her husband prioritising work over family duties. The inequality around division of labour and choice with respect to household duties, access to leisure and access to paid work is analysed in more depth in Section 2. Of note here is the impact on women's wellbeing when men do not perform aspects of household and child care duties. This lack of involvement after the child is born was unexpected for instance, in Mary's case, where she described having a more egalitarian relationship. For Lisa, her husband's behaviour reflected a continuation of a long standing more gendered distribution of roles which may explain why her distress occurred so quickly after the birth.

Women described mixed support from maternity care givers. Positive experiences were described like Linda's "fantastic midwife at Hospital who just happened to be on, she was divine – really good" and Julie's "very good postnatal Midwife who is a Lactation Consultant and she was just fabulous with the breastfeeding." Other women described midwives as coming up short of expectations. For instance, Andrea described several instances of criticism from a midwife while her child was in the neonatal intensive care unit, and Melissa's midwife resigned just after her baby was born "because I think I was her last person, cause she was going off to study to be an Accountant and had I known that way back at the start I wouldn't have gone with her" as she would have liked the continuity of midwifery care from pre to post birth visits.

What was surprising to me, however, was that whether or not women had good relationships with their midwife, they for the most part did not seem to be able to tell them about the distress they were feeling after the birth. Fifteen participants talked about ways in which they did not tell other people, particularly maternity care givers and other new mothers, about the distress they were feeling. It seemed to play a part in preventing the women from receiving practical and emotional support at an earlier time.

Discussion

The challenges faced by almost all women (20) during the birth of their baby, with their own health problems and/or their child's health and/or feeding problems were unexpected and affected them in many distressing ways for instance by causing pain, anxiety, exhaustion, sleep deprivation, loneliness and/or loss of confidence. A major compounding factor in these difficult circumstances, described by nearly all (21) women, was that they experienced insufficient or inadequate support from family, friends and/or maternity professionals.

The term social support is complicated by the multiple ways it has been defined across studies, however, one broad definition used in the literature is "the assistance and protection given to others, especially to individuals" (Hinson Langford, Bowsher, Maloney, & Lillis, 1997, p. 95). These authors also describe social support as coming in four forms; emotional support, instrumental support, informational support and appraisal support (Hinson Langford et al., 1997).

The participants' problems with accessing support could be conceived as gaps in the receipt of all four forms of support described in the literature. The women described four main kinds of support they would have liked like more of. Firstly practical assistance (instrumental support) with, or relief from, house work, grocery shopping and the preparation of meals were viewed as most useful. Secondly, many women said they would have appreciated more guidance on mothering skills (informational support) such as breast feeding and (would have) found the guidance they did get more acceptable when it was consistent and preferably from one trusted, experienced woman who could be a midwife, mother, or sister for instance. Advice presented as suggestions also seemed to be more acceptable and also worked better when it did not contradict the women's own preferred models of mothering. In contrast, however, several women also described wanting to be told when they had got the practices of mothering "right" which would be considered "appraisal support". Another kind of appraisal that women said would have been/was helpful was for people to acknowledge the hardship of mothering rather than providing reassurance, for instance, that "this is just a phase". The fourth kind of support that women described needing and is often associated with receiving the other kinds of support is emotional support and companionship during the long days at home with a baby.

Several restraints on women receiving support were apparent in women's accounts. Firstly, several couples had a rigid gendered distribution of the household and child care duties that were not adjusted sufficiently to accommodate the increased work load of women experiencing challenges to their health or their child's health and feeding. The prioritising of paid work was given as one justification for this practise. For instance in many cases men's sleep was prioritised over women's on the basis that they needed to be more able to function for paid work. Also a few men ruled themselves out of child care duties in ways it would be very difficult for a woman to do. This behaviour was consistent with the men being positioned by social discourses of parenting as having an option or choice in whether they took up child care practises while no free choice is allowed to women (Croghan, 1991; Sevón, 2012).

Several women did not get the help from their own mothers in ways they would have liked and there were multiple barriers that seemed to operate including geographical distance, mothers busy with paid and unpaid work, and family (the women's mothers, fathers, and husbands for instance) acting to prioritise the nuclear family and excluding the woman's mother from providing practical help and other support in the first weeks after the baby was born. This practice of prioritising the nuclear family may be a response to the movement over the past thirty years emphasising the importance of father's involvement with their children for instance by attending their birth, caring for infants and children and developing close relationships with them (Vuori, 2009). Also, the action by mothers to give the couple "space" (Erin) may have been conceived as a strategy to enhance the couple relationship. Alternatively, the women's mothers may have acted to guard against being positioned adversely by the negative social discourse as an interfering mother-in-law (Adler, Denmark, & Ahmed, 1989).

Chapter 7

Discussion

Multiple factors provided the context for postnatal distress. Almost all (20) women did not experience just one problem, but rather experienced multiple difficulties. The problems were often linked and compounding, which stretched women's ability to cope. In looking across the four contexts in which women experienced distress (traumatic or difficult birth, women's health problems, child's health and feeding difficulties, and lack of support), only two women described having just one area of difficulty, ten women had two areas, eight women had three contexts for distress and four women described having difficulties in all four areas.

The four areas identified as contexts for distress in this study are consistent with suggested risk factors from quantitative studies (for a summary see Beck, 2001). For instance, an early Australian population-based survey (Small et al., 1994) identified forty-five women who were depressed after the birth of their baby. The depressed women and a matched group of non-depressed mothers were then interviewed. The women who reported feeling depressed identified contributing factors to be lack of support, isolation, fatigue and physical ill health. These are all very similar problems to those described by women in the current study. Similarly, in a more recent American telephone survey of 720 new mothers, Howell, Mora, and Leventhal (2006) found that the women with depression symptoms were more likely to report higher levels of birth-related physical symptom burdens (such as caesarean-section site or episiotomy site pain and breast pain), more infant colic, receive less social support, and had lower self-efficacy scores compared to participants without symptoms of depression. These problem areas are remarkably similar to some of those described by women in the current study, despite a demographically different participant sample.

Alongside issues that were clearly beyond what was "normal", such as threat to life and significant and profound child health issues, women were managing the usual adjustments involved with first time motherhood that have been identified in other studies. For instance the women gave accounts of loss and adjustment (Nicolson, 1999), feelings of inadequacy, disillusionment and exhaustion because of the struggle to live up to idealised

and intensive models of motherhood (Choi et al., 2005; Weaver & Ussher, 1997), identity changes (Bailey, 1999; Weaver & Ussher, 1997), and bodily changes (Bailey, 2001).

Finally, there were two issues that were by the far the most frequently raised by almost all the women. These were lack of practical assistance and emotional support, and infant feeding issues in the form of poor infant weight gain, reflux, colic and spilling or the lived experience of long periods of inconsolable crying or screaming, squirming and vomiting. While the fact that these were such predominant difficulties may suggest that they are common problems faced by mothers generally, it is likely that when they occur they are associated with higher levels of distress for first time mothers. For instance, inconsolable crying and colic have been linked in quantitative studies with postnatal depression that can continue after the colic improves (Howell et al., 2006; Miller, Barr, & Eaton, 1993; Murray, Stanley, Hooper, King, & Fiori-Cowley, 1996; Radesky et al., 2013; Vik et al., 2009).When women experienced these difficult problems with infant feeding, lack of people they could call on to give them a break or provide emotional support compounded their distress. In the following section I explore participants' path to recovery from postnatal distress, which will provide some insight into why there is a delay in women feeling better after their babies crying decreases.

Another understanding regarding the impact of inconsolable crying and colic in infants is that because it is so unpredictable, aversive and unresponsive to parental or medical intervention, parents can become understandably frustrated. Two studies have found a similar timing and pattern of hospital admissions and publicly reported shaken baby syndrome with the expected curve of infant crying intensity and frequency. Consequently the researchers have suggested that early infant crying may be a stimulus for shaken baby syndrome or other physical abuse of infants (Barr, Trent, & Cross, 2006; Lee, Barr, Catherine, & Wicks, 2007). I do not want to suggest that participants physically abused their children, as there was no indication of this from the women's accounts. However, this finding does serve to highlight just how difficult it can be to manage inconsolable crying and colic. This is highlighted in Wendy's account of her child's crying and how her feelings of anxiety became desperation and depression:

> [Baby] sort of started screaming and screaming and screaming, couldn't console him/her and we were in this tiny little place you know there's nowhere to go couldn't escape, and then the big black clouds came rolling in literally and figuratively.

> Literally you know it started pouring with rain and, and then I just sort of felt this huge desperation wash over me, and I just kind of yeah plummeted from there really.
>
> Wendy

Therefore, the postnatal depression experienced by these mothers could also be linked to the frustration and desperation felt alongside an infant's inconsolable crying. The question remains as to why idealised expectations of motherhood are so obdurate to change in the face of the frequency for which mothers experience difficult challenges. For instance, Barr (2006) summarised results from two studies that suggest about 25% of infants cry for more than 3.5 hours/day and yet this was not a problem that the women expected. Studies that review and analyse the information to which mothers are exposed provide some insight into this question. For instance, two studies investigated how mothers and the practices of mothering are constructed: Hays (1996) analysed three leading child care books to see how motherhood and mothering practices were constructed at that time, and Williams et al. (2013) completed a discursive analysis of child care materials to see how infant feeding was constructed. Both identified very prescribed and intensive practices that were reified with little or no acknowledgement of the context in which women attempted to perform these practices. Held and Rutherford (2012) reviewed popular magazines and advice books to specifically examine how articles about mothers portrayed "the unsettling pairing of distress and motherhood" (p.1) and identified a dogged unwillingness to situate motherhood as the cause of distress. From these studies it is easy to conclude that media of all kinds position themselves as helpful experts, happy to provide advice and direction on the best practices for mothering, yet reluctant to acknowledge the distress that goes with following or not following those "ideal" practices. In so doing, media representations effectively perpetuate the intensive mothering paradigm and romanticised views of motherhood. Also, women receiving this advice and information attain the complimentary position as an uninformed and naïve consumer. Women in this study almost universally relied on parenting books and magazines for guidance about mothering practises and what to expect with their child. However books and information seemed to increase the anxiety of many of the women.

The reason for this anxiety may be explained by another study about advice and information to mothers (Catherine, Ko, & Barr, 2008). This study took a positivist approach and reviewed popular parenting magazines to investigate the advice and information regarding infant colic and crying. What was striking from their study was the sheer variation

and density of information and advice that was given. There were 105 different responses to causes of crying and colic and 231 different suggested responses for managing crying and colic which, according to the researchers, were very diverse and showed little agreement. When one of the definitions of colic is that the baby's crying is inconsolable, suggestions for management act to disempower women by raising a false expectation that she should be able to soothe her baby. Her work load is also increased as she searches for solutions and likely experiences a sense of failure when the strategies don't work. Also, the confusion created by the profusion would be disheartening at least.

Dawn's experience demonstrates the interaction and compounding effect of multiple difficulties in the context of expert advice. Her story is a fitting way to summarise this analysis of postnatal distress. During her pregnancy she was hit by a car while walking. However, a normal scan somewhat allayed anxiety about the potential effect on her baby. Dawn summarised several aspects of her experience that caused her distress as:

> The traumatic birth, the lack of family support or just you know network support,…[baby] having reflux so s/he was very unsettled for a very long time. We had to move house a number of times in the first year which doesn't help.
>
> Dawn

Dawn's account of the "traumatic" birth started with being induced and going into labour very quickly and painfully. Because the baby's heart beat dropped when she was not dilated sufficiently to give birth quickly, Dawn was sent for an emergency caesarean that she described as "a shock" that she was unprepared for:

> Oh I was upset but probably I think more that, 'Oh my God you know this is all going hideously wrong, this is not, none of this is what it's supposed to be like' you know it's just going from bad to worse sort of situation so yeah. Dawn

One effect of the birth was that Dawn described not wanting to hold her baby immediately after the birth. She attributed this to being very overwhelmed by the caesarean operation she had experienced:

> I was more concerned I mean is s/he okay yes, okay then that's all I need to know I can't deal with, with him/her right now I need to yeah all I can cope with is what's happening to my body it's yeah it's all just crazy yeah. Dawn

Following the birth, other challenges including being very unwell with a post-operative infection which required readmission to hospital, and her child's severe reflux and colic meant that feeding and soothing her baby was a challenge. Consequently, she described feeling anxious, and questioned herself as a mother: "I'm used to being a capable professional person out in the workforce and all of a sudden I was at home with this screaming baby. Why can't I do this? Why can't I handle it?" Dawn described difficulty bonding with her child for a long time. She also attributed a lack of support to both her and her husband's family living in other towns, and having no friends at the same stage of life. Her account of professional services was that they were unavailable and inadequate, in that her midwife was described as "breezing in for 10 minutes". When she went to her medical practitioner about her baby's feeding and "screaming" problems he told her that "reflux and colic are over-diagnosed." She described the Plunket offer of a half-hour respite as grossly inadequate and didn't take it up. This combination of challenging life events and circumstances would likely cause distress for any person, even without considering the disempowering comparisons with idealised discourses of motherhood and the heavy workload of the current popular paradigm of intensive mothering.

Analysis Section 2: Adjustment, Sedition and Recovery from Depression

Chapter 8

Brief Introduction

All the women described their second child as planned. To come to the point of deciding to have another child clearly involved traversing out of some, if not all of the aspects (emotions and contexts for instance) of the postnatal distress. Reading and rereading their stories made apparent a number of consistent patterns women journeyed in traversing postnatal distress to the point where they no longer considered themselves to be distressed. In this section I turn to these narratives of coming out of postnatal distress and continuing on with life over the course of the birth of their second child.

The two interviews provided different time points from which the women could look back and reflect on their experiences, as well as look to the future and described their plans and expectations about birth, motherhood, and life with two children. I made the presumption that women had reached a point of resolution of the distress because they were prepared to have another child. This seemed to be the case from women's accounts and so their reflections were from the position of having recovered from postnatal distress. Questions about how the women came out of postnatal distress seem to be salient for the women at the time 1 interviews because they were preparing for the birth of their second child. It seemed that many of the women had considered these issues prior to becoming pregnant and since their pregnancy began. This meant that their narratives were rich and detailed. Most women were able to give some indication of ways they were planning to parent their new infant and older child. The time 2 interview gave a much more detailed view of the women's changed and unchanged practices and philosophies of motherhood. The women themselves appeared to be making comparisons between the two birth and early motherhood experiences as they easily provided these narratives during the second interview.

Calling the women's journey out of postnatal distress recovery is problematic. Recovery has been variously defined. The term has been taken up as a service model within

public mental health services internationally and in New Zealand and yet a review of the concepts underlying this recovery service model showed confusion (Davidson, Lawless, & Leary, 2005). Two biomedical frameworks underlie the conceptualisation of recovery in this service model. On the one hand, recovery is defined as a decrease in the signs and symptoms of a mental health problem and a restoration of cognitive, social and occupational functioning (see for instance Andreasen et al., 2005). An alternative rehabilitation conceptualisation is that recovery involves a person living their life in a meaningful and gratifying way despite experiencing enduring mental health disability (see for instance Kelly & Gamble, 2005). Davidson et al. suggest that both concepts offer alternative paths to life with, after or despite serious mental illness. The two understandings are polarised. With respect to depression, the common understanding that it is a chronic and relapsing disorder (Segal et al., 2003) shifts it from being a problem that people can expect to overcome and move on from (the restoration idea) to a problem that must be continuously guarded against and managed (the rehabilitation idea). In this analysis I attempt to identify the ways in which the women take up or resist these biomedical conceptualisations of recovery from depression.

I adopted the term recovery within the study but did so cautiously so as not to preclude women's ways of describing their experience and not wishing to privilege medical understandings. I used the term recovered within the Participant Information Brochure (Appendix B) to describe a focus of the Time 1 interview: "how you make sense of being a mother for the first time and how you are coping with or recovered from the depression." Within the interviews, however, I tended to use more lay terms or questions that matched the participant's terms for their distress (e.g., how is the anxiety now?). Thus I only used the term recover within the interviews on three occasions to describe the purpose of the interview (when asked for more details by the participants), on two occasions to ask about mood, and I mainly used the terms to refer to physical health issues (10/16 occasions).

Of note was that within the women's accounts, the term recovery was almost never used in their narratives related to coming out of postnatal distress (only two participants, 3 references). This is consistent with the finding by Lafrance in her study of 'recovery' from depression and 'self-care' where neither term was "unequivocally adopted by the women [she] spoke with" (Lafrance, 2009 p. 12). A search of the transcripts in the current study found that the majority of references to 'recover', 'recovery' or 'recovered' were in reference to recovery from medical procedures or health issues usually associated with the birth or physical health issues (21/33 references) or being "in recovery", the area where patients are

placed after an operation (9/33). Other references related to other people and even recovering the couch. The predominance of the medical context for the use of the term recovery also occurred with one of the three references related to depression. Lisa linked the medical/psychological health care she received to her improvement in mood:

> So [maternal mental health team] was coming every week or two and everything and you know just keeping an eye on things... but she could see that I was on the improve as well yeah I did recover quite quickly. Lisa.

The only other two references to depression and recovery were framed within metaphors by Stephanie:

> I guess it's just understanding, for me I just feel like depression's like alcoholism, that you never fully recover from it and that you just have to be aware of that.
>
> I think when I started on the road to recovery as it were.

These metaphors frame depression as an addiction in the first instance and recovery as a journey in the second, a metaphor often used when referring to the return to health after a medical illness (Frank, 1995). Both are biological frameworks that Stephanie mobilised to add authority to justify the actions she had taken to improve her situation: being "nice to me" in the first instance and resolving a conflict with her mother in the second instance. Stephanie's story will be further analysed as an example of one of two recovery narratives that form the focus of this section.

It would seem that recovery is a medical term that has been adopted for use with depression within medical and psychological service models, research and therapy; however, it was not in common use by the women interviewed in this study. By contrast, many of the women used the terms depression or postnatal depression amongst many other terms and metaphors to describe their experience of distress. Also 18 of the women utilized antidepressant medication as part of their approach to managing postnatal distress so were engaged with medical discourse in this process. Despite this, their talk around their improving wellbeing was complex, diverse and contextualized.

The ongoing dominance of the natural/intensive mothering ideology on women's experiences of first time motherhood was identified in recent studies across several western countries (e.g., Choi et al., 2005; Miller, 2007; Sevón, 2012; Singley & Hynes, 2005). When

women experience a disjuncture between idealised motherhood and the reality of their lived experience they tend to look to their own resources (Miller, 2007), and work harder to meet the expectations (Choi et al., 2005). As women become more experienced over the first year, Miller identified that they were more able to resist aspects of child development/good mother discourses and instead draw on their own mothering experiences and begin to share child care arrangements with other people (Miller 2007). Within heterosexual couple relationships, traditional roles have generally prevailed through this early parenting phase. Gender perpetuates and is perpetuated by intensive mothering ideology. Sevón (2012) identified some women in heterosexual couples who managed to maintain shared parenting ideals as an alternative to intensive mothering but that this was achieved by the willingness and effort of both them and their partners. LaFrance (2009) similarly identified that women in heterosexual couple relationships who maintained self-care practices had partners who fully endorsed and supported this practice. Similarly in decisions about return to work and juggling leave entitlements for men and women having children, only the rare couple chooses to share parenting because they jointly have an ideological belief in it (Singley & Hynes, 2005). Otherwise couples chose a more traditional gendered distribution of roles , or structural factors prevail such as men's usually higher income, and male dominated workplaces being less supportive of staff using entitlements to care for children (Singley & Hynes, 2005).

In this section I focus on the women's narratives of coming out of the prolonged and intense distress they felt after the birth of their first child that came to be labelled postnatal depression. Once again I focus on their experiences within the context of their relationships (with baby, husband/partner, family, friends, maternity caregivers and other health professionals). In particular, I explored how the women wrestled with the distribution of paid work, house work and child care within the context of the couple and family relationships. I investigated the societal discourses that the women located their experiences within and how these assisted or blocked women's attempts to develop their wellbeing. For instance, I was interested in how New Zealand women take up or resist intensive mothering discourses and how this might influence or be influenced by experiences of distress and coming out of distress. Also, I was interested in how biomedical understandings about the chronicity of depression, relapse and recurrence might be taken up and acted on by women preparing for second time motherhood after "postnatal depression".

The narrative analysis of both time 1 and time 2 interviews provided a view of each woman's transition from first to second time motherhood within the context of their

relationships, the issues they faced, and the positions they took or were assigned. Within this section I explore two ways in which the women narrated their journey out of postnatal distress and these form the basis for the two analytic chapters in this section.

Chapter 9 explores the endurance test narrative that was most commonly reproduced in women accounts. Over half the women described how they came through by stoically trudging on. Women related improvement to the passive and slow movement of "time", however also gave accounts of three things that improved their lives as mothers: baby getting "easier", the women becoming the expert on their baby, and the development of relationships where open and sometimes seditious talk about the hardship of motherhood helped dismantle idealised notions of motherhood and babies.

In analysing the endurance test narratives, an alternative crisis turning point was described by some women as the point at which they took charge of their feelings of persistent distress. I explored the crisis turning point as the second major focus of chapter 9. The crisis turning point narrative was sequenced by the women as: a situation where they framed their emotional reaction as excessive and abnormal, which was then resolved by going to the doctor, being labelled depressed and being prescribed and taking medication. I explore the three aspects of the crisis turning point narrative. Firstly, I analysed the women's accounts of the crisis itself and the contexts for the crisis, namely a paid work setting and a thwarted self-care setting. Secondly I provide a more detailed analysis of an exemplar case (Melissa) which assists in uncovering the obscured gender inequity at the basis of the women's experience of the crisis. The crisis narrative sequence obscured the circumstances causing the women's "emotional breakdown" which related to their frustration and anger at the inequality of access to paid work or child free time. The third aspect of the narrative was that women went to the doctor and this seemed to serve three functions: to repair ruptures in the couple relationship, gain the added authority of the medical model to requests for practical support, and gain relief from symptoms.

The final focus of chapter 9 is an analysis of women's experiences of second time birth and motherhood when they had utilised an endurance test narrative of coming out of postnatal distress. I focus firstly on the accounts women gave of three areas of change in their understandings of mothering and babies; hardy babies, sharing responsibility and self-care a priority. Two final aspects of the women's experiences of second time motherhood are then explored to conclude this section on the endurance test narrative: women's experiences of the

second birth and women's accounts of the place of postnatal depression in their approach to second time motherhood.

Chapter 10 is titled Dealing with Emotional Baggage. This second "recovery" narrative was adopted by two women who identified that the work they did in dealing with the emotional baggage related to family of origin relationships was key to them coming through postnatal distress. This analysis highlights the contrast between a socially and relationally constructed narrative of postnatal distress and a biomedical construction and how they each impacted on the women's approach to dealing with distress and second time motherhood.

Chapter 9

Endurance Test

For just over half (13) of the women in this study, first time motherhood with a new infant was framed as an 'endurance test'. The endurance test was a phrase that Dawn used. It epitomised the women's accounts of how coming out of postnatal distress was a matter of time and getting through. Endurance was suggested by references to time moving slowly and was often stated as a contrast to what women had been led to believe, from friends and family. For instance, Amanda described how "it was just so slow" and contrasted it to the taken-for-granted stories she had heard from other people:

> Everyone said to me 'Oh they grow so quickly, they grow so quickly and it goes so fast' and for the first three or four months I just thought, I can't believe how many people lie to me about this 'cause it's not true. Amanda

Several of the women described their feelings of despair and helplessness as they carried on for long periods of time with the burdens of mothering in difficult circumstances. This was particularly the case for women with children with health and feeding problems as is presented in Wendy's account of "feeling hopeless and helpless that you know it was just going to carry on like that forever. That my baby was going to carry on screaming, and I was going to carry on not enjoying it."

Alongside the narratives of time moving slowly, most of the 13 women positioned themselves as stoic survivors and used traveling metaphors to highlight the ongoing hard work and loneliness of their experience of motherhood. Melissa described how she "trudged on", for instance, and Julie described motherhood as "one of those lonely roads that everybody has to go through on their own." Similarly, Mary framed motherhood thus: "it's that whole your own journey." Her statement suggests that each woman must find their own path. The "lonely road" reference seemed to capture the sense of isolation as the women strove to traverse the struggles of early mothering and motherhood.

Similarly, Linda described first time motherhood as a "freakish experience that can never be repeated and you just have to go through it to get to where you're at." Linda's account provides her conception of the adjustment to motherhood generally as a "freakish

experience" that women have to go through. Connecting the "freakish experience" with the journeying metaphor "you just have to get through to get to where you're at" presents first time motherhood as a path of initiation that women must travel alone. She also uses the impersonal pronoun "*you* just have to…" in her account. This frames her stoic response of "hav[ing] to go through it" as one potentially shared by others. In describing her experience of early motherhood as "freakish", Linda also frames early motherhood as outside of normal experience and thus, by inference, this provides a justification for her experiences of distress. Describing her own early motherhood experience as freakish acts as a counter story to the idealised narrative of early motherhood. However, rather than re-storying normal motherhood to encompass hardship and distress, it frames the hardship and distress as freakish or 'out of the norm' at least providing some resistance to the ideal.

Underlying the endurance test narrative was the women's lived experience of mothering as an extended challenge. There was a clear relationship between this narrative as an account of coming through postnatal distress and the contexts for distress identified in the Section One thematic analysis. All except one of the 13 women who used the endurance test narrative described their first baby as having child health or feeding problems, all described difficulty in relationships and/or lack of social support, and seven described experiencing their own health issues. Three of these women also described difficult birth experiences. Clearly these women experienced multiple challenges. Key to the endurance test narrative of coming through the distress was managing the challenge of caring for a baby with health or feeding problems while feeling unsupported, isolated and alone.

The women's persistence in coping alone in spite of the challenges can be understood from accounts the women gave that highlighted their sense of their moral obligation as mothers to accept the challenges without complaint, or as Dawn put it, to "suck it up". Dawn described how she stayed silent and dealt with feelings of not liking motherhood thus:

> I just I really thought for a very long time there was just like you know I just don't, I just plain don't like it but it's too bad because that's what you wanted and that's what you've got so you're just going to have to get on with it. Dawn

Dawn located her obligation to "just get on with it" within the neoliberal ideology of individual free choice illuminated by her statement "that's what I wanted and that's what I got". Nikolas Rose (1996) in particular, highlighted the punitive effects of neoliberalism in that people – neoliberal subjects – must live their lives as though they are free to choose the

course to take. As a neoliberal subject, Dawn did not have access to alternative ways of making sense of the constraints in her circumstances. Nor would she be aware at the time that her decision to have a baby was likely influenced by distorted and idealised presentations of motherhood. It could be argued that these societal constructions precluded informed choice by obscuring the hardship and distress that can also be a part of mothering. In line with the tenants of neoliberal subjectivity, Dawn instead accepted the choices she made in becoming a mother as freely made, and so then also accepted responsibility for the social and psychological consequences, that is, the fact that she did not like it. More realistic presentations of motherhood not only allow for informed choice but also allow women to be more prepared for the realities of motherhood.

While neoliberalism is viewed as a modern ideology, Dawn's statement of "that's what I wanted and that's what I got" also draws on the traditional homily 'you've made your bed, now lay in it'. This engenders a doubly powerful imperative of personal responsibility for coping without complaint for the (misinformed) decision the women made in 'choosing' to be mothers. Studies of stigma and depression identified that stigma was linked to ideas about people being responsible for causation and/or continuation of their depressive symptoms (Boardman et al., 2011). So for Dawn to take responsibility for the distress she feels because she chose motherhood would expose her to this risk of being stigmatised. This is a further reason for her to not express her feelings of distress openly. Consistent with this, a study of attitudes found that the more that people take responsibility for their depression, the less likely they are to seek help (Halter, 2004). Taking responsibility for being distressed, and thus expecting to be blamed or criticised for their distress, may provide one explanation for why this group of 13 new mothers were reluctant to talk about their distress with family or visiting midwives initially.

Blame or criticism was not just a private expectation; some women gave accounts of situations where they felt judged by their partners. Several women talked about their partners questioning them about their child care practices and about how they were feeling about motherhood. Julie described her husband being "a bit appalled" at her less than positive answer to his question "Well aren't you happy?" She goes on to describe her reply:

> …and I said, 'Well some of the time, yeah, when things are going well, I'm in, you know, I'm it's good, but it's not good all the time, and most of it's really, really hard'. And he was kind of, a bit appalled that I should not be happy, having kind of in theory

> got what I'd wanted for all this time. And I found that difficult, I guess, and was probably some guilt attached with that, because you think, 'Gosh I've, I've we worked so hard to have this baby and I've got this healthy baby, well reasonably', and, you know, 'I've got a supportive husband I'm not on my own we're not destitute, you know, shouldn't I be happier than this?' Julie

Julie's description of responsibility and guilt regarding her mixed and variable feelings about motherhood is remarkably similar to Dawn's, above, providing a sense of the narrowness of women's positions when they don't feel continuously happy and fulfilled by motherhood. Julie's commentary, however, also names the culturally mandated ingredients that a woman supposedly needs in order to be happy as a mother; namely a (reasonably) healthy baby, a (supportive) husband and economic security. This way of accounting minimised the hard work and challenges of caring for a child with extreme allergies and the losses in leisure time and social connectedness associated with that care. The list of ingredients is consistent with the qualities, defined by discourses of femininity and motherhood, ascribed to 'good' women and mothers. Namely, that women should be focused on relationships and gaining intrinsic happiness from just having those relationships. The omission of any other needs for happiness reflects the selflessness expected of mothers. So Julie's guilt relates to these ingredients not being enough to make her happy as they supposedly should. This couple's interaction clearly demonstrates the operation of femininity and maternal discourses in creating guilt and silencing alternative stories of the hardship of mothering. The endurance test narrative drew on prescribed ideas about mothering and neoliberal subjecthood. It left the women few options but to endure.

Women who utilised an endurance test narrative to account for their transition out of postnatal distress had two ways of narrating the process; for some women there was no clear point when things changed, they "just slowly got better". Alternatively, other women narrated a crisis or turning point. The crisis point seemed to relate to issues negotiated within the context of the couple relationship such as access to paid work and leisure, and the division of child care and house work tasks.

It just slowly got better

For some women the transition out of distress was gradual and not marked by an obvious transition. So, despite using a journeying metaphor, coming out of depression or distress did not arrive like a destination, but seemed to become slowly apparent to the women. For

instance, Julie described how it "just slowly got better". Linda stated "I don't know. I think it was just time to be honest, I don't um because I didn't talk to any health professionals." Consistent with the endurance test narrative, this positions the women as independent, stoic survivors. Taken alone, this position can be viewed as passive, denying any personal agency for instigating or speeding up the improvement. However, the women also described changes that occurred over time in themselves, as mothers and in their mothering practices, and in their child's growth and development. These accounts complicated a passive reading of the women's change. The processes can occur slowly and not always smoothly or with conscious awareness and so no clear turning point or point of "recovery" was described. The women gave accounts that presented three ways that motherhood got better; seditious talk, babies getting easier and the women themselves getting more expert in mothering their child. I will explore each in turn.

Seditious talk

Motherhood as an endurance test was likely related to the demands of conforming to an intensive mothering regime alongside the material challenges involved when caring for a child with special health and feeding needs. Social isolation likely compounded the women's reliance on parenting books which generally promote intensive mothering practices and the idea that mothers should be the sole caregiver to their children (Hays, 1996). These ideologies likely made it difficult for the women to feel empowered to enlist more support from the father, other family, friends or agencies. One argument, proposed by Firestone (1971, in Croghan, 1991) for why women have not succeeded in altering the current order of things is that women are particularly isolated when they are at home with young children and this isolation "militates against the alteration of consciousness which comes from shared grievance" (p. 244).

In fact, some women did manage to "militate" against intensive mothering and idealised mother and baby discourses, and this seemed to help them come through postnatal distress. For instance, several women attributed the improvement in their mood and coping over time to developmental changes in their baby. They did this by describing their babies as more responsive, fun and interesting. This is a somewhat risky attribution, as the inference can be made that the woman previously did not find the baby responsive, fun or interesting. So indirectly these women are offering a counter narrative to the normative idea of babies as innately appealing and mothers instinctively attracted from birth. The fact that the women

were able to provide this risky narrative to me does not mean they were able to admit this to anyone at the time, though it does suggest that they noticed it.

Some women did in fact give accounts of how they engaged in more overt seditious talk about their children at the time, and they indicated that this helped them endure the more difficult aspects of parenting. For instance, Michelle described how things got better when she developed a friendship with a woman who disclosed her own difficulties mothering a child with reflux and colic and how they shared subversive talk:

> Michelle: We use to laugh and we use to call [child] the devil spawn and they'd have little evil names for their baby as well (laughter) …
>
> Sue: So really black humour (laughter)…
>
> Michelle: Yeah and we were talking about this evil child, how we were going to get rid of [her/him], and sell [her/him] on Trade-me and all these sorts of things. But it was quite good to be, sort of be humorous about it, be able to joke about it with someone and know that she knew what it was like she wasn't just handing out [advice].

Advice is framed by Michelle as unhelpful compared with the mutual understanding gained from talking with another woman who had shared similar experiences and was willing to talk about them. Several women talked about advice they appreciated and this was inevitably received from a woman who had particular experience with the problem they were having. In Michelle's case, black humour and disrespecting the reified child discourses was more effective in decreasing her distress.

Having an outlet for 'seditious' thoughts was something Melissa achieved by keeping a diary to 'voice' "all the things that you want to say that you just can't". When I asked about the content of what she wrote, Melissa gave an account which highlighted the level of her distress and thoughts of abandoning or harming her baby:

> Quite happily leave [baby] on somebody's doorstep. Would like to throw [baby] across the room. All those sorts of things that you would never in a million years do but I still needed to get out of my system so I would just write it all down. Melissa

Unlike Michelle, who talked with women friends, Melissa did not develop a friendship where she felt safe to voice these thoughts. Though her husband was aware she kept the diary, he declined her offer to read it. In not taking up the invitation to read her diary, Melissa's husband positioned Melissa as having responsibility for her distressing thoughts and feelings and what might be causing them. This protected her from any negative judgements he might make. However, it did not give her the validation that a shared difficulty could have provided. As the following extract from Melissa's account shows, the diary only acted as a way to express her feelings, though she did put it on her list of things that helped with feelings of distress. She said she never voiced the seditious thoughts until the research interview:

> Just so I could just, and [Husband] never looked at it, I said to him 'You can if you want', he said 'No, no, that's where you vent, that's where you get everything out'. And so I would just get on there and rrrh, rrrh. Rrrh. Lots of swear words. (laughter)… Just as a way to get it out otherwise I was carrying all this baggage of resentment and what have you. Melissa

Melissa's account describes the benefit of having an outlet for resentful feelings. It did not however give her a reference point or validation for her feelings.

Linda described "having a good old whinge" with a friend as helpful for dealing with the difficulties of motherhood. She also stated that she would:

> prefer people to go 'it's a complete bitch, I remember this, it was awful, I felt terrible, my tits hurt….Yeah, my husband and I had the biggest scraps, it was yeah'. I want to hear, because that makes you feel normal, you know? Linda

This shared talk seemed to serve to dismantle the silencing effects of failing to live up to idealised motherhood and re-appropriate and give words to their embodied, relational, lived experience. When Linda described the shared talk as "making you feel normal" it signalled the legitimacy gained from "militating" against idealised constructions of motherhood. Linda was one of only four participants in this study who did not take antidepressant medication. It may be, as Firestone (1971, in Croghan, 1991) suggests, that "shared grievance" provided a powerful alternative to the predominant biomedical vehicle for legitimising Linda and other women's distress.

Baby gets easier

Another way the women presented the slow and gradual improvements in their distress was through talk of their baby getting easier. Most women restricted talk about their child to statements as to whether they were an 'easy' or 'hard' baby as opposed to a 'good' or 'bad' baby, following the cultural ethic that children are blameless. From this perspective, some women related their improved mood to their baby either gradually or more suddenly overcoming their health issue (such as reflux, colic or spilling). Melissa described several strategies she used to get through early motherhood with a baby who spilled and cried inconsolably for extended lengths of time. Her strategies included the diary, ear muffs and developing products to help deal with spills. For all of this, Melissa described how "slowly, slowly I started to enjoy having [baby] around me, yep." This occurred when her child "stopped spilling…..that we'd have more good days than bad, that I'd actually get out of the house."

Thus, for some women whose children experienced health issues, endurance of the hard times was assisted by some sort of "vent" for their feelings and thoughts. However, coming out of the hard time was most helped by their child's health and feeding improving, which then allowed for more freedom to partake in daily life inside and outside the house beyond caring for their child.

For other women, having their baby develop a more predictable routine was a key to decreasing distress. Linda framed this as "getting some control with [baby's] routine" and described this as a function of her personality and need for predictability. Presenting her strategies for parenting as "getting some control", implies that Linda was attempting to modify her child's behaviour. Conversely, Linda gave an account of a very child-focused project whereby she worked very hard (she kept detailed logs) to identify her baby's routine and adjust herself to it. Reading parenting books seemed to give Linda a belief that she could predict her infant's behaviour. However, it seemed that the book's prediction did not fit with her experience, as this account describes:

> Make some sense of what was happening and try and predict more what would happen next and understand that, you know try and understand whether that would be a tired or a hungry cry. Because the all the books talk about you know they're going to be out for sort of an hour and a half cycle, when it took me till s/he was about six weeks to realise that she was a 45 minute wonder and s/he was up. Linda

Linda described how she and her husband found the unpredictability of their infant's behaviour very difficult to manage. This was perhaps fuelled by parenting books which present themselves as assisting parents to manage babies and so give a false expectation that predictability can be achieved at a very early age. When the baby began to behave more predictably at about 3 months old, Linda and her husband made adjustments to accommodate those behaviours in order to have more of a social life. While Linda describes this as a need for control, the cost of not having a child-focused approach was learnt from:

> …too many occasions where we haven't, s/he falls asleep in the car, come home, s/he won't go to sleep in bed because s/he's had, you know, a catnap, the whole afternoon's screwed, s/he's shitty and tired and grizzly and it's just everybody's weekend is unpleasant. Linda

Linda described the benefits of creating a lifestyle that was "predominantly based on what works for [baby]…if s/he's happy and content and life's predictable for her/him, our life is so much better. We're so much nicer to each other and happier and where we're fitting in sort of with his/her routine, and it's not onerous". Linda also identified that this child-focused model of parenting worked because both she and her husband were in agreement. Linda's account demonstrates the interaction of parental adjustment and child development stage in creating more predictability that allowed for some return to a more sociable life. Linda did not alter her child-focused intensive parenting strategy to achieve this.

For women with children with health issues things got better when their children grew out of the problem. Other women described their life getting better when their children developed more predictable routines. In both cases the changes allowed the women to structure and plan activities inside and out of the home. When child care responsibilities eased, women who had continued to feel emotionally disconnected from their babies described becoming more loving and bonded.

Other to mother expertise

Three of the women who described mood improving over time were the parents of the children who experienced more chronic health issues (asthma, developmental issues, eczema). I have called their movement out of distress 'other to mother expertise'. Each woman described a narrative that began with high levels of concern for their child and receiving unhelpful and contradictory advice from professionals and family. This was

credited with increasing their sense of their own incompetence to manage their child's needs. Each woman described coming to a point where they assumed they were most expert in their child's health needs. This narrative was most clearly articulated by Karen, whose child had severe asthma. She described three phases in her transition from feeling incompetent, to accepting that her child's problem was not a reflection on her mothering skills, to being the expert in their child's health issue. At first Karen accepted other people's (aunties', mum's) advice and expertise. "It was devastating for me 'cause people were telling me 'this is because you're not doing this properly or you're not doing that [cleaning, vacuuming, etc.]' I was like 'okay okay' because I'm a new mother as well". Then Karen narrated how:

> by about a year of it, it got to the point where I was like accepted it and just said to myself 'it's not, it's not me, it's not the house and it's not, it's just the way [baby] is. It's just the way what [baby] has…you know and I'm not going to stress myself out by trying to.' Karen

From her experience she was able to develop her own conclusions about what was effective or not and had the confidence to ignore advice. The final part of her narrative was her statement indicating that not only could she ignore the advice of family, she had become the expert on her child's health issue even compared with medical professionals:

> Um I guess after understanding I understood when [baby] gets it like [baby]'ll get a little bit of a… I knew the symptoms…Of how it accumulated… And once I worked out how it accumulated I say just took [baby] to the doctors as well and I'd be telling them what [baby] needs and when [baby] needs it. Karen

So over time, Karen made the shift from initially feeling very unsure of her own skills and competence to coming to trust her own skill and knowledge from her experience of caring for her child, and then finally having the confidence to advocate for her child's needs in a hospital setting with medical practitioners who arguably have high degrees of mandated power. Though most exemplified when the health issues were chronic and severe, it was apparent that this transition from 'other to mother expertise' occurred to some extent in most participants. For instance, Cynthia puts it clearly when she describes how she had shifted from a disempowered position to feeling "in charge":

> Because maybe they saw me being not weaker with [baby] but uncertain with [baby] so therefore they felt as if they could say offer advice which actually made it worse.

> Whereas now ‘cause I’m confident they don’t feel that same need to offer advice and tell me what to do ‘cause I’m just doing it so there’s not the same need to give advice…Yeah and I’m in charge now I’m responsible [for feeding decisions].
>
> Cynthia

In summary, for the group of women who had children with health and/or feeding problems, a factor in their improved mood related to their child outgrowing their problem, something they had little control over. Unfortunately, consistent with the intensive mothering paradigm, women usually thought they should be able to change the course of their child’s problem and lost confidence when they could not. Developing expertise from experience gave women a sense of competence and confidence to care for and advocate for their child. In essence, the women gained a sense of control, or as Michelle put it “I knew that I could do something and it would work out okay and that [baby] would do it my way.” Child development and learning from experience takes time. This accounts for why the transition out of distress was framed as gradual. It “just slowly got better” as their baby grew out of health issues, developed more predictable behavioural patterns and became more responsive. At the same time the women themselves developed expertise and confidence and their distress decreased.

Crisis Turning Point

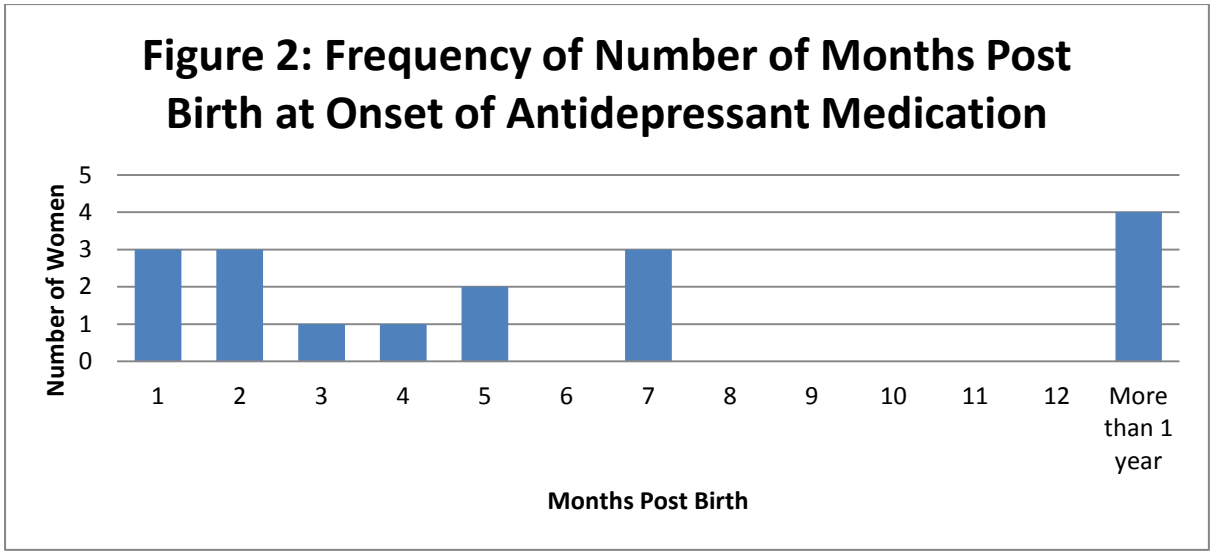
A crisis or critical event in a narrative can signal a turning point in a person’s sense of themselves, and can bring to the fore our understanding of “what drives, motivates and is important to us” (Crossley, 2000, p. 99). Eight women who experienced the early stages of motherhood as an endurance test identified a crisis or turning point in their narrative of coming out of postnatal distress. For four women (Cynthia, Mary, Julie, and Dawn) this occurred when they were at the planned point of returning to work and it became apparent that further compromise or adjustment was required. For one woman (Erin) the crisis occurred in her relationship with her partner when the couple disagreed on priorities regarding work and where they should live. For three women (Melissa, Wendy and Amanda) the crisis occurred when they were thwarted in an attempt to care for themselves. The “turning point” for the women brought to the fore the more complex negotiation of competing identities and roles as mother to their child, partner in their couple relationship and paid employee.

The extent of compromise that women were making however was obscured in the narrative. It only became apparent through careful reading of each woman's two interviews together and by identifying individual patterns of accounting. From this individual focus of analysis, the crisis turning point narratives were compared across participants and consistencies and contrasts were identified across participants. The way in which the women narrated the turning point did not deliberate on contextual circumstances like work, child care or access to free time, even though they formed part of the story. The "turning point" narrative redirected focus instead on the woman's own emotionality which was presented as unreasonable. This unreasonable emotionality was then framed as the (logical) reason for seeking medical treatment. In order to bring to light the obscured narrative that appeared to relate to the gendered inequities at play, I will first focus attention on the contexts and events surrounding the "crisis turning point". The women's narratives of the circumstances and events of the crisis will be related to the wider social contexts regarding support for women returning to work after having babies in New Zealand. Secondly, I am interested in the functions for the women of narrating their emotional response as irrational and unreasonable. Thirdly, I will investigate their action and the consequences for women of going to their medical practitioner and being named "postnatally depressed".

Contexts for the crisis turning point

Paid work context for crisis turning point

To understand the context for the crisis turning point it is helpful to first step back from the narrative analysis and note the broad pattern whereby most women in this study gained medical intervention in the form of antidepressant medication. Surprisingly, it was this pattern that gave the clue to the adjustments that many women had to make at the point when they had planned to return to paid work or when they initially went back to work. Five women described a crisis turning point at the time they were re-entering or negotiating re-entry into the paid work force. This negotiation seemed to account for the unusual pattern apparent in the timing for women seeking medical intervention for themselves (see Figure 2).



Eighteen of the 22 participants were prescribed and took antidepressant medication at some point during the months after the birth of their first baby. Figure 2 presents the timing of when they first took the medication. Note that data is for 17 women, as accurate timing for one woman who took medication was not obtained at the interview. An interesting pattern emerged whereby over half the women went to a medical practitioner (one woman was prescribed medication by a psychiatrist who visited her home) and were prescribed medication within the first 7 months post birth (13/22). In fact, half of this group (6) got medical intervention within the first two months. Beyond 7 months however there were no women prescribed medication for the first time after birth until the one year mark and beyond. The timing for seeking medical treatment after the one year mark post birth was related to women's paid employment problems and so not surprising within the employment climate of the time.

The participants' first babies were born between 2001 and 2007 (most in 2005-6). In New Zealand from 1 July 2002 biological mothers were eligible for 12 weeks paid parental leave which was extended to 14 weeks in 2005. Women were and continue to be eligible for unpaid leave up to 52 weeks, less any maternity leave taken, where they have job protection (with some qualifications) (Callister & Galtry, 2006). Many of the women in this study described taking leave from work for 9-12 months after their first child was born and, as 20 of the babies were born after 2002, the women likely received at least the 12 weeks paid parental leave (some women moved from overseas back to New Zealand during their pregnancies and so were not employed at the time they had their babies).

Within this context five women (Mary, Cynthia, Dawn, Julie and Stephanie) described a crisis point just before or after returning to paid work where events did not occur as they had planned or expected, as I will describe. Stephanie's account of coming through depression also incorporated the Dealing with Emotional Baggage narrative that forms the next analytic chapter. Consequently I will describe her narrative of coming through depression in the following section rather than here where there are several other exemplars.

The expectation that returning to work would be not only possible but welcomed was likely supported by the governmental policies and promotions at the time. Paid parental leave offers women the promise that they will not have to significantly compromise their paid career when they have children. The importance of women in the workforce was the rhetoric of government and feminist campaigners at the time. This was evidenced within documents campaigning for the introduction of paid parental leave and parliamentary media releases citing the then Prime Minister of New Zealand (NZ) Helen Clark's campaign to increase women's work force participation (see the New Zealand Herald, 2005) . In the Prime Minister's address to parliament she highlighted that workforce participation in NZ in 2003 was high compared to the Organisation for Economic Co-operation and Development (OECD) countries, however the "women's rate lags – and in particular sits below the OECD average for women aged 25 – 34". This social discourse created an expectation that women should be going back to paid work after having children and implies that impediments for women with young children have been resolved by laws, such as the paid parental leave entitlements within the New Zealand Employment Relations Act 2000.

The lived experience of returning to paid work was more complicated, however, for some of the women in this study (Melissa, Julie, Dawn, Cynthia and Mary), including three of those who started medication after one year (Mary, Julie and Melissa). The four women who gave a narrative account of a crisis in a work context (Cynthia, Mary, Julie and Dawn) identified the crisis as the incongruence of their highly emotional reaction in a context where they had not expected it, such as the paid work place. The focus of the account was on what they saw as their unreasonable emotionality, and the impact of this on them and the people around them. The broader context and events surrounding their emotionality was not the focus of the crisis narrative. For instance, Mary described being tearful when she started back at work, a place in which she previously viewed herself as high functioning. She initially related her tearfulness to missing her child and adjusting to a new part-time and demanding

position. Mary's account is an exemplar of the crisis turning point narrative in that the context of her life is subsumed by the focus on her "unreasonable emotionality":

> So I was at work and I'd be, like, drop her/him at day-care, cry all the way to work, hold it together for like a meeting, cry, you know I was, couldn't, it would take me hours to do the simplest of tasks and then one night I was watching the telly and um you know those programmes about the super nanny or whatever (clears throat) and um this child didn't get a sticker for a sticker chart because she was being a little witch basically and I was just sobbing. Saying to [Husband] 'That's the saddest thing I've ever, ever seen in my life. Like how could they not have given that child a sticker?' And he went 'I don't think you're just tired ay' and I went 'no I don't think I [am]' and it's the first time I'd ever gone 'yeah actually you know what I'm not just tired. Something's really not right if I'm crying about brats not getting a sticker' and so I went to my GP (clears throat) and he said 'god if it's not [child]' and I just said 'yeah I'm just you know a complete write off basically' and so started on antidepressants and responded really quickly and what a life saver. Mary

Later in the interview Mary described multiple reasons for being upset and emotional. The reasons included: her husband being very uninvolved in the family following the birth; the fact that against her wishes Mary was redeployed to a lower level position on returning to work; and on returning to work Mary experienced ambivalent feelings about letting go of the role of full time care giver to her child while also being frustrated at having to take time from work to look after her child when s/he was sick. None of these difficult life events and losses formed part of her account for her being upset.

When her doctor (general practitioner or GP) stated "god if it's not [child]" he was likely referring to the fact that, by her account, Mary had visited the doctor frequently about her child but this was the first time she attended for her own problems. It did not appear from Mary's account that she gave her doctor any more context for her distress than she gave in this account of the crisis point.

In most of these crisis accounts the partner is present and a witness to their emotionality. It is at this point the women name their distress as "something's really not right", as Mary put it, and starting antidepressants is presented as the solution to the whole problem. This narrative presents the ideal set of symptoms for a medical/psychiatric formulation, in which the context is generally irrelevant. In describing her distress as

"something's not right" Mary positions her emotional problems as a mystery and outside of her normal experience. This is consistent with a medical formulation, which frames her emotionality as illness. Mary's account of her quick response to the medication further supports the medical formulation of her distress.

Cynthia also described a turning point (at 7 months post birth) when she was in the process of returning to work. Restructures had occurred without her consultation and, like Mary, she was facing returning to a position under someone who had previously been her junior: "So that [changes in the workplace] really stressed me out…[I] wasn't being heard at work. I was being ignored and not consulted". Cynthia then also listed the other emotions she was already experiencing. These were related to difficulties with her infant's slow weight gain during the early months of her child's life, and pressure from her mother and husband, who had quite forcefully promoted their own very contradictory ideas about feeding. Cynthia gave a narrative of how she was at that time still "just totally tense and anxious and totally undermined, had no confidence at all and then it came to a crux when I was thinking about going back to work". This list sets an emotionally-focused scene for the remainder of Cynthia's narrative, which highlights two sequential incidents. Firstly, on her first foray back into the workplace, Cynthia described a man "telling [her] off" for using a phone during a break in a meeting, to answer a call from her mother about her child. She related her tearful, angry, verbal retort but also her sense that her emotional response was out of place and inappropriate ("in this waiting room tears were rolling down my face…this performance in public"). Cynthia related a second incident that occurred when she got home and expressed anger and then became tearful when her mother interrupted her conversation with her husband (" I'm like 'Don't interrupt me, stop asking me for, about friggen pizza.' And I stomped off just tears rolling down my face"). Both situations recount Cynthia's expression of anger at her autonomy being violated.

In line with the crisis turning point narrative, however, Cynthia provided the judgement that her behaviour and emotions were unreasonable in her statements that the first "incident was totally blown out of proportion" and that it "just isn't normal behaving like this, this tension level". She then went on to visit her doctor and start antidepressant medication. Cynthia described two situations where her autonomy was violated and she became angry and upset. In both situations she spoke up, however then regretted her reaction. The unacknowledged context for Cynthia's response to being criticised and interrupted was the loss of status in her workplace, the lack of personal power, and the feeling of being

undermined as a mother because of the strong positions both her mother and husband took with regard to the birth (her husband's family advocated for the planned caesarean birth) and how to feed her baby. Focussing their narratives on the specifics of the crisis and their supposedly excessive emotional reaction served to obscure the broader contexts of the women's dissatisfaction or distress. These obscured contexts seemed to relate to situations where they had been disempowered in their couple relationship (Mary's husband had disengaged and Cynthia's husband was experienced as too dominating) and the work environment.

Thwarted self-care context for crisis turning point

Returning to work could be conceived as self-care action. The following section focuses on accounts where women described the crisis turning point in a self-care context that was not work related. Self-care refers here to actions women take for their own benefit rather than the benefit of others. Lafrance (2009) suggests that for women to come out of depression they need to resist the total other-centeredness that is associated with feminine and motherhood discourses. She found that women came out of depression when they started to take care of themselves. Returning to work can be seen as a more self-focused action when women gain benefits beyond just earning the money to feed their families. The challenge of doing self-care while also meeting obligations as a 'good' mother raises conflicts that can create frustration and guilt. This crisis turning point narrative does not perform the same discursive actions of the *self-care through crisis* discourse identified by LaFrance (2009) as a way that some women justified self-care practices and avoided being blamed for their depression. How the crisis turning point narrative did operate will be explored further.

Both Mary and Cynthia (also Dawn, Julie and Stephanie) described the stressors and losses they faced on returning to work as a factor in their crisis turning point. Other women described the crisis in circumstances where they were thwarted in a planned self-care attempt. For instance, Melissa described the supposedly innocuous situation where she asked her husband to help connect the computer to a printer. Similarly, Wendy and her husband and baby had taken a weekend break at a holiday home, and Amanda, who had been a wind surfer, was at the beach with her baby while her husband wind surfed. The focus of these narratives was on how a seemingly innocuous or even a potentially pleasant situation went unexpectedly wrong. Consistent with the crisis turning point narrative, however, the women focussed their narrative on their emotional reaction, which was presented as excessive. The

impact of their emotionality on their couple relationship was sometimes stated but seemed implicit. The gendered inequity that may have contributed to their annoyance, tearfulness and distress was not a part of the narrative. As for Mary and Cynthia above, Melissa framed her emotional response as excessive and unreasonable:

> I was either really happy or I was really annoyed. And it could be the smallest thing, and the thing that, the thing that had me go to the Doctor was I was ready to divorce [husband], fully ready to just divorce him because he couldn't connect the printer to the computer (laughter). Melissa

Melissa presents her emotional state as extreme and unstable by framing her feelings as polarised (happy versus annoyed) and using intensifiers (really, fully) and trivialises the situation in such a way as to make her response of being "fully ready to divorce" her husband appear unreasonable. When I asked what the situation signified for her, Melissa identified her concern for the impact on her couple relationship as she described:

> That I was, this was not right. How could I be so mean to somebody that I'm supposed to love? I need to do something. I just need to go and put my hand up and scream and yell until something gets done. Until I get some help. Melissa

The decontextualised way that these emotional reactions were framed by Melissa, Mary and Cynthia, obscured what careful reading of both transcripts started to make apparent. The obscured contexts related to the unfair burden of unpaid child care and house work that they were trapped in, and the unfair access to paid work and child free time that was maintained by the distribution of roles and tasks between the parents. Behind each of these stories of the 'crisis or turning point' and the women's representation of themselves as unreasonable and over reactive, there was an obscured narrative. The emotional crisis, when understood within the context of the participants' broader life as women at home (i.e., unpaid worker in the home) with a young child, could also be viewed as the culmination of the frustration and sublimated anger engendered by the experience of the gendered inequality inherent in the situations the women faced.

Both Sevón (2012) and Croghan (1991) have highlighted the struggle for women in facing the gender imbalances that arise when families are modelled according to traditional and intensive mothering practices. According to Croghan, when women have experienced nominally reciprocal relationships prior to children, the transition to gendered roles and

inequities can be difficult to come to terms with. Women also may feel ambivalent about an alternative shared parenting role which involves giving up the primacy of their child caring role. In any case, women are positioned by current sex-role ideology as critical to child care while men are positioned as optional so have more power to choose what role they take (Croghan, 1991; Vuori, 2009). A more shared parenting arrangement would require willingness and effort in order to depart from intensive mothering which social structures support (Sevón, 2012).

The participants' narratives did not focus on this inequality and lack of agency. Melissa's account below exemplifies some of the conflicts for women in naming inequality. It gives some answers to why women would instead provide an account that focused on their emotionality and their action to seek medical intervention.

Melissa's story exemplar of hidden inequity

At Time 2, after the birth of her second baby, Melissa repeated her story of the crisis with the printer and the "mean" way she had treated her husband when he was unable to make it work. This time I questioned her further to understand why this was so frustrating for her. It was only after four "turns" in the back and fro of our conversation, that the significance of the printer became apparent. Melissa's story once again started humorously with a presentation of the crisis as "Yeah very funny story yeah I was going to do old [Husband] because he couldn't connect the printer to the computer it wasn't working, I couldn't get it to work." Which invited me into light irony with her [Sue: "that sounds reasonable. (laughter)"] to which Melissa responded with similar irony; "Highly reasonable I mean gosh." However she then gave a more serious account of the events starting with how she was baffled by her excessive reaction:

> And I don't know what it was, he doesn't know what it was but I got so wound up and so huffy and you know puffy and lots of swear words later and blah, blah, blah, blah, blah I'm getting a divorce…. Melissa

Humour acts to moderate the seriousness of the incident and her bewilderment about "what it was" acts to absolve her of some of the responsibility for her behaviour and allows her to be more explicit about 'bad behaviour' like "swear words" and threats of divorce. In her third narrative turn Melissa positions her behaviour as "irrational" and out of her control (in a way that is similar to what the other women described above):

> Yeah ‘cause at the time you know can’t connect the printer to the computer that was the be all and end all the world was going to end ‘cause it wouldn’t work and yeah I knew at the time it was irrational but I couldn’t stop myself. Melissa

It was not until her fourth turn when I had continued to ask her questions about the incident (I was genuinely mystified myself) that Melissa finally disclosed what was at the heart of her frustration and anger:

> Well I was doing something on the computer and I wanted to print it out and I was doing, I was doing a course at that point so I needed to print it out and yeah needless to say I dropped the course. Melissa

Far from being a superficial contingent, it surprised me that this was not part of Melissa’s initial or even subsequent accounts of the incident, as from the surface it appeared to provide a robust justification for her expressions of frustration and anger. The loss of her training opportunity was likely the focal point for all the accumulated sublimated anger and frustration related to the structured inequities within her relationship with her husband. However, rather than addressing inequities, Melissa focused on her irrational response and the impact on her husband and their relationship as she ended with a bitter sweet summary emphasising that narrative: “Yeah and it just was the big explosion over a printer, I still laugh about it now, [Husband] laughs. It wasn’t funny at the time...and it wasn’t funny for him either.”

In each case where the women described a crisis turning point, other factors that would have accounted for their anger and frustration were not a part of the narrative. For instance, Melissa related how she returned to work fulltime when her child was eleven months old. Because s/he was often sick in day care, Melissa was required to take significant time off work which made her job untenable. She ended up resigning after four months. Melissa’s initial account of these events presented the outcome very positively, glossing over the cost to her: “I stopped work and that was the best thing that I’ve ever done.” She then gave other reasons why being home was the right decision, however then made the incongruent statement “And then a couple months after that I put my hand up for medication” which gave me the clue that there might be a link between resigning from work and the ‘printer incident’. I therefore asked a direct question alluding to a connection: “Did you feel bad about not being able to go back to work and not, not being able to make that work?”

Melissa then gave a very contrasting version of what stopping work meant for her at that time:

> It was, well I'd finally found a job that I loved and that really sucked having to give it up. And yes, I guess because, you know, we figured it out on the monetary side of things, there was a bit of resentment there and there was also the I'm stuck in this everyday again and you get to go off to work, you travel, you go and have holidays, and then, you know, he travels away overnight and although I know he misses us dreadfully, you're in a Hotel and I'm stuck here with [child]. Melissa

Melissa listed the unfair contrasts between her and her partner's experiences. She also described how the decision for her to be the one to resign related to finances. This way of rationalising the arrangement of women staying at home while their husband worked was made by many of the participants and was framed as a choice the couple made together. This didn't stack up in Melissa's case because she "earnt more" than her husband. However, she justified the decision for her husband to remain at work because "he had the potential to earn more the fastest."

Melissa also described the unfairness of being required to take time off work on every occasion when her child was sick despite her stated belief (referencing the narrative of shared parenting) in equitable sharing of the responsibility: "I had a big old barney about that, cause it's, you know, we both have had this child therefore it should be 50/50." However, Melissa named several arguments that her husband presented as to why his work was less flexible (travel, important appointments) and these seemed to have won over. This exemplifies the way in which shared parenting ideals are subordinate to the power of men to choose their parental role and prioritise their access to work (Vuori, 2009).

In concluding this account of the decision for her to stop work, Melissa returns to a positive summary of the longer term outcome of these personal compromises and frames them as beneficial to both of them:

> It's worked out well because he's on quite a handsome salary as well as his bonuses now, and he's moved up within the company. So for him to, for me to stop and for him to continue it was the right move. Melissa

Melissa's ability to accommodate the compromises she made into a narrative of the couple both benefitting suggests that she has made some adaptation to a more traditional construction of her identity as a mother at home and as a partner to her husband in a similar way to women in Sevón's (2011) study.

Melissa's reluctance to name her frustration at being denied the opportunity to work or complete her course may reflect a number of discursive binds. Firstly, it may be that, having been a successful career woman, she found the position of "non-completer" in her course and her inability to re-enter into paid work inconsistent with her view of herself, and therefore uncomfortable. However, her anger directed at her husband suggests that the frustration was related to their contrasting positions and the fact that he did not suffer the restraints that she did. Within the current post-feminist, neoliberal rhetoric of women being able to have or do whatever they want, naming your lack of ability to negotiate a fair deal may be admitting personal failure. Jacques and Radtke (2012) propose that the discourse of individual choice and personal responsibility inherent in neoliberal ideology obscures the socio-political context, so that young women in their study avoided issues and concerns regarding gender inequality when considering career and motherhood. Drawing on the crisis turning point narrative to account for their frustration and anger allowed the five women who utilised the narrative to divert attention away from the gender inequity occurring in the crisis situation. In this way they aborted any attempt to negotiate a fairer deal and took the actions that appeared to mend any breach in the couple relationship. Melissa's positive framing of the decision "for me to stop and for him to continue it was the right move" acts to present it as ultimately pragmatic and once again, just based on financial realism, glossing over the inherent gender inequity.

Julie also provided an account of her difficult decision regarding work, which highlights the gendered difference in choice regarding who stays home with a child with health problems. Julie described her hope when pregnant to return to work part time when her baby was 9 months old:

> But the reality of parenting and how difficult it was and the amount of energy it took and the problems which we had with [Baby]…made us both realise that it wasn't going to be a good option me going back. And in fact at one time we talked about me going back at nine months, working full-time for a few months and [Husband] taking

> some time off to look after the child but I mean that idea, so went out the window, and you know, he would have had no desire to do that. Julie

Clearly the default option was that Julie had no choice and would stay home while her husband could choose to be home if he wanted. In the two situations where men in the current study remained at home while women worked full time, the men both chose to do this. For one man the situation arose because he was made redundant from his work and the woman had a job, which suggested there was somewhat of a forced choice. How roles are defined in couple relationships are not necessarily based on free choice but are guided by the positions society makes available to them.

There are contradictory discourses surrounding motherhood and the parental couple. On the one hand there are the intensive mother (Hays, 1996) and good mother (Villani & Ryan, 1997) ideals which prioritise women's role as care giver to children and partner. On the other hand, there is the presentation of parenting as being non-gendered beyond the biological imperatives such as pregnancy, birth and breastfeeding. There appears to be more promotion of men having more hands-on care of their infants. For example, La Leche League (2010, 2011) in both their web site and written material, encourage fathers "to spend time with their babies in order to get to know them better and get 'tuned in' to their needs". Books on child care are often presented as "parenting" books, continuing this picture of egalitarian, non-gendered roles for men and women in the care of their infants (Hays, 1996). This narrative of shared parenting (Sevón, 2012; Vuori, 2009; Woollett & Parr, 1997), where both fathers and mothers portion parenting responsibilities equally, has developed alongside the intensive mothering narrative (Hays, 1996) for women. A conflict clearly arises for women who, on the one hand, are attempting to share the responsibility, but who are also judged on their ability to accomplish the tasks of intensive mothering. This conflict is exemplified in an account by Cynthia, explaining her feelings of being "Very tense, I was trying to please mum, I was trying to please [Husband] and it got to the point where I was, I'd be nervous about [Husband] coming home, I'd be scared of him coming home cause he'd want to know how [baby] had fed."

The baby's poor weight gain appears to be a legitimate concern for both her and her husband even without a shared parenting paradigm. However, the husband's involvement in other aspects of child care was clearly following the principles of shared parenting. It seemed that Cynthia's husband wished to have more 'hands-on' involvement and had wanted to be

the one to bath their baby in the evenings. The difficulty arose for Cynthia when she found that the baby needed a bath and sleep earlier in the evening, which would exclude the father who was bound by the constraints of full time paid work.

> I think [baby] would have been five weeks or six weeks old by now and I'd know that, you know, s/he might want a bath at four and go down at five or something but [Husband] had said he was going to be home to do the bath, then it got to six and s/he was totally fractious and, so the whole, you know, by the time he did get home for the bath s/he was beside her/himself with tiredness and I knew I should have done it earlier. So the whole experience was totally unpleasant. Cynthia

This narrative describes the cost to Cynthia and her baby of following shared parenting as a paradigm. Cynthia's ability to prioritise her child's needs within this model appeared to be usurped by the father's mandate for involvement in child care. Furthermore, the prioritising of paid work responsibilities placed limitations on the father's ability to support intensive/good mothering practises that would prioritise the child.

Alongside men's increasing involvement in what had previously been a woman's domain of parenting infants and young children, women who are mothers have increased access to employment. The modern discourse initiated by the feminist movement of the 1970s, and extended by current neoliberal ideology, is that women can have it all – career and motherhood – and it is presented as their choice (Choi et al., 2005; Slaughter, 2012). The societal representation of women having equal access to paid employment even once they become mothers exists despite the fact that traditional societal structures still continue to guide the practice of the majority of fathers and mothers. Under these structures mothers remain the primary care givers to their young children and take time from their careers/paid employment to do this, while men remain as fulltime in the paid work force (Hakim, 2006; Johnstone, Lucke, & Lee, 2011; Phillips & Imhoff, 1997). Even at the point in time that couples have planned for the woman to return to work, several women (as with Melissa and Julie) described having to make further adjustments to their employment plans due to child care responsibilities while their partner continued as before.

Clearly women are placed in a bind, in that when enacting the societal representation of her "choice" to return to work, she also invokes the societal judgment inherent for women who place their own needs ahead of their children and family ('family' being a more morally couched term for 'husband' or the couple relationship).

While Melissa presented the crisis with the printer as out of context, in fact at different points in the interview, Melissa had talked about work and the "decisions" made by the couple regarding paid employment, and the adjustments she had experienced whilst her partner's paid work circumstances remained unchanged. Two discourses were inherent here: firstly, the expectation that women will compromise paid employment to meet the needs of their children and family; and secondly, the unquestioned right of men to prioritise work. While this conflict was not raised by many of the women in this study, others, like Melissa and Mary, experienced significant distress as they were required to compromise plans for work whilst their partners reneged on previously agreed child care arrangements.

Melissa's narrative positioning may have been influenced by knowledge of the societal censure of women who prioritise self-development over motherhood and the couple relationship. When she concludes with "needless to say I dropped the course" she positions the course as an unreasonable thing to have expected to do as a mother and that the inevitable happened when she dropped the course. The helplessness and disappointment at the loss are implicit.

The crisis turning point narrative began with a context and then continued with a statement about women's perception that their reaction was out of context and excessive. The conclusion of the narrative was that the women went to the doctor, which I will turn to now.

Going to the doctor

The crisis turning point narrative served to highlight the women's behaviour and emotions that would equate to "symptoms" that would support a medical diagnosis of depression. For instance, Cynthia described how her emotions were overreactions and not normal. Also, the narrative did not highlight aspects such as family conflict or gender inequities, which are not the province of medical doctors. The culmination of the crisis turning point narrative was that the women went to their general practitioner (or a medical specialist) and received antidepressant medication.

Lewis and Nicolson (1998) suggested that mothers who experience distress turn to a medical diagnosis because there are no alternative ways of conceptualising distress in the context of motherhood, which is socially represented as a positive and fulfilling experience for women. The action of going to the doctor effectively named their expressions of emotion (anger, frustration and hopelessness) as postnatal depression (PND) and appeared to have

three functions. Firstly, diagnosis worked to repair fractures in the couple relationship caused by their expression of their annoyance, anger, frustration and/or hopelessness directed at their partner and family (as with Melissa, Amanda and Cynthia). Secondly, diagnosis functioned to add the authority of the medical establishment to requests for added assistance and respite from child care in Wendy's case. Thirdly, diagnosis was accessed to gain relief from feelings. I will explore each of these functions for going to the doctor in turn.

Mending fractures in the couple relationship

Cynthia provided an account of going to her doctor explicitly to get antidepressant medication. However, she did not present this motive directly to the doctor. She described how in the doctor's office (surgery) she "started crying there and then in the surgery and saying this is how I'm feeling and I didn't want to say straight out "Give me some drugs. (laughter)". Cynthia clearly understood the cultural protocols of patient/doctor interactions requiring her to allow the doctor to diagnose her "illness" and then prescribe treatment. However, she also presents herself as agentic and clear about what she was seeking, which was drugs and, by association, a diagnosis. The act of going to the doctor, after expressing anger and being upset and tearful, is complicated for many reasons.

Turning once again to our exemplar, Melissa; after the emotional crisis, supposedly over the printer, she described a plan of action-"I went to the doctor". Interestingly she told the story explicitly highlighting the fact she did not tell her husband why she was going to the doctor, but presented him with the fate accompli:

> The next day I went to the doctor…Like he'd come home early for something and I said 'Oh great, well you can mind [child], I'm just off to the doctor's.' And he said 'Why?' And I said 'Oh no, I'm just off to doctors.' And I'm just [expressive noise] off to the doctors, came home and said 'Right, I'm on Aropax now'…And he noticed a difference straight away and it took me two, three weeks before I noticed a difference. Melissa

Like Cynthia, this narrative also positions Melissa as taking charge. In not allowing her husband to provide an opinion, she protects herself from his judgement and also from raising and potentially dashing expectations that a "solution" to her negative emotions may be found. Her comment that "he noticed a difference straight away" suggests that her strategy was positively viewed by her partner perhaps assisting in repairing any ruptures in the couple

relationship caused by her reaction (over the 'printer'). However, having her annoyance and frustration renamed depression silenced her expressions of dissatisfaction regarding the unfair distribution of access to paid employment.

In positions of powerlessness, and with the requirement to care for and manage other people's feelings, women may use passive strategies to maintain the ability to have choice and control. For instance, when Melissa decided to go to the doctor after the 'printer incident' she did not tell her husband that she was going, seemingly to avoid his judgement or disappointment.

> It wasn't going to be, 'So how did the doctor go today?' Yeah I did exactly the same thing with the soccer. I didn't tell [husband], I didn't tell [child] what we were doing, it was, 'Right we're going.' So I had up until that very last second to pull out…..so that I wasn't going to be disappoint, if I had have told [child] and then we didn't go he would have been gutted, I would have been setting myself up for failure if I had to pull out. Melissa

As Melissa makes clear, letting down her husband or child would position her as a disappointment and failure as a wife and mother.

Julie also presented her account of her decision to seek medical treatment as related to her mood and the couple relationship. However, rather than mending a breach related to becoming upset and emotional, it was prompted by her desire to change her husband's mind regarding having a second child. Julie listed the reasons why her husband "was pretty adamant that one would be it because it had been so difficult for us both". The difficulties included her child's serious allergies that "needed so much extra work and supervision and there was no end in sight to that, really, that it would be just stupid to have another one." Julie gave her reasons for wanting another child and also identified her "postnatal depression" as the reason for her husband's reticence:

> Part of it, I think, was the was needing to get on top of the postnatal depression, because it was realising that if I can't do that and can't get myself into a happier place there really is, it really will not be a good idea having another one for anybody, anybody's sake. And, I guess, it sounds a bit horrible but [Husband] being able to use that the stick to beat me with, you know, if you're still depressed from number one then you certainly shouldn't be having another one. So that was, I guess, was a bit of

> an incentive for dealing with it, and finally persuaded [Husband], I guess, over just over a period of time really. Julie

I asked Julie "How did you deal with the depression. What did you do?" and her blunt response was "Took drugs, is really the main strategy." This narrative presents her use of medication as an agentic act to persuade her husband that she was emotionally fit to have another child. She identified that she supports the logic in part with her comment "If I can't get myself into a happier place then…. it really will not be a good idea". However the main thrust of her account is that her goal in going to the doctor and getting antidepressant medication was in order to influence her husband. The implication was that she would not have gone to the doctor without the need to influence her husband to have another baby. Being seen to take action on depression by going on medication seemed to be as important as "getting to a happier place." This account highlights the multiple ways in which medical constructions can be taken up and utilised beyond the individual, biomedical way they are generally conceived. Taking antidepressant medication can position people as 'depression sufferers', however Julie also took up the position in order to present herself as a 'fit mother' to have another child.

Added assistance and respite from child care

Wendy's story is similar to Melissa's in that her narrative of a crisis involved self-care attempts going wrong. She does not completely "fit' the crisis turning point narrative as she had already gone to the doctor and started taking antidepressant medication the week before. The crisis did however mean she went back to her doctor, as I will describe. Also, she did not appear to obscure these self-care strategies, perhaps because they related to her child care role and were in the context of trying to do 'something nice as a family', not just for herself. Her narrative of the crisis, then, started by framing her previous visit to the doctor within a list of actions she had taken to take care of herself. She included her action of getting medical treatment (antidepressant medication) for anxiety and sleep deprivation and then arranged "a bit of a holiday" with her husband "so that he could have some more time helping me" with their four-month-old child. Wendy's baby had experienced poor weight gain initially and ongoing problems feeding, with reflux and long periods of inconsolable crying. Wendy described feelings of "huge desperation", "helpless and hopeless", as things did not turn out as they hoped:

> [Baby] sort of started screaming and screaming and screaming, couldn't console [baby] and we were in this tiny little place you know there's nowhere to go couldn't escape, and then the big black clouds came rolling in literally and figuratively. Literally you know it started pouring with rain and, and then I just sort of felt this huge desperation wash over me, and I just kind of yeah plummeted from there really.
>
> Wendy

Wendy gave an account of then returning to her doctor. Her doctor initially continued with a medical approach: "you'll just have to wait for the drugs to kick in". Wendy described being persistent in stating her level of distress: "I remember saying 'I can't feel like this for another three weeks I just can't.'" Wendy's doctor then "prescribed" social support. This seemed to add the weight of the medical model to requests for assistance (from her husband and mother), which had previously gone unheeded.

> So I think that's when my mother came up. My mum came up and [Husband] took some time off work and I sort of slowly sort of got some people rallied around to help out, and then the drugs kicked in (laughter) thank goodness. Wendy

This way of accounting frames the practical help as something to sustain her until the medication "took effect". In this way the biomedical discourse supplants the importance of practical assistance in helping Wendy manage the difficult child care role.

Wendy's narrative tended to position both her and her husband as impotent in the face of society's prioritisation of paid employment. The strength of this discourse may explain the helplessness she felt. Her narrative about her husband's roles was trivialising about his ability to cope with their child's problems, sympathetic to the restraints of his job and poignantly sad at the impact of this on her.

> Oh (laughter) poor boy he was a bit kind of perplexed by it all. I think (laughter). I mean he being a man wanted to just fix it and of course he couldn't, and so yeah he was, he was quite finding it very stressful. And he's you know he's got quite a high pressured job and he was finding it difficult. Because I was sort of not coping fairly regularly and saying 'please can you stay home and help me' and he was saying 'no, no I've got to get to work I have to go to work today, I've got you know people coming to see me and I've got this and the other happening'. And so it was hard for

> him cause he was sort of being pulled in two different two different directions. So he was pretty pleased when I finally went to the Doctor yeah. Wendy

Wendy provides several constructions of her husband's inability to give assistance even in a crisis. They each serve to relieve him of fault and avoid positioning him as uncaring. In this way she maintains her sympathy and warmth towards her husband. However, these constructions do not allow any challenge to the unhelpful structuring of roles and society's prioritising of paid work obligations. Medical treatment is positioned as the solution. Consequently biomedicine appears complicit with the neoliberal agenda in identifying the woman's biology as the location for intervention as opposed to deconstructing societal organisations of work and family today.

Other women identified their husband's work obligations interfering with his ability to provide practical help and emotional support when their children were infants. This was particularly the case for Donna, whose husband went overseas for several weeks for work, two weeks after the birth of their baby. She described feeling "black and miserable" and very tearful. Donna provided medical constructions to account for her misery including being more sensitive to her hormones, as her medical practitioner had explained. She was however able to articulate other contextual causes of her distress including that her distress may be "normal" considering the circumstances.

> 'cause part of the problem was that it's perfectly natural for you to mind that you are on your own with a two week old baby and your husband's gone overseas and it's perfect- that's sort of normal… so I'm not quite sure exactly what point I started to realise that this is not just me. Donna

Donna's reference to realising "that this is just not me" indicated that the biological explanations for her distress located the problem within her. While diagnoses of depression or postnatal depression are sometimes experienced as externalising and validating, Donna's account suggests that she experienced a biomedical explanation as a personal vulnerability, or that she was the problem. Other authors have identified that diagnosis of medical illness for emotional distress can be problematic because it obscures other ways of understanding distress including adverse social conditions (Lafrance & McKenzie-Mohr, 2013). In this account, Donna made the shift from a purely biological account of her distress and identified her husband being away so soon after the birth as an adverse social condition.

Beyond this account of realising it was normal to be upset in the circumstances, Donna provided no critique of the decision by her husband or his employer for her husband to travel. These three accounts (Melissa, Wendy and Donna) suggest a taken-for-granted, and therefore unchallengeable, prioritising of men's paid work for these professional couples. Biomedicine, once again, was complicit in facilitating this normalised understanding by framing women's distress about the inequity as postnatal depression, as opposed to a reasonable reaction to unjust circumstance, loss of paid employment opportunities and/or little help with the burden of child care.

A counter story to the predominant accounts of women going to the doctor and being diagnosed and prescribed antidepressant medication was provided within Dawn's account of going to the doctor but being "prescribed" paid work. The other action the doctor took followed tradition in that she was also prescribed antidepressant medication. However, this was not the focus of her account. Dawn's account was that she reached a crisis point after several difficult months with a child described as "fractious" (also with feeding problems, reflux, and colic) and very little adult company or assistance beyond her husband. The emotional crisis happened when her family, who lived in another town, visited and then returned home. Dawn experienced intense sadness as she described missing the brother that she was very close to, and her family: "[I] just couldn't stop crying and I was like you know this just can't be right you know…" Judging her response 'not right' led Dawn to go to her doctor, who recommended she return to work. Interestingly, Dawn provided an explanation of the doctor's action as not ignoring that she might be depressed and reiterated the doctor's rationale. This suggested she was aware that the doctor's recommendation was unorthodox or at least unexpected from a doctor.

> Yeah I went to the Doctor and just said look you know, 'I just don't yeah I think I'm getting depressed' and she's like and she's like, 'I think you need to go back to work'. But not that she was discounting the depression side of it but you know but this, because this is so what you're used to you're used to being out working and now you're in this situation that if, if there's some way that you can do both sort of thing I think that would really you know sort of help you and balance it. Dawn

Dawn clearly approved of the recommendation as she described it as "a bloody good idea actually". Dawn's doctor located going back to work as a biomedical solution and essentially provided Dawn with a discursive solution to the bind women with young children who return

to work face, namely that they are going against the expectations of intensive mothering which requires an exclusive child focus and selflessness. She went on to explain how she enacted the recommendation by "temping one day a week and [child] went to crèche one day a week." She described the impact on her mood as "bliss". Alongside this account of how paid work helped her mood, Dawn also credited antidepressant medication and counselling, which she sought out for herself, as the most useful for helping her feel better.

Concluding the crisis turning point

In concluding this exploration of the endurance test narrative it is apt to return to the key aspects of how women came out of postnatal distress largely by "sucking it up" and enduring. Michelle Lafrance (2009) theorised that women come out of depression when they prioritise and care for themselves. This was made more difficult for women whose children had higher needs and required higher levels of care and tolerance. Also, many of the more severe child health issues such as asthma and eczema required specialist care that the women did not believe could be managed adequately by non-parental caregivers. Coming out of depression in these circumstance involved waiting for their baby to improve or finding ways to resist the intensive mothering ideology and for instance, return to paid work (part-time) as Dawn managed.

Shared parenting has arisen as an alternative ideology (Sevōn, 2007; Vuori, 2009) however Sevón identified in her study that in order for it to be enacted both partners in the couple relationship needed "willingness and effort" (p. 60). Most women in her study, even if they started with a shared parenting ideal, reoriented to a traditional gendered structure of father as paid worker and mother unpaid caregiver. Mothering continues to be guided by the intensive mothering ideology for both mothers working solely at home or in paid work (Hays, 1996). Thus, women are hindered in taking steps to prioritise themselves whether at home or in paid work while men have the option to prioritise paid work or parenting (Vuori, 2009). Also work cultures continue to be structured to support "the breadwinner-father and stay-at-home-mother reality of the 1950s and 1960s [rather] than the parent-workers of today who are struggling to enact both roles simultaneously" (Johnston & Swanson, 2006, p. 510). Consequently for women such as Melissa and Mary, who were unable to negotiate a shared parenting arrangement that would allow them to maintain paid employment, coming through the distress involved reorienting to a more traditional couple and family structure in order to maintain their couple relationship and commitment to mothering. Their transition was similar to the turbulent transformation described by the women in Sevón's study. Both women

described developing home-based businesses. Interestingly, Melissa took advantage of her mothering experience and began a business developing products to help with children who have reflux and vomiting.

Nicolson (1999) proposed that women turn to a postnatal depression diagnosis because there is no other legitimate explanations for distress in motherhood. For some women the crisis turning point narrative acted to position women's frustration and anger as "postnatal depression" and served to mend breaches in the couple relationship, gain access to practical help and/or relief from symptoms. For some women, however, the crisis occurred because they had been defeated in attempts they were making to reclaim their professional career and were coming to terms with a shift in position to "at-home mother" for the foreseeable future. By the time I interviewed women, most had returned to work, usually part time, suggesting that work became more tenable as children got older and required less intensive care from mothers. In the following section I will explore the changes and outcomes of the women's endurance journey through first time motherhood.

Birth and Motherhood second time round-coming to the end of the endurance test.

In Time 1 interviews the focus turned from how women came through postnatal distress to the changes and adjustments they had made over the course of raising their first child. As they considered birth and parenting for a second time, they identified knowledge from experience that they felt would assist them in this project. These changes could also be considered part of their journey out of postnatal distress to become confident, experienced mothers. Having the accounts of the women's experience of birth and motherhood again provided a view of how women enacted this knowledge and experience when they were faced with similar or new challenges and circumstances. In the last part of this endurance test chapter, I will explore the ways that women approached and enacted second time motherhood after coming through the "endurance test" of first time motherhood.

At the Time 1 interviews the women were about equally optimistic or cautiously optimistic about their coming birth and motherhood with two children. Cautiously optimistic refers to accounts where women were both pessimistic and optimistic, such as "I'm hoping I won't but you never know" (Linda) and "it can't be as bad this time but what if it is?" (Dawn). Linda described both pessimistic and optimistic views. In the first part of her account she gave a medically framed view of her emotions as being out of her control when

she experienced postnatal distress. This way of constructing her experience left her worried about recurrence:

> Yeah, I mean I am a little bit worried just because I know that the emotions weren't, like it's not like more hands on deck are going to help it or it really felt like an uncontrollable hormonal overtaking of your brain…That over thinking and anxiety and so I do worry that that will come back. Linda

Several women similarly described concerns about the return of postnatal distress after the birth. Others who had experienced difficult births were more concerned about the birth itself and bonding with their new baby. Despite this, most women, like Linda, had hopes that they would cope better the second time round. Linda described changes in her perception of her competence, a decreased perception of risk and an increased sense of a baby's hardiness that all gave her hope that the fears that fuelled her previous anxiety have been allayed by experience:

> But you know I'm hoping I don't have that same (pause) huge anxiety, panic attack because I know that you can't break them, that they do keep breathing, that you know the monitor, the sensor pads in the cots do work (laughs), that you know you're not going to just randomly drop them or so all those sorts of things that I ah, worried excessively about, I know they don't happen. Linda

Thus Linda was able to counter a medical framing that created a position of vulnerability and fear with her account of her position as an experienced mother, which provided her with hope and confidence.

Hardy Babies

The hardiness of babies was a key theme of several women's talk about babies, epitomised by Michelle's statement about her approach to second time mothering:

> My approach to the whole thing I think will be a bit different this time around. We're both a bit, 'Oh well, we'll just go with the flow, she'll be right mate, the first one survived, the second one will have to.' Michelle

Michelle's account demonstrates a shift from the view of babies as fragile that pervaded first time experiences of babies. This was replaced with a view of babies as much hardier. Linda

and Michelle attributed a more relaxed "go with the flow" approach with this new understanding of babies as hardy.

A second shift in women's views of babies was that second babies would have to "fit in" rather than their needs being prioritised over everyone else's. This departure from the intensive mothering principle of children's needs taking precedence comes about partly because women understood that it was impossible to prioritise both children. This breach in the intensive mothering ideology perhaps made it more possible for women to resist other intensive mothering expectations. The idea of 'babies having to fit in' can be inferred from Michelle's comment "the second one will have to" but was put more explicitly by Amanda, who attributed her optimism that she would not get distressed again to with being too busy with a toddler and a baby: "Next time I don't feel like I'm going to get postnatal, because I've got [older child] to run after and I can't sit on the couch and feed [baby] all day."

Women gave an account of a third change in their perception of babies that had developed from experience. They described coming to the understanding that babies develop and change over time and that even difficult patterns of behaviour don't last forever. Women had previously described finding advice that referenced this idea unhelpful and trivialising. For instance being told "It's just a phase" or "It will get better at 6 weeks" was not found helpful, even though they had come to this kind of understanding through experience. The second time round, women did not describe time moving slowly. It may be that having milestones to look forward to assisted in providing a context for even difficult behaviour. Two women, for instance, had a second baby (as well as their first) with reflux and colic.

Women who had children with health or feeding difficulties described hoping that this would not recur in their second baby, but had also prepared ways to manage if it did recur. "Forewarned is forearmed and so I kind of knew what options there were available to me to do something about it" as Wendy put it. Both Wendy and Melissa described very similar pessimistic expectations that did eventuate, with both children experiencing reflux, colic and spilling (bringing up milk). They also presented a much more proactive approach to managing it.

> [First child] was spilly. We knew that [second baby] was going to be spilly. It was just like it'd be my luck I'd get another spilly one so I'll just prepare for a spilly baby and if s/he's not- great, if s/he is- okay. So we did lots of talking to [first child] about sometimes babies just cry and you can't make them stop. Melissa

Melissa's pragmatic approach shows an acceptance that babies cry inconsolably and her task was to prepare herself and her older child to cope with the crying. This account attests to the clear dismantling of idealised discourses of babies gained from her lived experience of life with a baby. Melissa also seemed to have overcome the unhelpful belief that babies can always be consoled if mothers just follow the right techniques. This belief arises from the multitude of parenting help books all offering advice which is not necessarily consistent (Catherine et al., 2008). The belief in always being able to console your child was dismantled by women attempting strategies and finding that some worked and others didn't. Melissa's approach, while pessimistic, also seemed to help her prepare for second time motherhood which she described as less stressful:

> God, good it's a lot different to last time. I found my recovery [from birth] heaps easier and I guess one of the real, I mean being a mother of two children one of the real main factors that I'm enjoying is the fact that [first child] goes to school. So I've got the day, nine till three just me and [Baby] and I can still get all the bits and bobs done and there's none of that stress, yeah. Melissa

By viewing babies as more hardy, women could by implication be more flexible regarding how they approached the job of providing nourishment. The way that women approached infant feeding was another main shift in the women's approach to second time motherhood. Within Time 1 interviews breast feeding was framed as a moral imperative consistent with how Crossley (2009) described it. This was still apparent in women's accounts in Time 2 interviews in that most women were still prioritising breastfeeding over bottle feeding formula. However, the women narrated a more flexible commitment to breastfeeding. Dawn described having mixed support in getting started with breastfeeding her second child but described her commitment to "try as long as I could" and was still breast feeding when interviewed four months after the baby's birth, despite describing it as "a struggle":

> Well it was just like, well I just gotta, I wanted to at least sort of try as long as I could sort of stand it sort of thing, so I'd sort of give myself okay well it's, we'll go to two weeks and then we'll go to six weeks and then we'll go to two months and that sort of thing to try and sort of see how it's going to go. Dawn

Melissa had a similar way of narrating her commitment to breastfeeding. However, she found breastfeeding very painful "like glass was being sucked through my nipple" so she stopped after two weeks:

> I wanted to try this time, I had always had the, I'll give it a go, if it works fabulous free food, if it doesn't okay that's fine as well yeah. Melissa

This way of narrating their commitment on the one hand positions both women as committed to breast feeding as their primary aim, however also presents them as confident enough to change to formula if needed. Both women described using formula "top ups" to meet the child's demand for food from 2 days old, so they were demonstrating a flexible approach to feeding from the start. Melissa, however, did significant work in her narrative to support the decision to stop breast feeding, which suggests that the current societal pressure to breast feed was still at play in her decision. For instance, she cited her husband, her midwife and her Plunket nurse as giving her permission to stop. She also listed the tests she underwent to try to diagnose the pain without success, and also named previous postnatal depression as a rationale for not continuing.

> No and when the midwife had said, 'Give it till Monday and if you're still finding you're not coping' she's like 'switch to formula.' Because she also knew of the depression as well I'd been quite up front with her and she's like, 'For you, you switch to formula, don't think that I'm going to jump up and down and go 'breast is best' or wave the flag' kind of thing. Melissa

When babies are viewed and treated as hardy, women are freed to take up new positions with respect to mothering. Two key issues seen as gold standards of good mothering appeared to have been undermined. These two cornerstones of good mothering are the expectations that women will prioritise caring for children and relationships before caring for themselves, and that they will breastfeed exclusively. This new position allowed women to devolve aspects of parenting responsibility, engage more practical help and take on more self-care practises.

Sharing Responsibility

Firstly, all women seemed to devolve some of the responsibility for child care of their older child particularly and most were able to devolve some housework. All retained the role as primary care giver to their baby; however, they actively sought help from family, friends,

lead maternity caregivers (midwives usually), and agencies before the birth and then were much quicker at accessing these resources when and if they were needed after the birth. Practical assistance came in the form of extended family coming to stay and helping with housework and cooking, friends cooking meals, maternal mental health services providing added support while in hospital, help with caring for the older child and so on.

Maternal mental health services were involved by women who had sought help from the service after their first baby. The women themselves initiated contact with the service which had protocols for the kind of help they could provide. So for instance, Lisa was able to have a private room after the birth of her second child rather than going to a ward and was visited by staff from the service soon after the birth. Staff on the ward were informed of the women's previous involvement in mental health services and this was described as helpful as nursing staff provided more assistance with feeding and rest if required. Some women were provided a script for antidepressant medication that they could fill if they became distressed again.

Husbands were usually assigned a greater role for caring for the older child, while women took responsibility for the infant. Fathers consequently were described as having a lesser role with their new baby as a consequence. Women described discussing the distribution of roles with their partner and appeared more confident in advocating for their preferred structure.

The women's active engagement of practical help indicated that they had made several changes in their understandings of motherhood and mothering. Firstly, women had, over time, developed genuine and reciprocal relationships with other women and couples with young children that meant they had more ability to ask for help. Being close to someone was identified by Hansen (2004) as an important consideration before people can ask for help with childcare for school-aged children. Other rules that people in her study considered before asking for help with childcare were: only ask if your request does not impose upon someone, ask only if your request falls within the hierarchy of recognized needs, do not ask if the price seems too high, and do not ask if you know your request will be rejected.

Wendy gave a detailed narrative of her experiences of giving and receiving help which reflected some of the considerations described by Hanson (2004). She started first with a rationale was not in Hanson's (2004) list describing that being helpful can be beneficial to the helper; "It's hard to ask for help but people do appreciate being asked in a way because it

shows you trust them and that they're your friend..." She then gave a more nuanced statement about the economics of helping when I asked if there were any downsides to asking for help.

> Well there is and there isn't. I mean when I first had [Baby] and people were helping it was fine I didn't sort of so much feel indebted because when there's a brand new baby people, you know that people don't expect you to be doing anything and that they just like to help. But then after once the baby gets to a certain age and you sort of feel like you're kind of meant to be coping by now and everything's kind of more under control you sort of start feeling like, 'Okay I should be reciprocating this help.' So like it's definitely at the stage now where if somebody has [child] for a play date I feel like I need to reciprocate and have their child back here for a play date. So yeah there is that side of it. Wendy

Wendy identified several rules she experienced of asking for and accepting help and how the rules change as children get older. She identified that people perceive new mothers to be needy and deserving which would suggest that this group would be considered more deserving within Hanson's (2004) hierarchy of recognised needs.

Prior to having children, women working in paid employment would have less opportunity to provide the reciprocal help to friends with children. Women with children may also feel reluctant to ask for help from friends without children because they may consider it as imposing. Thus new mothers are unlikely to feel they have the closeness to other mothers or accrued reciprocal arrangement that would allow them to ask for help.

Self-care

As well as engaging more practical assistance, most women were more able to prioritise their own needs in order to manage sleep deprivation and other difficult aspects of having a new baby. One way women advocated for added assistance with child care was by identifying themselves as vulnerable to "postnatal depression". For instance Wendy identified her need for sleep as a priority for avoiding becoming exhausted and unwell. By naming depression herself she adopted a medical discourse to support her request for day time sleep which may previously have been seen as less of a priority compared to other household or care giving duties:

I think this time around I felt more like I knew what I needed like I knew I needed to sleep whenever I could and I just made sure I did it. I just said, 'Right I need to have a sleep now so everybody else needs to beggar off and…' (laughter). Wendy

Michelle Lafrance (2009) identified the "self-care is like an oxygen mask" discourse. Constructing self-care as important because it helps you take care of others enables self-care to be positioned as unselfish and consistent with the good woman identity. This discourse was apparent in Melissa's description of the change she had made in caring for her second child:

Melissa: I think it's that whole, you take care of everybody else and then you come last. Whereas I've got to bump myself further up the list because if I'm happier then the whole household is happier yeah.

Sue: Yeah and are there things that you're doing to bump yourself up?

Melissa: I make sure I eat even if I put [Baby] in his/her room and s/he's having a big old scream it's well I've got to have my lunch, if you if I can't if it's something where I can't console him/her and s/he just needs to have a big old cry, in your room you go and all the doors get shut and I sit all the way up here, up the other end of the house so yeah.

Sue: And would you have been able to do that the first time?

Melissa: No.

Sue: No so that's kind of…

Melissa: Because the crying I would have felt responsible for the crying. That it was my problem to solve. Whereas now it's like s/he'll cry, sometimes I can solve the problem oh if your nappy's wet, you're hungry, you want cuddles, whatever but sometimes I know that I can't solve the problem. I don't know what his/her problem is, why should I take that on board.

This sequence highlights the shift in responsibility that Melissa made, relinquishing the expectation that she should be able to resolve any situation where her child was crying. Her list of parenting problem solving and care giving provides evidence of her confidence and competence (as opposed to being uncaring or negligent) in making the decision to have her lunch. Her ability to leave her child crying is facilitated by the hardy baby discourse and her

use of the oxygen mask discourse. In this way she maintained a good mother identity while taking steps (having lunch) to care for herself while her baby cries.

Healing Births

For three women with endurance test narratives, their second birth experience was narrated as redemption. The redemption appeared to relate to a much better experience of the birth and of bonding with their new baby very quickly after birth. As Karen summarised "you get a second chance type thing… to get it right". Karen, Dawn and Julie all described their first births as shocking or traumatic in some way. Karen began her narrative of redemption by describing the shock of her first birth and then provided a very romantic account of holding her second baby for the first time.

> The birth, now yeah, as I've said before it's quite different to what I had with [Child] and I think with [Child] I went into shock and kind of just didn't want it to happen, you know, that's how it progressed, the depression. But this time it was kind of more with, I didn't even recognise, like when I saw the, when I held the baby for the first time and they were saying to look at him/her and I looked at him/her and I just thought, you know, 'Oh my gosh, this is made out of love,' and I turned to [Husband] and I said, you know, I said to [Husband], '[Husband] we did this, we did it.' And then I was just crying and he said, 'Yeah, we did it.' And I said, 'I love you,' and he said, 'I love you too.' And that moment, you know, turned around, 'cause I'd forgotten everyone was in the room, turned around and everyone was crying and I was like, 'Oh why are they crying for?' So yeah. Karen

The shock of her first birth was in part related to her grief at having her first child without a partner to create the family that she had always envisaged and that society privileges. This very loving scene of a couple bonding together with their baby is consistent with the ideal. It brought Karen back to her stated identity as a traditional family-minded person. In the first interview Karen had described being shocked to be having a baby without being in a loving couple relationship as she had always envisaged. She reaffirmed these family values in the Time 2 interview by presenting a treatise on the modern problem of women "doing all, doing too much" and her belief that women should stay at home with preschool children. It is possible that Karen did this narrative work to affirm her identity as a mother in a nuclear family, and to defend against any residual censure she might expect

because of societies denigration of women labelled “single mothers” who raise their children without a male partner.

Julie described second time birth and motherhood as “a really healing experience”. Her first birth was by forceps and she suffered severe post birth complications that left her in pain for several weeks. Her first baby also suffered a severe health issue that required intensive care giving on her part. In the following account Julie provides an alternative discourse to the medicalised understanding that there is an increased risk of recurrence of postnatal depression with a subsequent baby and advocates for the promotion of the benefit of a positive birth and mothering experience.

> So yeah I mean I do feel it would be a really good message to be out in the media more, the second time around issue, and it may well help some women who are deciding whether they’re going to have another one or not or feeling that they couldn’t cope realise that well actually most other people have a positive experience. And it’s almost like a really healing experience, I remember saying to somebody, ‘Goodness you have to have a second child to get over having the first,’ and that is how it felt. I’ve sort of felt like especially having such a positive birth experience has really helped put the first one into perspective and having and feeling so much more competent has sort of helped with putting into perspective the first time being so difficult and so awful and yeah just sort of kind of balance things out a bit more yeah.
>
> Julie

Julie’s account presents her first and second birth and mothering experiences as polarised. The account highlights the very positive second birth but also serves to highlight how bad the first experience was. Highlighting the second birth as healing and helping her to “get over the first” suggests that the first difficult birth and mothering experiences had lasting impacts on her well beyond getting through postnatal distress.

Dawn provided a very similar discourse of her hopes about her impending birth during the interview at Time 1, referencing the same healing and balancing metaphors that Julie had used.

> So yeah one can only hope that we have the dream experience would be nice obviously. We can you know so we can have some healing from the last time. So we’ll sort of try and balance it out… so yeah certainly a better birth experience would

> be the first and most major thing I guess that would really provide some healing to it all. Dawn

Dawn however did not return to this redemption narrative during the Time 2 interview even though she did describe the second birth (a planned caesarean) as "Well it was better (laughter) than the last time, it wasn't an emergency caesarean this time." Her narrative of the birth was overtaken by unexpected circumstances that she summarised at the outset of the interview thus:

> Well just before [baby] was born [Husband] got made redundant, so he is now going to be an at-home dad and I go back to work in three weeks' time, full time.
>
> Dawn

The disruption created by her husband's unexpected job loss, 8 weeks before her baby was due to be born, disrupted their family structure and plans particularly after their baby was born:

> [Husband] and I were finding it hard to both be at home sort of thing together and that was, yeah quite stressful, so yeah it was all just too hard…I just think that we were probably both quite independent of how we wanted to do things and so we're just butting heads every time…Also he was processing the redundancy, pretty down about what had happened. Dawn

Dawn also described other difficulties at the time including her older child getting chicken pox just after she came home with the new baby. She also recognised that her new baby had reflux. All these stressors resulted in her once again feeling like "there was no enjoyment, it was more like endurance". While Dawn said her husband was "pretty down", she described her action of starting antidepressant medication using a script provided by maternal mental health before the baby was born. It was framed as her "taking one for the family" and is similar to the oxygen mask discourse (I can't take care of others if I don't take care of myself).

> Well, we're heading into Christmas and it's going to be all four of us at home 'cause crèche isn't going to be going and that sort of thing, so I need to be feeling better for us to be able to handle all that, it's not just about how I'm feeling it's gonna affect the whole family, so. Dawn

Dawn's action of taking the medication to help the family get through Christmas positions her convincingly as the family caretaker. It may be that Dawn wished to solidify her identity as family caretaker to balance the contradictory role as primary earner outside the home she was preparing to take (in two weeks). Her husband had volunteered to be fulltime caregiver to their children. This decision was presented as a happy marrying of their preferences, thus ending a narrative that lead to a satisfactory transformation, if not the redemption for which Dawn hoped.

> He's come to the idea, the realisation that he doesn't actually want to work and I know from last time that I don't want to be a stay-at-home mother. So much as I don't actually want to go back to work it's more about it's been quite nice having the three of us doing our thing, we've got into quite a nice groove and obviously it's been the summer time sort of style, but yeah. If conversely I don't want to stay at home with the kids and that sort of thing either, it's just, unfortunately, not me, so. Dawn

Dawn made two statements in this account about not wanting to be a stay-at-home mother and suggested staying at home is not part of how she views herself with her statement "It's just, unfortunately, not me". She also did little work to reconcile the shift from her original plan to stay home with her new baby. This account suggests that she identified strongly with her independent identity outside motherhood (Elvin-Nowak & Thomsson, 2001). Her account also suggests that the opportunity to return to work, facilitated by her partner's decision to stay home, enabled her to take the role she preferred and also maintain the couple and family integrity. Dawn summarised returning to her working woman identity as "I lock back into the path, put the suit on and in the zone".

Dawn's narrative of managing the return of difficult feelings (she did not label them depression) in the months after her baby was born, was a contrast to the accounts of other women who had experienced first time motherhood as an endurance test. I complete this chapter by describing the approach other women took to prevent postnatal depression recurring after second time motherhood.

When women had taken a longer time to bond with their first baby, second births were in most cases experienced as redemption, with warm and loving feelings for their new child experienced as effortless. The women, however, gave accounts that indicated they held residual feelings of guilt and sadness about their lack of emotional closeness with their child and some had concerns that the lack of bonding may have caused lasting problems for their

child. One woman gave a narrative of the irreparable damage to their child and feeling that she continued to lack a close emotional relationship with the child. Most of the women provided an alternative narrative of how their blossoming relationship with their oldest child required careful nurturing to maintain. In particular, the women described their emotional commitment to their oldest child by giving examples of how they, for instance, prioritised the needs of their oldest child over their infant and took steps to spend individual, focused time with the older child.

Avoiding Depression Recurrence

Contrary to biomedical understandings about the chronic and recurring nature of postnatal depression, no women (other than Dawn who resolved her difficulties relatively quickly) experienced the intense and prolonged distress that would be labelled depression after their second child was born, at least not in the time before the interview. Several women described becoming anxious or sad for brief periods but responded to the feelings by seeking out practical help and advice from trusted family and friends. Donna was the only woman who went to her doctor and increased her dose of antidepressant medication when she became anxious and sad for about two weeks when her partner was once again planning work related travel away from home.

Several women framed their actions in preparing for second time motherhood as being preventative strategies to avert the recurrence of "depression". The spectre of postnatal distress was apparent in their accounts and this seemed to prompt them to make plans. The strategies women described incorporating in their plans for the second birth and motherhood included aspects that were described earlier in this chapter, such as increased practical help from husband, family, friends, lead maternity caregivers, maternal mental health and other agencies. Linda's story of her first weeks epitomised the comprehensive approach and positive outcome for most of the women who experienced first time motherhood as endurance:

> Oh yeah, I was concerned before [baby] was born that I was going to [feel] the way I felt with [first child]. It was like is this uncontrollable, is that going to happen to me again? Am I going to be highly anxious? And, so I had lots of things in place so and [Husband] was, he took the first week off and then he went back to work and then took the other week off, because course Mum was up here as well. And just had my mother and not my father here as well which 'cause dads don't know what to do with

> themselves and Mum's just great. She'd just make dinner and go and get groceries without me having to write a list and I mean she's one of those great mums. So I had it all prepared for it, if I was going to have a bad time but it just it didn't happen.
>
> Linda

Linda's account highlights her concern that she might have a repeat of the anxious feelings she experienced after the first birth. This concern may have been the spur for her to prepare for the worst by organising family assistance from the people she believed would be most helpful. Her statement that she had lots of things in place suggests that it was Linda who instigated the plan and made the requests for what she needed.

Most of the women also said that medication was something they would go back to if needed: "sitting on the fence" as it was termed by Melissa. By this she meant that she did not have a plan about whether she would take it or not but would wait and see how she was feeling. Dawn had a prescription in case she felt she needed it and took the medication 6 weeks after the birth, as was described above. Most other women said they would go to their doctor if they felt they needed medication.

Only two women (Wendy and Donna) took medication while they were pregnant and immediately after the birth. Both considered themselves very vulnerable to depression and reluctant to "risk" being medication-free because they did not want to have to suffer while waiting for new mediation to take effect. Donna described her plan before the birth:

> Well I'm going back to see I'm expecting that I will stay on the antidepressants and I am on like 25 milligrams or something and that often you'll take up to you take a 100 is the normal dose so I imagine that I will just see you know like possibly once I've had [Second baby] I will put the dose up because that is sort of like the kind of danger period straight after s/he's been born. So I'm kind of and I feel like I've got like you know this sounds so naff but you know I've got a team of people who'll kind of you know like be aware of that…
>
> Donna

Donna's account presents a prescribed medical plan for managing her mood that includes the risk discourse associated with relapse/recurrence of depression. Describing the time just after the birth as a "danger period" for depression, diverges dramatically from the idealised instinctive bonding discourse that dominates images of new babies and their mothers. As a neoliberal agent Donna accepted responsibility for managing the risk by following the

prescribed medical programme. Her account of previous experiences of distress that was treated with antidepressants may explain why medical accounting for her distress had high salience. Both Donna and Wendy described having partners who were unavailable because of their paid work obligations. Both women took steps to incorporate other practical assistance into their plan as they prepared for second time motherhood in order to protect from the risk of relapse which suggests that they, like other women in the study, viewed distress as related to social and practical aspects of caring for babies, alongside having a biological vulnerability.

Linda did not take medication during first time motherhood, but during the Time 2 interview gave an account that she had reconsidered this as part of her coping strategies if required: "Well if I do feel this mass of anxiety it would be, I'd much rather have medication that stopped me feeling so anxious than not."

Four women described a narrative that positioned them very passively in relation to depression. This is articulated most clearly by Melissa, who described how she essentially gave permission to her husband to identify and name depression if he saw it:

> Yeah 'cause I, I've have, I mean I've said to him, 'Now if you see me sliding downhill, I don't care, ring somebody I'm not going to hold it against,' I mean I might initially, 'Oh you dobbed me in,' I said, 'but you need to ring somebody, ring the doctor or ring the midwife, ring somebody. If you see me going downhill and I'm not admitting it,' yeah. Melissa

Melissa described some of the restraints that may have been a barrier to her partner previously naming her distress. Melissa gave him explicit permission to name depression and assisted him in doing this by framing herself as essentially "blinded by the illness" and needing his help. This narrative positions Melissa as less responsible for the distress should it arise and assigns responsibility with her husband to identify, name and get help for her. Melissa then described her position of precarious vulnerability by referencing the metaphors of being "on the fence" about taking medication and at risk of "sliding downhill". This vulnerability provides justification for her need to access (medical) help more quickly:

> Yes and no 'cause I, if I and I'm still on the fence as in which way I'll go, I mean I take each day as it comes. If I do start sliding downhill yeah, yeah yes and no

> worried. I don't want to take as long as I did last time to ask for help if I need help this time yeah. Melissa

Melissa had enlisted family and friends to "Yeah to keep an eye on me yeah" informing them of her "early warning signs" which she described as "if I stop calling them that's when they know that like if I start isolating myself that's when they'll start ringing a bit more."

Melissa's account positions her as both vulnerable to depression and taking charge to manage it if it occurs by enlisting the help of partner and friends. Her act of assigning her friends and partner to identify depression should it occur serves to inform them that the disorder is not in her conscious control, thus positions her as blameless. It opens the possibility for communication about her mood and feelings; however it increases the likelihood that in the future, negative feelings she expresses (for instance about other people's actions) may be named depression, invalidating her ability to legitimately express strong reactions.

Discussion

Second time motherhood acted as an opportunity for the women to enact changes that they had made in their understandings of babies and mothering practice gathered from their experience. This is consistent with Miller's (2007) finding that women become the authority on their children over the first year of motherhood. The women also described second time motherhood as occurring within a community of friends and family assistance and emotional support that they had developed and nurtured. In this way, second time motherhood was experienced as transformational. Most women described having more practical assistance from partners particularly, with respect to taking more responsibility for the care of their older child. Having more flexibility and confidence about their mothering practices was a shift from their rule-based application of recommendations from parenting books for instance. This flexibility meant the women did not experience the previous anxiety and thus allowed the women to focus on developing their relationship with their new baby and maintaining their relationship with their older child and partner. These changes reflected a dismantling of many of the ideals of intensive mothering such as the imperative to breastfeed at all costs and do everything yourself. While women were all taking the primary role of caring for their new infant, their identity as good mothers did not seem to require that they maintain sole responsibility for infant care. Having successfully raised their first child through infancy appeared to provide the proof of their competence as mothers. This also

likely helped women undo ideas about babies being fragile and vulnerable (Lupton, 2014) that arose when strategies for managing feeding and health issues did not immediately resolve problems the first time. While women still viewed babies as precious, they also saw them as hardy "little furry animals" and with much simpler basic needs as Cynthia described:

> Those first six weeks the poor baby doesn't have a clue (laughter), you have to feed them and you have to cuddle them and be that physical and love them and just they're just little furry animals then eh? (laughter) So allowing yourself to do that is quite a big thing 'cause I didn't allow myself with [first child]. Cynthia

It is difficult to conceive how women can come to these changed understandings without experience, unless women have access to other experienced mothers who are willing to share their stories of difficulty in mothering, provide practical help and cautious advice. Seditious banter also seemed to act to normalise difficulties and help women develop a voice about the difficulties and restraints in their lives as mothers.

None of the women described problems bonding or attaching with their second baby. Experience helped them question idealised views of the natural process of bonding so it may be that their expectations were that they would develop the bond over time if it did not occur immediately after birth (Eyer, 1992). This understanding, described by three women, would take the anxiety away from the all or nothing expectation of an automatic natural bond at birth. Also most women described their second birth as much better than their first experience and so this also likely facilitated the women's capacity for feeling warm and loving towards their infant soon after birth. Promotion of this understanding of bonding and attachment being something that grows with time and by women providing the care for their infants may help women adjust their expectations from the risky and unhelpful all or nothing natural instinctual understanding of bonding. Some women, like Lisa, actively advocated for changes to their birth plan to facilitate their bonding with their second child. Lisa asked for there to be no use of pethidine and to have early skin on skin contact with her infant after the caesarean birth, which was agreed to by the surgeons, though not their usual practice. Lisa's awareness suggests that there is wider circulation of the recommendation for skin on skin contact to facilitate bonding and breastfeeding (Moore et al., 2014).

For most women who had experienced difficult and traumatic births (including those who did not describe recovery as an endurance test) second time birth and the initial connection with their new baby were described as redemption or a "healing experience".

Even when women experienced an operative birth for the second time they seemed to cope better. All six women who experienced emergency caesareans the first time went on to have a caesarean birth for their second child though two attempted a "trial of labour". Having prior experience of a caesarean seemed to prepare women for the experience rather than create more anxiety. Also having the caesarean planned or part of a "trial of labour" plan seemed to return a sense of control to the women. This provides support for guidelines that promote women having an arguably, informed choice about whether to attempt a trial of labour or have a planned caesarean after experiencing a previous caesarean birth (Auckland District Health Board, 2011).

While women had developed in their confidence and identity as mothers, the gendered roles were consolidated for most women prior to having their second child. The crisis turning point that several women described related to a point when their frustration at the constraints of motherhood and gendered inequity became something they could no longer contain. Women in Sevón's (2011) study also described reaching a point of "relational turbulence" (p. 72) related to anger at partners not being involved enough in child care or not showing understanding about how tough mothering was for them particularly when infants were difficult to care for or had high needs. The women in Sevón's study then reoriented from their original philosophy of shared parenting to a more traditional gendered pattern matching that of intensive mothering ideology. Women in the current study appeared to reach a point of relational turbulence also but mobilised a medicalised discourse that focused attention away from the unfairness inherent in the situations that they reacted to.

The use of this discursive device can be understood in relation to the conflict for women who likely came into motherhood positioned as neoliberal citizens. That is, autonomous individuals in nominally egalitarian relationships with the freedom to make choices about their lives and taking responsibility for managing their emotions and problems. Faced with their options narrowed, the women took steps to resolve the problems while obscuring and accommodating the gendered inequality in their situation. This pattern of obscuring inequality and taking responsibility may have been set before women became mothers. A study of young Canadian women college students identified that they envisioned and privileged lives as mothers and wives (as opposed to other alternatives) but ignored or glossed over talk about gender inequality and critiques of traditional family and work life arrangements. Instead they positioned themselves as autonomous individuals free to choose what they do in their lives and personally responsible for managing the problems that may

arise (Jacques & Radtke, 2012). Women in the current study may have also glossed over gender inequality because faced with an impasse at negotiating a better deal, the women chose to maintain their relationship rather than risk it by pushing for a better deal.

The dominance of neoliberalism and biomedicine was apparent within the women's accounts of coming out of postnatal distress. However women's experience and developing relationships with other mothers and families allowed for many of the women to militate against unhelpful discourses surrounding mothering practice and advocate for the assistance they wanted for their second birth.

Chapter 10

Dealing with Emotional Baggage

> To start with it was really tough yeah going back to work …… And having to deal with that and then trying to figure out where I fit into my own family yeah and dealing with that and then my husband was being really assertive as well cause he was like 'yes I must show the world that I can do it'. Yeah and just trying to let him know that just to back off and you know we can do this together. Stephanie

This précis was provided by Stephanie at the beginning of our first interview, and summarised the key aspects of what I have named the 'Dealing with emotional baggage from family of origin' narrative, or as Stephanie framed it, "trying to figure out where I fit in my own family".

This narrative was provided by two women as the key to their resolution of postnatal distress. Other women described family dynamics that, for instance, made their parents less available for support, or alternatively the parents were overbearing. However, resolution of their distress did not seem to rely on changes to these relationships as it did for Stephanie and Jennifer, who both described witnessing and experiencing severe parental dysfunction in early life. In this chapter, I look more closely at this narrative, even though the particular dynamic of experiences was only represented by two women. Their stories were of remarkably similar experiences and both women described detrimental impacts on their bonding with their child and in their family relationships. Yet each described a recovery narrative that lead to very different positions in relation to postnatal depression and second time motherhood. The women's childhood family experiences seemed to have led to three key patterns; firstly, their identities as strong, independent women, secondly, the rekindling of childhood experiences of betrayal at the birth of their first child and, thirdly, their enactment of less common mothering practices and identities. I will describe these three shared patterns in the following sections. Then I will provide a brief summary of the women's mood and relationships with their child and family, followed by an analysis of their recovery narrative.

Strong, independent women.

Both women were the oldest child in their family. They described being positioned generally and within their families as strong, independent women. For instance, Stephanie narrated two situations where she doubted her abilities, and her husband by contrast affirmed her strength to cope. She described how he told her: "'Stephanie you know that you can do anything that you set your mind to and this is not going to be any different.'" When Stephanie described having doubts about whether she was "strong enough to go through labour" she reported that he provided her with a strong affirmation of her strength thus: "he just said 'oh my God woman you're the strongest person I know.'" Jennifer's narrative throughout both interviews positioned her as an assertive, agentic woman in charge of her feelings and family. While the women were positioned as strong and independent, the lack of confidence that Stephanie described experiencing arose within the context of becoming a mother.

Reignited experiences of being unfairly treated.

Both women described having experienced their own mothers as having unfairly favoured other siblings, which continued to cause them distress into adulthood. Both described how their feelings of hurt, being left out and anger were reignited by parental actions around the birth of their babies. For instance, Stephanie's mother was at the birth of her baby and her description of events portrayed her experience of her mother being uncaring to her while caring for her sister even at the birth. She described how her mother said "oh well toughen up" in response to Stephanie's feelings of failure about having an epidural, and showed an uncaring attitude according to Stephanie:

> The whole time that she was there she was going on about how tired she was, how much she'd paid to get here, talking to her partner on the phone cause they have a business together about what he needed to do, I just didn't feel supported at all.
>
> Stephanie

Stephanie described this as being the point where she told her mother to "just get out" [of the birthing room] and ended contact. In recounting this narrative of events Stephanie highlighted not only how unsupported she felt but also the unfairness of seeing her mother's warm response to "my sister [who arrived at the birth] had you know given her big hugs and that's what I wanted, I just wanted her to say 'I'm here now it's going to be fine.'"

Jennifer's circumstances at the birth of her first child were different in that her mother had died several years before her first child was born and she was living overseas and away from extended family. She described how her father got remarried the day she came out of hospital. Consequently her family were unable to be there for the birth of this first grandchild. The significance of this became clear as she described her strong feelings of betrayal: "my father getting remarried. I mean she's great but the timing was shit, you know". Jennifer had described her father as the person she could express her feelings of distress to and she felt that his new marriage would mean that she would not have his support. This was more important because she also did not have her mother. She described the feelings associated with these losses: "I had completely lost the plot. I couldn't stop crying, I was foul, I just, yeah, I didn't know what was going, I resented [Step mother] being in dad's life and it not being mum". She did not describe expressing these strong feelings until she returned to New Zealand several months after the birth.

Both women expressed feelings of vulnerability at the time of their first child's birth and described feelings of anger and loss at not having a mother's support (albeit for very different reasons). It appeared that both extended families did not recognize this emotional vulnerability. This may have been related to their perception of their eldest daughter/sibling as a strong, independent woman. For both of these women, however, the lack of support was viewed as a betrayal and may have played some part in both women's difficulty feeling emotionally warm to their babies at birth. These feelings may have been triggered by early life experiences.

In a grounded theory study of seven women who had experienced depression, Hurst (1999) theorised that the women had depressive episodes when they became demoralised by experiences of being abused, disrespected or left. For some, these experiences had occurred in childhood and the women had become further demoralised when similar "betrayals" occurred in later life. The distress experienced by Stephanie and Jennifer appeared to similarly be reignited by the experiences of feeling hurt, angry and let down by parents at the birth of their first child.

Motherhood identity and practice.

Both women described not wanting to parent in the way their parents had. For instance, Stephanie stated that her model of mothering was "to be the opposite from mine, how harsh does that sound?" In this statement, Stephanie also made clear that she recognised

that her philosophy ran counter to the culturally expected reverence of parents and mothers in particular. Walzer (1995) also found that some of the pregnant women in her study "spoke explicitly about not wanting to be like their mothers" (p.598). Walzer identified that her finding was contrary to previous theorising (Chodorow, 1978; Fischer, 1986) which supported the idealised notion that, during pregnancy there is increasing closeness and identification between mothers and daughters. Although this may be the case for many women, identification and closeness in their relationship with their mother is likely to be problematic when a mother does not fulfil the 'good mother' ideal, as it was for Stephanie and Jennifer.

Jennifer described how she "spent a lot of time looking at what I didn't like in her [mother's] parenting style and what I wanted in mine." Jennifer's practices of mothering her infant were profoundly influenced by her knowledge of her mother's "horrific postnatal depression" and how she had been violent toward an infant sibling. Her feelings were complicated by feelings of "grief" for the loss of her mother who had died a few years before her baby was born. Also, she identified similarities with her mother which she makes clear in this account:

> Like she was a huge part of our lives and huge personality and, I mean we're very similar in lots of ways but also had a terrible relationship so I guess a lot, I think a lot of what happened was a lot my grief came back and maybe I wasn't ready for that. I don't, I don't, I think I hadn't really registered what, you know, what, probably what that was gonna look like and that probably became, it totally preoccupied my whole being and [baby] just got left behind. Jennifer

Jennifer was in the unenviable position of trying to avoid repeating her mother's 'mistakes' in parenting, while grieving at not having her support. Her vulnerable position as 'her mother's daughter' was further consolidated by biomedical discourses portraying postnatal depression as genetically transmitted and intergenerational. Even as she prepared for the birth, medical staff linked her experience to her mother's as they predicted she would have a long birth like her mother and "they just said to me 'Yeah, you'll, you will get postnatal depression because you're just in the high risk category, what's happening in your life.'" Jennifer's father had also raised the same concern about postnatal depression being transmitted by her mother:

> Dad's fear of my postnatal depression is that cause hers got worse with each child and he thinks that I'm in the same risk category, because the circumstances [both had

> their mothers die and not be there to support them with their own birth and child care] are so similar, he said that. Jennifer

The strength with which this familial risk factor for postnatal depression was presented conflicts with the lack of any published evidence to support the conjecture (see Beck, 2001, for a meta-analysis of risk factors).

Although Jennifer herself never made direct statements indicating that she feared she would be violent towards her child, close reading of both her interviews provided support for the suggestion that she positioned herself in ways that would defend against the potential that she would, like her mother, be dangerous to her child and partner relationship if she allowed her negative emotions to be released. For instance, she appeared to position herself as a woman and mother in charge, well prepared and emotionally unreactive ("very consistent" like her father and unlike her mother).

Consequently, it appeared that Jennifer and Stephanie were active in attempting to form an alternative mothering identity and practices. Perhaps freed from conformity with a parental ideal, both women had negotiated aspects of their mothering role that were less common within the accounts of the participants and current social norms. Stephanie for instance, returned to work full time when her baby was 3 months old and her "husband's full time at home". While many women return to work soon after having a baby, it is still less common for men in New Zealand to be the full time care giver to their children. The responses Stephanie described experiencing attest to the continued predominance of gendered parenting roles within society. Attitudes about who should be at home when couples have a choice are apparent in this account Stephanie gave of other people's attitudes to her returning to work:

> To start with it was really tough yeah going back to work and trying to deal with being a working mum and having people look at me funny because you know like 'oh is your child in childcare?' And I'm like 'no' at home with hubby and they were kind of like well 'if one of you could stay at home why is it not you, you know you're the mother that's your role?' Stephanie

As the family enacted this less conformist structure, Stephanie described a series of challenges that caused her distress and raised early feelings of being left out. Stephanie faced these judgements from other people that positioned her as 'outside the normal' while also

feeling excluded from her place as mother. She described her husband being "very assertive" as he was trying to "show the world that I can do it" which meant he took over many child care roles and decisions that she thought she would retain. Another difficulty that arose when her husband developed new friendships with other people at home with young children who were (of course) women, Stephanie said this made her feel insecure about their relationship.

Jennifer enacted a mothering role which devolved much of the early infant care to her (then) de facto partner and other family members who came to stay. Jennifer described how she did this seditiously; "I conned him basically" perhaps to avoid societal and family censure. She described how she achieved this by encouraging her partner to take over child care activities (feeding, changing nappies and so on) by being "very good at" persuasion and suggesting he needed the practice while she did not:

> 'you've never had experience with it [whereas] I've got a brother who's ten years younger than me, so, and I've done a lot of nannying over the years,' so I kind of knew what I was doing with a baby, if you like…'Oh no, no, you need practice, I'm fine, I'll do it at home.' Jennifer

Through this Jennifer explained that she "just kept getting him [partner] to do more" particularly as he did not question her actions: "he didn't sort of say 'Oh no, maybe you should, maybe you should be having a bit more to do with this.' The narrative presents her as confidently and consciously avoiding taking up the practices of mothering. Her awareness that this was a conscious strategy is highlighted by Jennifer's statement "Yeah, it worked for about six weeks at home too", which concluded her story of how she coped with motherhood to begin with. The narrative identifies her as emotionally "fine" and in charge at this time, and resisting motherhood. This stance is evident in her description of her response to her husband's comment that "he seems to be getting a raw deal. (laughter) 'Well that's not gonna change buddy'". This position seemed to act to prevent her husband and others from questioning the role she had taken with her new baby, despite the fact they were contrary to current intensive mothering ideals requiring mothers to place their child's needs first and to take primary responsibility for them (Hays, 1996). Jennifer continued with this stance of being in charge within her mothering role and resisted intensive mothering expectations with both her children. At the same time, Jennifer validated her mothering position through strong allegiance to expert recommended application of routine focused child management models (she described reading child care books for 6 months before her first baby was born). For

example her second baby is “only allowed a certain amount of sleep a day. It’s timed”. So while on the one hand Jennifer resisted some aspects of hegemonic mothering, in other ways, such as her reliance on mothering texts and involving close family in child care, she reproduced other dominant mothering practices. This highlights the limited options available for women in “choosing” their ways of mothering even when they are resisting the dominant option.

Impact on relationships

The emotional and relational aspects of enacting their mothering identity caused both women significant difficulty in their relationships with their child and other close family. For instance, both Stephanie and Jennifer described experiencing a sense of disconnection from their baby at birth. Although they both attributed this in part to their long and difficult births, family of origin issues were seen as affecting bonding more. Stephanie named her fear that “the bonds with my parents aren’t exactly the most, the best either”. She was concerned when she wasn’t “crying with the joy” as is depicted by idealised portrayals of instant mother-child bonding. Stephanie described the process of developing warm feelings toward her child, beginning with a crisis of anxiety about a week after her baby was born:

> There was a day I, I nearly had a panic attack I was like ‘oh my God what if that’s it, what if that happens [cot death, baby choking]’ and I just sort of went and I just went ‘you know what, we’ll just take it day by day and just deal with it’ [and this perspective] really settled me down quite a lot. Stephanie

For many of the participants, fear for the welfare of their baby led to feelings of intense anxiety. It is understandable that this anxiety and fear interfered with their ability to feel warm and loving. This anxious oversight of an infant’s health and wellbeing is likely a function of the societal positioning of the mother as principally responsible for the child, (Hays, 1996) combined with the pervasive discourses of risk and regulation of self (Petersen, 1996) and the child (Lee, 2008; Lupton, 1999) that are prominent in maternity.

As Stephanie became “a bit more relaxed [she] just started to kind of kiss and cuddle [baby] more…start to build the bond up”. As with other participants who experienced difficulty feeling warm toward their child immediately after birth, Stephanie shifted to the alternative story of bonding. That is, that bonding is a process that develops over time (3-4 weeks in her case) like any other relationship (see Eyer (1992) for a critique of bonding ideas).

When her child was three months old Stephanie returned to work and her husband became primary child care provider. It was at this point (as described above) that Stephanie described feeling increasingly distressed. She related this distress to unreasonable demands, as she began to doubt her identity as a good mother as people questioned her about her role. On the home front, she began to relate this distress to the sense of being excluded from her child and partner's lives as is revealed in this extract:

> At home being told 'no this is not the way we're doing it any more', change and then thinking 'Well I'm not a normal mum and where do I fit into all this and who needs me anymore' that was like the final straw. Stephanie

About four months after returning to work Stephanie described a crisis point where she linked her loss of self-esteem as the reason for her distrust of her husband:

> when I feel down about myself then I feel down about my relationship with my husband and I went through his phone and found a message from a lady I didn't even know her name. And the banter between them sounded to me very personal and I was thinking well they obviously know each other and that's the last, that was the last straw. And I just collapsed completely. Stephanie

Stephanie described her couple relationship as "very strained, very distant". This was a narrative turning point as Stephanie described her process of recovery and transformation starting with how she "talked to him" about what she had found. This served to begin a process she described as developing mutual understanding and building trust. In describing all these issues Stephanie positioned herself within the neoliberal discourse as a reflexive, agentic self. She described emotional distress and anxiety as a response to contextual stressors. She also responded to clarify the issues and then took action to resolve the issues (described below).

Jennifer's action of resisting gendered societal expectations of mothering practice may have been (consciously or unconsciously) empowered by her alliance with a more fundamental societal expectation that people and mothers particularly, do no harm to their child. While not overtly proposed by Jennifer, it may be that the emotional disconnection was a function of total emotional control enacted to avert the risk of harm to her child and the consequences this would have on her child and couple relationship.

The lack of initial emotional connectedness was evidenced by the fact Jennifer did not describe feeling distressed until "at about six weeks [Husband] was like 'What's going on here' and I, then I felt that terrible guilt cause I said 'I'm not bonding and I don't like her/him.'" Jennifer described how "it took me 6 months to really bond with her/him and to want to be with her/him". This feeling of guilt was the first outward sign of distress that Jennifer described expressing. The depth of this feeling is underlined by the considerable work Jennifer did to explain her lack of "bonding" that drew on current understandings around the need for early mother/child contact (Eyer, 1992). Jennifer's early contact with her baby was made more difficult as a result of an emergency caesarean birth, pethidine which she felt made her emotionally disconnected for days after the birth and being unable to breast feed so did not have the physical closeness that this involves. Other work that Jennifer did to explain her lack of bonding included normalising in her statements that other people "struggled with bonding", and "it's not uncommon".

Naming her lack of feelings of connectedness to her baby repositioned Jennifer as a person with "postnatal depression", a position familiar in the family who named their mother's distress postnatal depression. This position then allowed Jennifer's partner and family to assume care giving roles and offer ideas for problem solving. It also allowed Jennifer, as the postnatal depression sufferer, to begin expressing her grief and anger, not to her child or partner, but to her father and new stepmother as agents of her family of origin.

Jennifer's care in not presenting her negative emotions to her partner contrasted with her description of strong expressions of anger, and "crying hysterically" directed towards her father and stepmother (see above) when her partner was not present. She stated "I was angry, yep. It was easier to take it out on dad at that stage than [Husband]." This statement highlights Jennifer's priority of not "taking out" her anger on her partner, though it is difficult to know whether this refers to anger at his actions or protecting him from exposure to her strong emotions. She may have felt more need to protect the relationship because it was relatively new (they met a month before she became pregnant) and did not have a settled home having shifted countries while pregnant with plans to move again.

Recovery narratives

Both Stephanie and Jennifer described how talking to their parents about feelings of "betrayal" and lack of support was a key aspect of their overcoming postnatal distress. Both groups of parents (Stephanie's mother and Jennifer's father and stepmother respectively)

were described as responding helpfully. It seemed from the women's accounts that mutual understandings between them and their parents were formed. It appeared that both women within their families were positioned or had positioned themselves as strong, independent women. Thus the families had been unprepared for the women to be experiencing feelings of vulnerability at the birth of their first child and were unaware that they wanted more motherly support than was available to them. I will describe each woman's story of the way in which she and her family made the shift to reposition the woman as more vulnerable and thus open an invitation for motherly/family care.

Jennifer's Recovery Story

As described above, Jennifer described the beginning of her recovery as the point at which she named her feelings of detachment from her child. This gave her the impetus to talk with her father and stepmother about her feelings of anger towards them about the timing of her father's remarriage and the unsolicited "advice" from her stepmother. This disclosure was described as key to opening dialogue between them. Prior to this, Jennifer had cried in all her phone calls with her father but had found it difficult to say what was causing her distress. Jennifer described how her father assisted in restoring the positive relationship she had previously had with her stepmother by making a distinction between a mother and stepmother's roles.

> He [father] said to her [step mother] when I was about that, you know, 'You can't, you can't provide that, you can't say that to you, she's not your baby, she's going through a horrific stuff, process at the moment, she want, all she wants is mum, so, yeah, you can't kind of be the substitute, you can't criticise her parenting or tell her what she should or shouldn't be doing.' Jennifer

Through this, Jennifer and her stepmother re-established a "great relationship" which was consolidated by Jennifer asking her to come to her home for a week after her second baby was born "and Dad can't [come] and so she's a brave woman."

Jennifer's narrative of recovery also seemed to be assisted by her father's positioning of her distress as grief at not having her mother. Jennifer seemed to accept this as an explanation, at the time, for her distress:

> …feeling, I'm not sure I knew, like I still couldn't quite work out what was going on, cause I don't think by then I recognised I had postnatal depression I just thought that

> it was grief and it was still normal… it's only looking back that I realised that was such a black time in my life. Jennifer

Grief frames the distress as distinct from mothering and is less morally loaded. Jennifer also framed it as grief that the whole family was experiencing, at the loss of their mother/wife. In this way Jennifer settled her distress responses within the context of her family of origin, diffusing the load of responsibility:

> The family weren't coping with the fact that I had a baby, 'cause I was the first one to have a baby in our family and so a lot of them weren't coping with mum not being around either…the problem was that dad wasn't bonding [with her baby] either, 'cause he, he wasn't dealing with the grief, and he'd just got married so he, and he, for him if he'd known what was going to hit him he would never have got married at the same time as his first grandchild was born. Jennifer

Consolidation of other relationships (couple, mother-child, friendships) seemed to follow. Consistent with her style of presenting herself as a positive woman in charge, Jennifer described events in ways that juxtapose the emotional vulnerability that had gone before. For instance she unromantically described how "Oh we got married, so I had a big project." Jennifer also resisted the "precious and sacred child" discourses (Hays, 1996; Lupton, 2014) at several points in the interview when she talked about her increasing feelings of responsibility for and closeness to her child. For instance she described how "[baby] got older and less annoying maybe and just sort of, I really began to enjoy it when [baby] got to about nine months 'cause [baby] was giving so much back". Jennifer instead references the "uncivilised child" discourse where children are portrayed as behaving inappropriately and spoiling adults' experiences (Lupton, 2014). Lupton suggested that this discourse was more likely to be taken up by people who do not have responsibility for children because it is so contradictory to intensive/good mother ideals. The increasing closeness Jennifer described experiencing with her child contrasted with the sadness apparent at points where Jennifer worked to rationalise the reasons for the previous feelings of disconnection and when she planned ways for prioritising her first child's needs, when the new baby came.

Developing friendships was also a key part of Jennifer's moving out of distress as she re-established contact with friends without children. She also described how she "got into a coffee group and I've met three or four, you know, four really, really good girlfriends who have got kids the same age." Jennifer's caution in showing her vulnerability was something

she highlighted in our first interview as she described how she let two good friends know she had experienced postnatal distress:

> I told two of them today I was doing this [postnatal distress study] their mouths opened going 'Well what?', and I said 'Yeah…It's quite big that I'm telling you' and they're like 'It's huge.' (laughter) Jennifer

Difficulty telling others about their distress was a recurring theme through the participants' narratives of distress and many described the action of telling someone (partner or other women) as a step in their recovery process. For Jennifer and Stephanie, the people they told were their partners and their parents.

The contrast between Jennifer's emotional distancing and her actions to consolidate and increase her relationships may reflect the risk Jennifer perceived she had of acting to harm her child and the consequences (loss of relationship, condemnation) of others knowing she has had these 'dangerous thoughts'. In an interview study of 6 women who had experienced thoughts of harming their infants, the women similarly identified the thoughts as intensely conflicting with good mother ideals (Murray & Finn, 2012). Murray and Finn summarised two ways the women negotiated thoughts of intentional harm; firstly externalising or attributing the thoughts to the less stigmatising (than bad mother) label of postnatal depression. Alternatively women saw the thoughts as a sign of their child's vulnerability and this prompted them to act to protect their child. Jennifer appears to have accessed both these devices by controlling her [negative] emotions to protect her child and at a later point enlisting the postnatal depression label.

Jennifer described how her father named her distress postnatal depression. Jennifer did not say that she resisted this label at the time; however, she did not follow the biomedical practices that the label invites. For instance, Jennifer did not go to a general practitioner, nor did she receive a diagnosis or medication as part of dealing with her distress which suggests it was an identity (postnatal depression sufferer) that she did not wish to accept. When she became pregnant for the second time, however, Jennifer enlisted maternal mental health services for support after the birth, but was never prescribed or took medication.

Jennifer's understanding of her distress as socially located (to grief and isolation from family) provided the space for a restitution recovery narrative in that she reinstated herself into the close relationships with her family of origin, that she experienced growing up.

However, a narrative of continuing vulnerability was maintained by her being positioned as a postnatal depression sufferer. The understanding that there is a risk of recurrence with depression was named in Jennifer's account of her father's statement: "Dad's fear of my postnatal depression is that cause [Mum's] got worse with each child and he thinks that I'm in the same risk category". The risk of recurrence influenced Jennifer's pregnancy and preparation for the birth of her second child. Jennifer's strategy while pregnant was to enlist help from expert services (maternal mental health), family and friends "to know I have support there if I need it". By using her organisational skills, Jennifer formulated an even more comprehensive plan than she had for her first pregnancy, paying her sister to fill her freezer with meals and having a schedule of extended family members to stay continuously for the first 6 weeks after her baby is born.

Jennifer voiced a hope for redemption focused very much on facilitating her bonding with her second child, which may explain the lengths she went to in preparation:

> I also view this pregnancy … or the birth as, as a, not a second chance, that's the wrong word but... as an opportunity to, like not, not to take the drugs because then I can try and do the bonding, but to be much more conscious of it and to enjoy, to try and enjoy the first three months that I kind of felt I totally missed with [first baby]. And not, yeah, not to have another go at it but to, yeah, I don't, I can't describe it except that I want to really enjoy the first six months this time. Jennifer

Stephanie's Recovery Story

By contrast, Stephanie's narrative of recovery was one of transformation. She described being better than ever before:

> I'm actually better than I was before. [Sue: "Oh that's fantastic."] Before my pregnancy yeah cause I know now where I'm coming from and I've dealt with my past and I'm better with myself and on myself and I'm trusting my husband and God that's so hard. But I'm like yeah I'm really trusting him and with trust comes you know the openness I guess back and the better relationship back and we've talked about a lot of stuff so I understand him a lot better so I feel better than I and stronger than I ever have in my whole life. Stephanie

This statement, combined with the précis she gave at the beginning of our interview (at the opening of this chapter) emphasised the recovery as a process of relational and self-

transformation. The process of recovery seemed to be initiated by Stephanie taking action to deal with the crisis in her relationship with her husband which involved opening communication about her fears of his infidelity and then initiating couple counselling, as she describes:

> Well he explained himself and just said you know the biggest, I think the biggest lesson for me with us was he said 'I can't tell you things anymore cause you jump down my throat so why would I? You know like if I tell you what I'm doing you get so suspicious that I'm just not telling you anymore.' And I was like 'oh wow that's a good point' you know so it was kind of so I, that's when I went 'okay well I need some, I think we need some counselling.' So we started marriage counselling and the counsellor said 'you are chemically unbalanced and you need to rectify that before you can move on.' And that's when I went to the GP and got some Prozac yeah.
>
> Stephanie

In asserting the need for couple counselling Stephanie resisted other aspects of this account which framed her as the problem, for instance her being "suspicious", and her biology being "chemically unbalanced". Stephanie made many statements during the interviews that indicated she understood that her problems were in part caused by the actions of others. For instance she named things her partner did that were undermining: "at home being told 'no this is not the way we're doing it any more', change and then thinking I'm not a normal Mum". She also stated that her "boss was really horrible".

Stephanie's understanding of her early life was also focused on the action of others (rather than herself) as the cause of some of her problems. However, these understandings of the impact of her parents' early behaviour resulted in her sense that she had more enduring vulnerabilities as a consequence. For instance, Stephanie described herself as "a relationship phobe for ages. I didn't really know that cause my dad cheated on my mum and left and so I've automatically assumed this is what happens."

Stephanie's understanding of herself as insecure in relationships may account for her acceptance of a more shared responsibility for the relationship problems with her husband. The idea that her problems may be enduring ones may account for her lack of resistance to the biological framing of her distress. Throughout the interviews Stephanie positioned herself in the recovery process as actively taking steps to resolve her issues with her husband and mother through communication, developing a shared understanding and a sense of increased

closeness and commitment to the relationships. For instance, Stephanie described how when she "started kind of on the road to recovery" she rang her mother for support and got the usual response of "toughen up come on get through it…" This time, however, she was able to state her feelings and begin a dialogue about her needs of her mother:

> 'Right this is what's made me angry and let's talk about this' and you know we were in tears for about an hour on the phone to each other and she said to me 'you know you didn't need me.' And I said 'I did and it's not your decision to tell me what I need'… [since then] she has made a huge, huge effort …to be there for me that was really nice and yeah so she understands that and I kind of understand where she's coming from 'cause she's saying you know you have a husband you have a great husband who supports you so she just assumed that her role with me wasn't as much as she needed to be there with my sister. Stephanie

This narrative frames Stephanie, ironically, as assertive in claiming her need for her mother's care and attention. The assertiveness may have been empowered by her sense of injustice at not receiving the same care as her sister. The importance of this fairness issue is emphasised by its placement at the closure of this narrative.

An important aspect of Stephanie's recovery narrative was clarifying for herself, and negotiating with her husband, the ways in which she would enact her 'good mother' identity. Her description frames the process as an open exchange allowing each to put their point of view to guide how they would each change their interaction. For instance Stephanie described how she responded to being told she was "suspicious":

> I said to him 'you know I want to be part of your life, not because I'm spying on you it's because I'm away from you and [Baby] so if you tell me what you're up to and what you do on a daily basis then it makes me feel included'. Yeah so he was starting to do that and then I was like 'I will not be suspicious, I will not be suspicious'. You know and I found like the first time he tried it he was like you know I could tell in his voice he was so uncomfortable and like … I was like 'uh-huh okay'. And so the more that I listened the more he opened up and yeah. Stephanie

This account presents the couple as initially cautious but committed in overcoming their problems with communication and trust. Their negotiation and collaboration in clarifying and

resolving Stephanie's problems with her mothering and working roles is evident in this account:

> Yeah and you know I'd say 'okay you need to back off and stop being the super dad and give me some room to move as a parent'. And he said 'well why don't you take [child] out like once a week?' So what I did was when I quit my job as [educator] and came down here I started doing four ten hour days so I had Mondays off so [child] and I would go out to lunch, go shopping together and have that one on one time and it was really cool. Stephanie

Stephanie gave many accounts that framed her as vulnerable to depression; however she also balanced these statements with her action to counter the threat to her mood or self-esteem. Her identity as an agentic woman and her transformational narrative helped her resist the more passive position of postnatal depression sufferer.

Doing it all again

Both Stephanie and Jennifer described second time motherhood as better than their experience of becoming mothers the first time. For instance, Jennifer stated that it had "just generally been a heaps more positive experience" and made the comparison with her first experience to illustrate this:

> I think with [first child] I just wanted the time to go so fast so that I would, it would be over that horrid sort of new born stage, but this time I just love every day and I think oh I, slow down (laughter) I can't believe you're [new baby] already thirteen weeks or nearly fourteen weeks. Jennifer

Stephanie described enjoying motherhood. She also referred to time going quickly over the three months she took the full time care role before going back to full time work, while her partner took over the full time care of their two children:

> You're already mum so you don't question yourself as a mum 'cause you've done, you know that you've done a good job the first time, so it's just kind of, yeah that doubt wasn't there anymore, it was fine. You know, I just really enjoyed it and I thought, 'Well my time is so short and precious I'm just gonna enjoy it.' 'Cause I did for a while, you know, for the first few weeks just think, 'Oh it's over and I feel sad,' and then go, 'No, just enjoy it, it's not over yet, so enjoy it, you'll always have your children and they're good kids.' Stephanie

The shortness of her time as full time care giver influenced Stephanie's approach to mothering in this time, which she described as trying to be the "ultimate Mum, you know trying to keep everything up and feeling like you have to do everything". In this way she embraced intensive mothering expectations, perhaps to bolster her identity as good mother when she returned to work. Stephanie described once again receiving negative judgements from people about her return to work but gave accounts that suggested she confidently defended her decision:

> It doesn't bother me now, I've had a few people saying, 'Oh please tell me you're not back at work full time?' I'm like, 'Yeah, and? What's your problem with that?' My husband's at home, it works for us, I'm enjoying myself, so you know, I'm quite proud of myself that I've been able to do, to work full time, support my family and still breast fed, right on. Stephanie

Stephanie gave other accounts which attested to the appropriateness of her and her partner's paid work and child care arrangement. For instance, she described encouragement from her husband and friends to apply for a new job and gave an account of the interview:

> It was kind of interesting going as a fully pregnant woman 'cause it was kind of like, the [interviewer] was looking at me, looking at my tummy and going (noise made), and she, you know, she asked the question of, 'When baby comes what's gonna happen?' And as soon as I said I had a house husband, I'm really flexible, all barriers were lifted I think. Stephanie

This account provides a positive framing of Stephanie and her partner's child care arrangement. It also suggests that the reversal of the usual structure of families was viewed positively by the employers. Stephanie's idea that "all barriers lifted" was confirmed by her being offered the job. The fact that her "house husband" was considered an asset to her employment suggests that work cultures continue to expect the benefits that are usually gained from a breadwinner father and stay-at-home mother family structure (Johnston & Swanson, 2006). When men with young children work it is assumed that they will prioritise work. When Stephanie as a pregnant woman applied there was a presumption that this would create a conflict until she reassured them about the child care she had in place. It would be hard to conceive an interviewer asking a man the question Stephanie was asked: "'When baby comes what's gonna happen?'"

The work that both Jennifer and Stephanie had done on building their relationships with their partner and extended family were described by both as pivotal to their feeling supported and generally more confident at the Time 2 interview. They achieved this in different ways. Stephanie described consolidating her relationships with her partner and mother by talking and getting mutual understanding. Stephanie described her appreciation of her mother's shift to being more caring towards her:

> So this time it was like, 'Oh my god that's what a mum's supposed to do,' you know, she came in and she had positive things to say and did washing. We went shopping for trees and, yeah, and she had lots of good advice so it was like, 'Wow this is, would have been really great the first time, but I'm taking it now.' Stephanie

Jennifer did not have her mother and this seemed to be one reason that she took very active charge of second time motherhood. The steps that she had taken to involve maternal mental health, whom she summarised as "amazing", set in play several interventions. This included counselling, a single room in hospital after the birth, a note to say she would not be breastfeeding and psychiatric review soon after and then 4 weeks after the birth. Jennifer was assertive in making clear that she did not want pethidine pain medication during the planned caesarean birth and just before her birth met with the head midwife to talk about breastfeeding. The following account gives a sense of Jennifer's assured approach in the hospital setting that she had previously found disempowering:

> [the hospital] is just pro breastfeeding and they're Nazis when it comes to the women who don't want to breastfeed and so I must admit in that respect I was thinking, 'Oh my god are they going to be really mean to me?' But when I got there before I had my caesar I met the head charge midwife of, in the ward I was on and I said to her, 'Do you have a copy of my Maternal Mental Health plan?' 'cause I thought that might help. And she's like, 'Yep,' she said, 'so you don't breastfeed?' And I said, 'I can't breastfeed so and I'd really appreciate if there's no pressure you know it's a decision that I've made and I had [operation] and they don't work and I'm taking the pill straight after I've had the caesar so there will be no milk production.' And she must, she was amazing so she must have told them all and not one person said a word. Jennifer

Jennifer adopted the power of the mental health service and possibly the implied threat of her postnatal depression sufferer label to support her request for acceptance of her not breast

feeding. Her actions attest to the power of the pro-breastfeeding imperative (Crossley, 2009; Williams et al., 2013). Jennifer's confidence is apparent in her assertive approach.

Jennifer also confidently followed through on her plan not be alone at home for the first weeks after her baby was born and organised for extended family members and her partner to stay for the first 5 weeks after the birth. She also invited "family and friends in terms of just being here probably from about four o'clock till say six when [Husband] comes home and meals, I didn't cook meals for the first six weeks." Jennifer's own analysis of her need for company was made more apparent in this account:

> I kind of waited for it [distress] to happen again that's the weird, I did kind of and I wondered whether that's why I put people around me for five weeks just so I didn't maybe you know it's that whole if you keep busy enough and you keep people round you long enough that you don't actually have to face, deal with the reality. (laughter) And I suspect that that probably was why I made sure I had cover 'cause I was terrified of being on my own and terrified of how it would feel to have two children 'cause I just remember that awful feeling of being left on my own with [first child], but it never came. Jennifer

Jennifer's statement "it never came" identified the distress as out of her control and positioned her as a passive victim "waiting for it". Her strategy of engaging people around her was framed by her as not so much to prevent distress but to distract and get through it should it come. These passive stances are a negative effect of a biomedical explanation of women's distress as located in the individual (Lafrance & McKenzie-Mohr, 2013). While it impelled her to create this supportive network it still left her "terrified" of her emotions. Jennifer did however manage stressful events during that first few weeks (baby in hospital with potential meningitis for 5 days, post-operative infection which involved admission to hospital for her) which suggests the practical help and company did provide her with the resources to manage second time motherhood.

Another negative effect of a diagnosis is that it can become the default explanation for any distress a woman displays (Ussher, 2010; Ussher et al., 2007). Stephanie described an incident when she resisted being identified as depressed:

> on Saturday I had a bit of a cry because I was getting a bit frustrated, because you kind of feel like you're the mum all the time, you don't get some time out and I was a

> bit ratty at [Husband] for being an insensitive man and I had a few too many wines and that's always a depressant and someone said, 'Are you, is this the depression coming back?' I'm like, 'No it's not' because with the depression it was all my fault and I was terrible and I wasn't a good mum and all that sort of stuff, whereas this time it was like 'no'. He's just being a crappy man and if I don't cry I'm gonna smack him in the face and I know which one's just a bit more logical, bit more constructive.
>
> Stephanie

Stephanie described a strong reaction to her tearfulness being named depression. In order to validate her feelings as reasonable and defend against being treated as unwell, Stephanie provided a list of symptoms she experienced when she had "depression" that were not consistent with her experience at the time. She then described the reasons for her tears which were related to being angry at her partner but resisting showing this in an aggressive way.

Despite Stephanie's description of her defence against being labelled depressed, she used depression as part of a discursive device to justify self-care practices:

> I just feel like depression is like alcoholism that you never fully recover from it and that you just have to be aware of that, it can just come back, yeah and that for me is a really good lesson…it means that I just have to be nice to me, yeah. Stephanie

By comparing depression to an addiction, Stephanie is referencing one understanding of alcoholism being a lifelong vulnerability. This account suggests that Stephanie continues to view herself to be vulnerable to "depression" despite coming through the distress of first time motherhood, and framing herself as transformed, particularly in her family and couple relationships. Stephanie, however, adopts the depression is like alcoholism metaphor to support the need for constant awareness and "to be nice" to herself. She then goes on to articulate what she means by self-care. She also provides further support for self-care practices as good for preventing mothers "spiralling down":

> No. No, it's just sometimes you forget and like you hear of mothers who say, 'I've lost myself and I don't know who I am,' because they don't give something back to you, back to themselves and just thinking well, just doing little things for myself to make me feel like a person and still being a mum so that I don't get then tripped into that cycle of downward spiral again. Yeah, so like going to buy myself a nice pair of shoes or just having a shower by myself and having a nice soap or something, just

> something small. Yeah, and just saying, 'I deserve this 'cause I'm a mum and I work hard,' and yeah. Stephanie

This accounting allows Stephanie to do nice things for herself and attribute it to a biomedical rationale as a "prophylactic measure" that is, to prevent "depression".

Discussion

Stephanie and Jennifer's experiences of the early years of motherhood allowed an in-depth exploration of how early life adversity within a woman's family of origin can impact on their relationships and experiences as they become mothers for the first time. Early adversity and the way the women were positioned in their families as strong and independent, acted both to exacerbate and facilitate the resolution of their problems. This in-depth analysis contrasts with studies of risk factors, which rarely identify the ways in which adversity can act both to advantage and disadvantage. In this discussion I initially focus on the women's narrative and conceptualisation of why they were distressed and how they overcame the distress. Thus the focus is on their relationships particularly with their mothers. I then contrast this social framing with the biomedical understandings which were pervasive but provided an out of context conceptualisation of the women's experiences and consider the effect for the women of these combined and possibly competing understandings.

When a woman becomes a mother for the first time she reconsiders her relationship with her own mother (Chodorow, 1978; Fischer, 1986; Walzer, 1995). A key aspect of Jennifer and Stephanie's narratives of distress were the feelings of loss, hurt and anger related to their mothers. For both women, becoming mothers themselves raised conflict. On the one hand, both stated that they did not want to be like their own mothers. On the other hand, both felt the absence of a caring mother to assist them with the challenges of birth and motherhood for the first time. Women can feel that they want to approach motherhood differently from their own mother and the ambivalence can relate to also recognising "their mother's positive qualities and/or the social constraints their mothers were under" (Walzer, 1995 p. 598). Wanting the practical, social and emotional roles that a mother can provide at this time has also been identified as important even while women have developed more individualised, self-reflexive identities as seemed the case for Jennifer and Stephanie (Mitchell & Green, 2002). Mitchell and Green also suggested that this mother daughter kinship relationship can help women develop their self-identity as a caring and capable mother. For Jennifer, who had observed her mother be violent towards a sibling, the risk of identifying with her mother

placed an obstacle in her development of her identity as a caring, emotionally safe mother. At the same time she felt grief for the loss of her mother who had died some years before. Both women described feeling angry, hurt and let down by parents (Jennifer's father and Stephanie's mother), after the birth, reigniting feelings from earlier in their lives. Women who have experienced maternal loss can have lasting impacts of the early independence, feelings of insecurity and being unsupported and having early memories retriggered (Lokker, 2010). Stephanie's similar feelings may suggest that lack of maternal support and parental couple dysfunction in early years can have similar effects.

It appeared that these early experiences impelled the women to develop a strong, independent identity and be less bound by traditional nuclear family structures and the intensive mothering expectation that women take primary responsibility for their children. For instance, Stephanie exchanged this role with her husband and returned to work while he became primary caregiver. Jennifer incorporated her wide extended family in helping her care for her children rather than doing it all herself. Stories of resisting the expectations of intensive mothering ideals were rare amongst the participants, so Stephanie and Jennifer's stood out. The women's agency in initiating the conversations with their parent were pivotal in beginning a dialogue that helped them develop mutual understandings of why the breakdown in their relationship had occurred and the impact of early life experiences. From these conversations, the women developed a conceptualisation of their distress as related to grief at the loss of her mother in Jennifer's case and distrust in relationships in Stephanie's case. This gave them the impetus to develop the closeness with important people in their lives. For Stephanie this involved mending the breaches in her couple relationship and for Jennifer it consisted of developing her close feelings and mothering practices for her child. Talking about their anger and hurt with their parents also acted to reposition the women as more vulnerable and in need of "motherly" care, which opened doors for extended family to provide the practical assistance, care and closeness the women craved.

The women's narratives focused on their difficulty in relationships, with their mothers, fathers, partners and their babies, and how they managed to develop mutual understanding and closeness that benefitted all relationships. They described their struggle with their identity and roles as women and mothers and enacted their mothering role in less traditional ways, showing some resistance to intensive mothering expectations.

Alongside these social and relational understandings of their distress and paths to living well, biomedical discourses were pervasive in the women's narrative accounts. For instance, ideas regarding the genetic transmission of postnatal depression, the risk of recurrence of depression and the chronic vulnerability to depression were all named by others and were also evident within the women's own understandings. Both women experienced having their distress named depression by friends and family and they themselves named depression in order to access increased assistance and justify self-care practices. Both women showed resistance to being named depressed at points when they were trying to address their feelings of anger to family members about how they had been treated. This highlights the invalidation that naming depression in these circumstances can have (Lafrance & McKenzie-Mohr, 2013). However when the women were accessing services they followed the biomedical suggestions that were made to them.

As early as 1990, concerns were raised about whether "antidepressants may encourage dependency, passivity and a victim psychology in women, which could reinforce depression over time" (McGrath, Keita, Strickland, & Russo, 1990, p. xiii). Jennifer and Stephanie did not seem to relinquish an agentic approach to managing their way out of their difficulties and distress because they had been labelled postnatally depressed. Both responded to understandings of the recurring nature of depression by engaging family assistance and emotional support at the birth and afterwards. Stephanie had taken medication after the first birth on the advice of her counsellor but did not involve medical professionals beyond birth care providers before, during or after the second birth. This suggests that the changes she had made in her ability to trust and be close to her mother and husband gave her the confidence to not seek medical surveillance or intervention. Stephanie described the changes as transformational and her experience of second time motherhood seemed to consolidate her identity as a caring and capable mother, wife, daughter, and paid working woman.

By contrast, Jennifer's approach to second time motherhood seemed to be framed within a biomedical risk of recurrence discourse. Jennifer named postnatal depression in order to access increased support and oversight from mental health services. She also gave medicalised accounts that highlighted her risk of experiencing a depression recurrence. She did not however feel she needed medication before or after the birth and the psychiatrist who saw her at these times agreed. This suggested that Jennifer did not view herself as so bio-medically compromised that she required medication to prevent depression. Her

organisational skills and confidence in asking for and accepting wider family assistance after the birth suggests that she felt vulnerable to postnatal distress but remained agentic in trying to build the support that she believed would help her deal with depression if it 'arose'. Jennifer did not seem to believe that she could prevent depression, which suggests she considered it a vulnerability that was out of her control. Jennifer could be viewed as having a double jeopardy with regards to personal vulnerability to depression. Being named at risk of postnatal depression because of her mother's postnatal distress creates a "familial or genetic vulnerability" which is then compounded by her vulnerability associated with ideas of depression recurrence. Both understandings are individually and internally located in Jennifer which may account for her lack of belief in her ability to prevent depression.

It is hard to know whether Jennifer's belief in her vulnerability to depression will interfere with her life in the future. Because it is located as a postnatal phenomenon, it may be that her view of herself as capable and caring, alongside her close and supportive relationships with family and friends may decrease her understanding of herself as vulnerable to depression.

A question arises as to whether the biomedical discourse assisted Jennifer and Stephanie in any way as their account and conceptualisation of their distress and coming out of it was so socially and relationally located. Practitioners and researchers have been focused on trying to prevent postnatal distress or intervene early. However, even though hospital staff at her first birth suggested to Jennifer that she might be at risk of postnatal distress, she did not seek assistance from health services when she became distressed. Both Stephanie and Jennifer addressed their issues with family members. Stephanie sought couple counselling at the point when her and her husband came to a crisis in their relationship. This suggests that women who have had control and agency in their lives previously, will access relevant professional or other assistance when they see it is necessary. For women who are capable and have social resources, resolving issues through communication and building relational closeness and practical help may better maintain women's agency rather than an early labelling of their distress as postnatal depression with its baggage of vulnerability and risk of relapse discourse. Would Jennifer and Stephanie have taken charge of second time birth and motherhood if there was not a risk of relapse imperative? It would be consistent with their "strong and capable but needing support" identities for them to maintain their agentic approach to life's challenges. This of course can only be surmised.

Chapter 11

Discussion

When women become mothers in Western countries they are thrust into an identity that is dominated by natural/intensive mothering ideology (Bobel, 2002; Hays, 1996). Alongside the natural/intensive mothering paradigm is that of biomedicine which governs most women's experience of birth and aspects of caring for their child and also comes into play if women become distressed while they are caring for young children. If women are assigned or mobilize a medical understanding of their distress as postnatal depression they are then subject to socially accepted understandings about depression. For instance, there is a widely held view that women who experience depression after the birth of their first child are at an increased risk of re-experiencing depression following a subsequent birth (Cooper & Murray, 1995; Philipps & O'Hara, 1991). This reflects common understandings of depression as a chronic and relapsing illness (Segal et al., 2003). By contrast, the current study builds on the work of feminist scholars (Lafrance, 2009; Lafrance & Stoppard, 2006; Lewis & Nicolson, 1998; Mauthner, 1999; McKenzie-Mohr & Lafrance, 2011; Nicolson, 1999; Stoppard, 2000) who have sought to understand women's experience of depression and recovery within the context of their lives and the social, relational and political systems that affect them as women and mothers.

Taking a feminist critical realist approach and using a longitudinal narrative interview methodology, I completed two semi-structured interviews with 22 women who were pregnant with their second child and who identified as having experienced depression after their first child was born. The first interview focussed on their experiences of and recovery from postnatal depression and their preparation for the birth of their second child. The second interview three to four months after the birth focussed on the birth and early motherhood with two children. The research was designed to generate in-depth and contextualized understandings of the women's experiences of depression, recovery, and then relapse or resilience.

I adopted two analytic approaches. A thematic analysis of time 1 interviews provided a contextual understanding of the women's expectations of motherhood and babies, and the profound contrast between these expectations and their actual experience. Four general circumstances appeared to make motherhood more difficult: traumatic or difficult births, women's physical health problems, child's health and feeding problems and lack of support.

These last two were by far the most common. The four contexts for distress are consistent with studies of risk factors for postnatal depression (Beck, 2001). Lists of risk factors however, like lists of symptoms, fail to represent the meaning of the experiences or how they interact. What became clear with hearing women's accounts of mothering was that the circumstances that made mothering more difficult were compounding in many cases. Most women experienced two to four of these key sources of distress. For instance, operative births for many of the women left their health and emotional coping compromised in the first crucial stages of initiating attachment and breastfeeding. These problems could then be compounded by child health or feeding problems. Several infants had problems with poor feeding behaviours and slow weight gain that made breastfeeding more challenging and also more urgent, thus increasing women's (and their partner's) anxiety. Lack of support then made these sorts of problems overwhelming for women.

Lack of support was an almost universal problem for the women and encompassed multiple issues. The women who were most isolated and distressed during early motherhood were those with little or no extended family assistance or involvement and/or a partner who was unavailable emotionally or physically because of work and/or social priorities. Women also described the advice and information they received from family, friends, parenting books and maternity professionals as ranging from very helpful to undermining. In line with other studies (e.g., Mauthner, 1999), helpful support was generally described as practical assistance with household duties and information about child care that was respectfully cautious, timely, and from a trusted and respected source (usually an experienced mother). Similarly, other studies have identified that information and advice can be understood paradoxically by new mothers as useful on the one hand, and/or, an indication of their failure because mothers expect that they should know (Choi et al., 2005; Mauthner, 1999).

The most striking aspects of these contexts for distress were how challenging they were and how hard women worked at motherhood despite them. The women's persistence despite their difficulties and distress can be seen as reflecting their commitment to natural/intensive mothering ideology (Bobel, 2002; Hays, 1996). The women's response to work harder is consistent with the superwomen approach of participants in Choi et al. (2005) study, who similarly found the reality of motherhood contrasted starkly with their idealised expectations. Women in the current study had heard stories of the difficulty of motherhood, however had disregarded them because of their confidence in themselves as capable, responsible, problem solving neoliberal subjects. Dominant discourses such as

natural/intensive mothering act to obscure alternative discourses (such as the difficult work of motherhood) that are inconsistent or contradictory. For instance, ideas about motherhood being natural and instinctual alongside the neoliberal idea of women being capable problem solvers make consideration of the difficulties that may arise in caring for infants superfluous. Also idealised representations are attractive and tap into culturally valued ideals. This could account for why these idealised images continue to hold such cultural cache (Held & Rutherford, 2012).

Finding motherhood much more difficult than it is represented significantly impacted early motherhood, in that women initially blamed themselves for their shock and distress, which served to undermine their confidence. Intensive mothering ideals then compound difficulties because women are positioned as having primary responsibility which leads them to work harder and makes alternative solutions untenable. Intensive mothering seems to be structured to be most compatible with traditional family structures whereby men are the breadwinner and women take the unpaid role of child care which usually extends to housework (Johnston & Swanson, 2007; Sevón, 2012). An alternative arrangement when a family has a child with health problems requiring intensive care, for instance, would be a shared parenting arrangement to meet the needs of the child effectively while maintaining the wellbeing of both parents. This requires both parents to be willing and proactive to achieve (Sevón, 2012) and was not a framework described by women in this study. Women's and infants' health and feeding issues are not predictable and are part of the lottery of parenting. The wisdom the women gained from first time motherhood was that they needed to have more practical help and more flexible ways of dealing with the difficulties of parenting and in particular breastfeeding. Finding ways to make this wisdom available to women prior to becoming mothers and in the early months of caring for infants is the challenge for services and society.

So, while adjustment to first time parenthood is likely to cause some issues of loss and distress as previous studies (e.g., Nicolson, 1999) have suggested, many of the women in this study described circumstances that were clearly beyond the realm of "normal" experiences; for instance, threat to life and significant child health and feeding issues combined with shortcomings in the level of practical assistance, useful information and emotional support they had available to them.

A narrative analysis of both time 1 and time 2 interviews provided a view of each woman's transition from first to second time motherhood within the context of their relationships, the issues they faced, and the positions they took or were assigned. The most common narrative was that of the endurance test whereby over half the women described how they came through by stoically trudging on. Improvement was related to the passive and slow movement of "time". However, women also identified changes in baby getting "easier" and/or they became the expert on their baby. The endurance test reflected women's gradual adjustment to motherhood and consolidation of their identity and expertise as mother. It also reflected the developmental changes of their child over time to less work intensive and more interactive behavioural patterns. Parenting experience helped dismantle idealised notions of motherhood and babies. Women also developed more genuine relationships with other new mothers over the first year which gave an additional source of information about lived experiences of mothering and increased cooperative practical help with child care.

A more active form of resistance to intensive mothering and idealised infant discourses was achieved by several women who described sharing seditious talk about the difficulties of their children, their partners and their lives as mothers. This shared talk seemed to give them a voice that overcame the silencing effects of failing to live up to idealised motherhood and gave words to their embodied, relational, lived experience. When Linda described the shared talk as "making you feel normal" it signalled the legitimacy gained from "militating" against idealised constructions of motherhood. Linda was one of only four participants in this study who did not take antidepressant medication. It may be, as Firestone (1971, in Croghan, 1991) suggests, that "shared grievance" provided a powerful alternative to the predominant biomedical vehicle for legitimising Linda and other women's distress. The increasing popular literature that presents (humorous) accounts of the lived experience of motherhood (e.g., Sleeping Through the Night… and Other Lies by Sandi Kahn Shelton, 1999) may begin to provide women with a model of a less "earnest" (as Cynthia described it) and more confident and irreverent approach to first time motherhood.

Some women utilising the endurance test narrative identified a crisis turning point that occurred at the time women were planning to return to work or attempting to expand their lives beyond mothering. The crisis turning point narrative initiated a medical intervention and was sequenced as; their emotional breakdown, resolved by going to the doctor, being labelled depressed and prescribed medication. This sequence obscured the circumstances of the "breakdown", which related to their frustration and anger at the inequality of access to paid

work or child free time. The crisis turning point narrative and sequence of actions served to repair relational ruptures, added the authority of the medical model to requests for practical support and provided symptom relief. Going to the doctor can be conceived as the women seeking a new solution having used up all their own resources. Alternatively it could be viewed as the women silencing their anger and frustration in order to maintain the integrity of their couple relationship (Jack, 1991). As neoliberal subjects it may be hard for women to name their powerlessness and inability to negotiate a fairer deal.

Several studies have noted that nominally egalitarian couple relationships become structured more in line with traditional gendered roles when the first baby is born (Croghan, 1991; Hakim, 2006; Johnstone et al., 2011; Sevón, 2012). Men's contribution to caring for infants has been constructed as a personal decision and optional while women's contribution is constructed as a societal duty (Croghan, 1991; Petrassi, 2012; Vuori, 2009). Women in Sevón's study also reached a point in early motherhood where their frustration and anger at the inequity of their partner's contribution to child care and housework caused turbulence in the couple relationship. This was resolved by women giving up on shared parenting ideals and adopting a more gendered structure in line with intensive mothering principles. Similarly women in this study adjusted their paid and unpaid work to accommodate the needs of their children while men in only two cases adjusted work life to meet family needs and they both became the primary care givers to their children while the women returned to work full time. Studies of workplaces suggest that structural issues may make it harder for men to be flexible with work (Singley & Hynes, 2005) which may account for why these two men went full time at home as opposed to attempting to negotiate a more flexible or part time alternative.

A second narrative of recovery was adopted by two women who identified the work they did in dealing with the emotional baggage of early abuse as key to coming out of postnatal distress. Both women identified that their relationship with their mother was impacting on their other important relationships. Both women gave a narrative of the work they did to resolve issues to do with their mothers that then assisted them to develop closeness with their baby, partner and other important family members. Both women described a clear resolution to their issues based in their communication and social relationships (assisted by a counsellor for one woman). The importance to women of their relationship with their mother when they have children has not decreased in this age of individualism and autonomy (Mitchell & Green, 2002; Walzer, 1995). Mothers were the first people, after their partner (sometimes before) that women turned to for practical and

emotional support. This was also the case for women in Mauthner's (1999) study who turned to female members of their family for support. Two women whose mothers had died cited their grief as a significant part of the postnatal distress they felt, which highlights the gap women feel when they do not have their mother at this important time in their lives (Edelman, 1994). Several women described barriers to their mothers being available to support them (old age, mothers prioritising care of their partner, other care giving and paid work responsibilities and mothers giving time for the nuclear family to consolidate). Prior to their second birth, several women actively worked to encourage their mothers to have more part in postnatally supporting them, than they had the first time. It seemed that first time both some women and their mothers had not anticipated how much women would need their mother's help. Second time round, most women were very clear they wanted more practical assistance with their older child and house work and advice about managing infant care issues.

In preparing for their second birth, the women described three main concerns. Firstly, women who had experienced traumatic or difficult births were hopeful that their experience would not be repeated and that they would have a better birth. Related to this, women who had taken a long time to bond with their baby were concerned that this might happen again. The third concern that many, but not all, women described was that they might become postnatally distressed (anxious or depressed) again.

For women who had emergency caesareans, traumatic or difficult births most described the birth of their second child as redemption and a "really healing experience" even when they experienced a second caesarean. Prior experience and choice about the birth plan seemed to enhance women's confidence and the birth outcome for women. This provides support for guidelines that promote women having an arguably, informed choice about whether to attempt a trial of labour or have a planned caesarean after experiencing a previous caesarean birth (Auckland District Health Board, 2011).

No women described having trouble bonding with their second baby and this also was described as healing by women who experienced difficulty bonding with their first child. Women who had difficulty bonding with their first child described continuing feelings of guilt and concern for their child and most described taking steps to maintain and prioritise their relationship with their first child when the new baby came.

Eighteen of the 22 participants were prescribed and took antidepressant medication as part of the strategy for coming out of postnatal distress and so had received a diagnosis of postnatal depression. Perhaps as a consequence of this diagnosis many of the women expressed concern that they might potentially become anxious or depressed again. This understanding seemed to act to propel them to gather their resources in preparation for second time motherhood. As early as 1990, concerns were raised about whether "antidepressants may encourage dependency, passivity and a victim psychology in women, which could reinforce depression over time" (McGrath et al., 1990, p. xiii). This did not seem to be the case for the participants. Despite most women having been diagnosed as postnatally depressed and all self-identified as having been depressed, they all described overcoming the depression prior to becoming pregnant for the second time. They all gave accounts that indicated they were aware of discourses around risk of relapse after a subsequent birth, however, this seemed to create a call to action which seemed to protect them from a recurrence of anxiety or depression.

The most surprising finding was that no women described experiencing prolonged distress again after their second child was born, though some described difficult feelings which they managed relatively quickly. The only woman who initiated antidepressant medication after the second birth experienced multiple stressors including her husband being made unemployed a few weeks before their second baby was born and himself feeling depressed, the oldest child getting chicken pox, and the new baby having reflux. Taking medication was described as helping the family through Christmas until she returned to work full time. There are a number of explanations for why no other women described becoming distressed again; at least not in the time before I interviewed them at about 4 months after the birth of their second baby. One explanation relates to the particular participant sample. One of the main limitations of this study is the homogeneity of the participant sample. All but one woman claimed to be pakeha/European and cohabiting or married to the father of both children. All were middleclass, had post-secondary education, and were heterosexual. The women also self-selected into the study and there was a relatively small sample size. Hence, in the first instance, the findings of this study are not generalisable to a wider population or to other cultural groups.

It may be that the group of women who volunteered to be interviewed while they were pregnant were a particularly well resourced, proactive and reflective group. Other researchers have found recruiting pregnant women for research or therapy challenging

(Carter, 2004) and so for women to take the step of volunteering suggests that it has particular salience for them. It may be that coinciding with the women being interested in reflecting on their experiences of postnatal depression the interview process acted as a medium in which women developed insights and made plans for managing second time motherhood better.

A challenge for longitudinal research is to avoid as much as possible intervening in the process or events being studied. This is particularly challenging for qualitative interview research (Thomson & Holland, 2003). I attempted to make my questions open and non-leading and I certainly did not make suggestions or give advice. However, I did acknowledge what they said with non-verbal and verbal encouragers that could have been taken as positive affirmation. Also, the framework of the semi structured interview schedule may have acted to guide participants to reflect on their previous experience not just to describe it. When asked to describe how they were approaching the birth and mothering of two children they usually described plans and actions for coping. This process would have given them space to reflect and voice potential strategies if they had not already done so. Some women did describe how they had reflected on issues before or after the interviews or had developed insights during the first interview.

It is unlikely that one research interview would have the effect of preventing recurrence of depression. Most of the women described how they had already talked to other women about their experiences. Once women gained confidence in a relationship with another mother they described cautiously talking about their “postnatal depression”, and found they gained further support and affirmation from other women’s shared stories of less than ideal mothering. Second time round most of the women reported being more able to talk about their experiences good and bad and enlisted help earlier. They appeared to have dismantled many idealised views and developed more flexible alternative models of motherhood and babies. So while I believe talking about their experiences and plans was key to relapse prevention, the women in the study had clearly initiated this long before they saw me.

It is more likely that women were able to hold a dual understanding of their distress that encompassed medicalised notions of depression and risk of recurrence alongside the understanding they had each gained about their own contexts for distress that were largely located within the adjustments to first time motherhood. Having dismantled some of the ideas

of natural/intensive mothering and babies, consolidated their identity as mother and increased their network of friends and family supports the women were able to take charge of the aspects of second time motherhood that they could. Most women had returned to work in some form before they became pregnant again and all described ways that their lives had become more connected with other people and activities outside the home even if they were mainly focused around family. The women's narratives of themselves as second time mothers affirmed their transformation to being more confident, flexible and socially connected.

Alongside the limitations associated with the largely homogeneous participant characteristics and longitudinal research effects described above, it is important to note that the narratives that form the focus of the analysis of recovery were not the only narratives of recovery within women's accounts. The more detailed narrative analytic method precluded the wider exploration of all women's accounts of coming through postnatal distress. The particular narratives that were focused on seemed to provide most insight into the experience of two quite different but convincing ways of accounting that highlighted the social, relational and political impacts on women's experiences of coming out of postnatal distress and experiencing motherhood for the second time.

Implications

If women have experienced postnatal distress this does not mean that they will experience it again. Having a second child after postnatal distress can act as a healing experience even if the child has a health or feeding issues, like their first child. Information about this positive outcome for women should be promoted to women who have experienced postnatal distress in order to counter the relapse risk discourse that predominates. Provision of information concerning the strategies that facilitated women's resilience is also important including: the importance for women to have choice about their birth plan where possible particularly after an operative birth; incorporating practical help from friends, family and/or services before birth (e.g., meals in the freezer), while in hospital (e.g., managing visitors, help with breastfeeding) and once home with the new baby; and women being more flexible about the birth and child care practices including breastfeeding.

Coffee groups set up by antenatal courses and Plunket may support women better in the early months of new motherhood if there was a more diverse group of both new and more experienced mothers in the group. This may help to overcome new mothers' reluctance to

talk about the difficulties they may be experiencing or at least might provide sources of information that are based in other mothers practical experience.

Lead maternity caregivers need to be enabled with time and the mandate to talk with women about how they are experiencing motherhood when they complete home visits. While this occurs in some cases it would be better if it was incorporated as a matter of good practice in all visits. Also, women who use obstetricians as their lead maternity caregiver would benefit from getting to know the midwife who will be visiting them after the birth before they have their baby. While women described being reluctant to talk about their difficulties at this early stage, improving their opportunity to do so may assist in early provision of assistance and advice if needed.

Ultimately, for women to remain empowered as they take on the challenges and joys of motherhood, ideologies of natural/intensive mothering and femininity must be moderated to encompass the reality of women's lives as mothers, partners in couple relationships and in paid employment. These discourses facilitate the gendered inequality that continues to narrow the options for women when they become mothers and serve to isolate women and undermine their confidence as they set unreasonable expectations of women and make fathers contribution an optional extra (Croghan, 1991). Incorporating practices from more collectivist societies and de-gendering workplace and family roles without devaluing male or female styles of parenting may work to undermine the current societal views of mothers as the primary if not exclusive care giver to infant and young children.

To better understand women's resilience to depression it would be useful for a study to incorporate participants from broader cultural and socioeconomic groups and at other life stages. To better understand how people resist the dominant intensive mothering discourses it would be useful to extend the work of Sevón (2012) and hear more stories of couples who manage to achieve more egalitarian and shared parenting arrangements. Lafrance (2009) identified that advertisers take up seditious talk inviting women to be selfish and take up self-care practices that involve buying their products. It may be that similar subversive strategies can be adopted to dismantle idealised portrayals of motherhood, babies and "women having it all".

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Appendices

Appendix A

Sample (reduced size) recruitment advertisement for Participants

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
Te Whare Wānanga o Tāmaki Makaurau

Advertisement

Second Time Motherhood

Tell Your Story

Are you pregnant with your second child and did you experience depression after the birth of your first child?

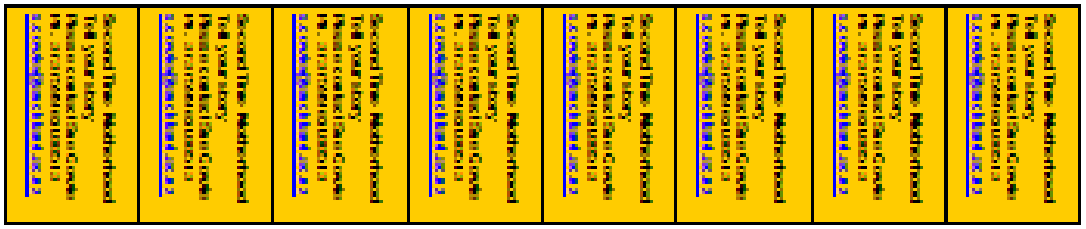
If so I would really appreciate your time to be part of a study where I will meet you at your home or another suitable place and interview you two times; firstly, while you are pregnant to find out about your experiences of becoming a mother the first time and your plans and expectations of having a second baby, and secondly, after your baby is born to find out how it all went and how you are finding motherhood with two children.

The first aim of this study is to understand better the long term effects of experiencing depression particularly what helps to improve mood and coping and what doesn't help. The second aim is to develop strategies to prevent or at least decrease the severity and impact of depression by sharing the understandings gained and wisdom of women with other women, professionals who work with women who are having children, and policy makers.

I am a mother and a registered Clinical Psychologist and am completing this research for a PhD. If you would like to find out more or take part please contact me:

Sue Cowie
Ph. 3737599 ext. 88513
Email: s.cowie@auckland.ac.nz

This study has received approval of the Northern X Regional Ethics Committee



Appendix B

Sample (reduced) Participant Information Brochure (Side 1)

Baby, Baby. A study of second time pregnancy and motherhood for women who experienced depression after the birth of their first child.

Participant Information Sheet for a Two Part Interview Study:

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND
Te Whare Wananga o Tamaki Makaurau

If you have any queries or concerns regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act:
Telephone (NZ wide): 0800 555 050
Free Fax (NZ wide): 0800 2787 7678
(0800 2 SUPPORT)
Email: advocacy@hdc.org.nz

To inquire about participation in this study, or for further information, please contact:

Sue Cowie
Ph: 3737 599 ext. 88513
Email: s.cowie@auckland.ac.nz
Or write to the address inside.

Many Thanks

If you would like more information regarding this study, or have any concerns you may contact:

Sue Cowie
Senior Tutor
Department of Psychology (Tamaki)
The University of Auckland
Private Bag 92019
Auckland Mail Centre1142
Ph. 3737599 ext.88513
Email s.cowie@auckland.ac.nz

Research Supervisor:
Associate Professor Nicola Gavey
Department of Psychology
The University of Auckland
Private Bag 92019
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Head of Department:
Associate Professor Fred Seymour
Department of Psychology
The University of Auckland
Private Bag 92019
Auckland Mail Centre1142
Ph. 3737599 ext.88414

This study has received approval from the Northern X Regional Ethics Committee.

Appendix B

Sample (reduced) Participant Information Brochure (Side 2)

If you are pregnant with your second child and experienced depression after your first child was born then you are invited to participate in this study.

My name is Sue Cowie. I am a mother and a Registered Clinical Psychologist. I am conducting PhD research at the University of Auckland, supervised by Dr Nicola Gavey and Dr Fred Seymour. The focus of the study is on women's experience of second time pregnancy and early motherhood when they have previously experienced depression after the birth of their first baby. Depression after child birth has been described as the thief that robs women of the happiness and love they expected to feel towards their infants. Women who experience depression after the birth of a child have described a range of feelings including guilt, loss, anger, sadness, isolation and anxiety.

The first aim of this study is to understand better the long term effects of experiencing depression particularly what helps to improve mood and coping and what doesn't help. The second aim is to develop strategies to prevent or at least decrease the severity and impact of depression by sharing the understandings gained and wisdom of women with other women, people who work with women with young children and policy makers.

Participation will involve taking part in two conversational style interviews which will be confidential and last about 2 hours. We will arrange the interviews so that they take place at a time and place that suits you. The first interview, 3-6 months before your baby's birth, will focus on how you make sense of being a mother for the first time and how you are coping with or recovered from the depression. The focus will then be on your expectations of second time birth and motherhood. About 3 months after the expected date of your baby's birth I will contact you again to arrange a second similar interview with you which will focus on your experience of the pregnancy, birth and life with another child.

Risks: I hope that taking part in the research will be a positive experience however as we will be talking about experiences with depression it is possible that sensitive issues and/or difficult emotions may arise. If you do participate and later wish to discuss anything related to your participation in the research, you are most welcome to contact me or my supervisor. I will myself contact you one week after the interview to give you an opportunity to talk about any issues or feelings that may have arisen for you in the interview. If I have concerns about your safety or the safety of someone else arising from what you tell me in the interview I will first discuss this with you and then I would take steps to facilitate appropriate support and care, for instance by contacting a close friend or family member or your general practitioner. While staff at Auckland and Counties Manukau District Health Board may have told you about the study, they have no other involvement in the study and so participation will not affect any involvement you have with them.

The interview will be audio-taped and will be transcribed by myself or a third person who will be hired for this purpose. The person will be required to keep strict confidentiality regarding the information transcribed. You will not be provided with copies of the audiotape, nor will you be given copies of the transcribed interview to edit. However, you will be provided a summary of the research at the end of the study (which is some years away).

Your participation in the research is entirely voluntary (your choice). You do not have to answer any questions you don't want to, you can stop the interview at any stage and can withdraw from the research, without giving reasons, prior to and during the interviews. You would also have the opportunity to withdraw all or part of your interview material from the study up to one month after each interview.

No material that could personally identify you will be used in any reports of this study. While transcribed extracts of your interview may be used in my thesis, publications or presentations arising from the study, any potentially identifying information will be changed and an alias given to any of your words used. With your consent we would like to retain the data from this project for future use in related research. Data will be retained securely in both audio and written forms for at least 10 years and until further interest in the data has passed. After that the audio-tapes and written documents will be destroyed and computer files deleted.

In the unlikely event of a physical injury as a result of your participation in this study, you may be covered by ACC under the Injury Prevention, Rehabilitation and Compensation Act. ACC cover is not automatic and your case will need to be assessed by ACC according to the provisions of the 2002 Injury Prevention Rehabilitation and Compensation Act. If your claim is accepted by ACC, you still might not get any compensation. This depends on a number of factors such as whether you are an earner or non-earner. ACC usually provides only partial reimbursement of costs and expenses and there may be no lump sum compensation payable. There is no cover for mental injury unless it is a result of physical injury. If you have ACC cover, generally this will affect your right to sue the investigators. **If you have any questions about ACC, contact your nearest ACC office or the investigator.**

Thank you for your time

Appendix C

Sample Copy of Transcribing Confidentiality Agreement

TRANSCRIBING CONFIDENTIAL RESEARCH INTERVIEW TAPES

STATEMENT OF CONFIDENTIALITY

Research title: Baby, Baby: Women's experience of second time pregnancy and motherhood when they have experienced depression after the birth of their first baby.

Researcher: Sue Cowie

I, _____ will do my utmost to maintain the anonymity of participants in this research and the confidentiality of the material discussed. I will not discuss details of these interviews with anyone other than Sue Cowie, Nicola Gavey and Fred Seymour.

Signed: _____

Name: _____

Date: _____ Department of Psychology

Department of Psychology
The University of Auckland
Private Bag 92019
Auckland Mail Centre 1142
Ph. 3737599 ext.88513
Email s.cowie@auckland.ac.nz

Appendix D

Sample Consent Form for Participants Time 1

Consent Form

Baby, Baby: A study of second time pregnancy and motherhood for women who experienced depression after the birth of their first child.

WOMEN'S STUDY TIME ONE INTERVIEWS

Research: Two interviews with women about their experience of pregnancy and becoming a mother for the second time when they have previously experienced depression following the birth of their first baby.

Researcher: Sue Cowie

- I have been given and understand an explanation of the research.
- I have had an opportunity to ask questions and have them answered.
- I understand that as a participant in this study I am agreeing to be interviewed on two occasions and I understand that I will be audio taped.
- I understand that I may withdraw myself or any information I have provided from the study any time up to one month after each interview without having to give any reasons.
- I understand that I will be contacted in the week following the interviews to see if I would like the opportunity to talk about any issues or feelings that may have arisen for me in the interview, or to add further thoughts or comment on the interview.
- I agree to be contacted two months after the birth of my baby to confirm the time for the second interview.
- I understand that the audio tapes of the interviews will be transcribed into written form, and that the person who undertakes the transcription will sign a confidentiality agreement.
- I understand that this consent form will be stored in a locked cabinet for at least 10 years and that all information I provide will be stored separately from this consent form.
- I consent to my information being stored for future research into postnatal depression subject to ethical approval being given by a New Zealand approved ethics committee.
- I wish to receive a brief summary (up to one page) of the research results via email at the end of the study. **Email address:**

I agree to take part in this research.

Signed:
Name (please print clearly):
Date:

Appendix E

Sample Consent Form for Participants Time 2

Consent Form

Baby, Baby: A study of second time pregnancy and motherhood for women who experienced depression after the birth of their first child.

WOMEN'S STUDY TIME TWO INTERVIEWS

Research: Two interviews with women about their experience of pregnancy and becoming a mother for the second time when they have previously experienced depression following the birth of their first baby.

Researcher: Sue Cowie

- I have been given and understand an explanation of the research.
- I have had an opportunity to ask questions and have them answered.
- I understand that as a participant in this study I am agreeing to be interviewed on two occasions and I understand that I will be audio taped.
- I understand that I may withdraw myself or any information I have provided from the study any time up to one month after each interview without having to give any reasons.
- I understand that I will be contacted in the week following the interviews to see if I would like the opportunity to talk about any issues or feelings that may have arisen for me in the interview, or to add further thoughts or comment on the interview.
- I understand that the audio tapes of the interviews will be transcribed into written form, and that the person who undertakes the transcription will sign a confidentiality agreement.
- I understand that this consent form will be stored in a locked cabinet for at least 10 years and that all information I provide will be stored separately from this consent form.
- I consent to my information being stored for future research into postnatal depression subject to ethical approval being given by a New Zealand approved ethics committee.
- I wish to receive a brief summary (up to one page) of the research results via email at the end of the study. **Email address:**

I agree to take part in this research.

Signed:
Name (please print clearly):
Date:

Appendix F

Demographic and Administration Form

Women's Interviews

Background Questions

Participant to complete

1. How old are you? _____
2. What was your age at the birth of first child? _____
3. How old is your first child now? _____
4. How many weeks pregnant are you? _____
5. What is the due date of your baby? _____
6. What is your ethnic identity? _____
7. What is your relationship situation? _____
8. Are you in paid employment? (circle) Yes / No

   If Yes, What is the job? _____

   How many hours a week do you work? _____

9. What educational qualifications do you have?

_____

Researcher to complete

1. Date of interview _____
2. Consent to both interviews_____
3. Date for second interview_____
4. Participant Code_____
5. Summary of research to be sent Yes/No Email/Mail

Appendix G

Sample copy of Semi-structured Interview Schedule

Baby, Baby: A study of second time pregnancy and motherhood for women who experienced depression after the birth of their first child.

INDICATIVE AREAS OF QUESTIONING

WOMEN'S STUDY TIME ONE INTERVIEWS

1. **Can you tell me who is in your family?**

2. **How are things going?**
   - Depression screen if indicated
   - How is the pregnancy going?

3. **Can you tell me about your pregnancy and birth with your first child?**
   - How was your health? Health of baby?
   - What support? Family circumstances? Financial stability?
   - Did things go as expected?

4. **How do you think you adjusted to being a mother for the first time?**
   - What do you wish you had known or been told?
   - How did it match your expectations?
   - What was different than you expected?
   - What helped/didn't help?

5. **How did your partner adjust to the changes?**
   - What role did he play?
   - How did he feel?
   - What helped/didn't help him?

6. **What is your baby like then and now?**
   - Health?
   - Temperament?
   - Level of care required?
   - Most challenging things? Most pleasurable things?

7. **Tell me about your experiences of depression (or name for the feelings the participant chooses)?**
   - Screen for depression at time

- What do you call the low mood you experienced?
- What do you think lead to the “depression” (or participant’s term)?
- What helped you feel better?
- What didn’t help?
- Do you believe you have recovered from the “depression”? If so, how did this happen? If not, how is it now?
- When and how did you come to understand that your experiences were depression?
- What have you found out about postnatal depression? Where did you get information about postnatal depression?
- What would you tell other women who are depressed after their first baby?

8. **Have you returned to work since baby was born?**
   - How did you make the decision?
   - How has this gone?
   - How did you manage childcare issues?

9. **What lead to your decision to have a second child?**

10. **What are your expectations for how the pregnancy, birth and early motherhood with two children will go?**
    - Self, children, supports

11. **What steps if any are you taking to prepare for the birth and early motherhood?**
    - What will you do differently/the same this time based on your experience the first time?
    - Are you doing anything in particular to deal with depression?

Appendix H

Sample copy of Time 2 Semi-structured Interview Schedule

Baby, Baby: A study of second time pregnancy and motherhood for women who experienced depression after the birth of their first child.

INDICATIVE AREAS OF QUESTIONING

WOMENS STUDY TIME TWO INTERVIEWS

1. Can you tell me who is in your family now?

2. How are you feeling now?
   - Depression screen if indicated
   - Have you experienced any low mood or depression since I last met with you?

   If no depression
   - How have you been getting along?
   - Have there been any challenges to your coping?

   If depression
   - How long have you/did you feel like this?
   - What do you think lead to the depression?
   - What helps you feel better/worse?
   - What doesn't help?
   - Did you/are you receiving treatment? Is it helping or not?
   - Are you doing any other things to help you cope?
   - What do you think will/did help you recover from the depression?

3. Can you tell me about your pregnancy and birth with your second child?
   - How was your health? Health of baby?
   - How was your couple relationship/partner over this time?
   - What support? Family circumstances? Financial stability?
   - Did things go as expected?

4. How do you think you are adjusting to being a mother for the second time?
   - How is it different or the same to first time motherhood?
   - How did it match your expectations?
   - What was different than you expected?
   - What helped/didn't help?
   - What would you tell other women who are thinking about having another baby?

5. How has your partner adjust to the changes?
    - What roles does he play?
    - How does he feel?
    - What helped/didn't help him?
    - What advise do you think partners need who are thinking about having another baby?

6. What is your baby like?
    - Health?
    - Temperament?
    - Level of care required?
    - Most challenging things? Most pleasurable things?

7. How has your first child and family coped with having another baby in the family?

8. Have you returned to work since baby was born?
    - How did you make the decision?
    - How has this gone?
    - How do you and your partner manage childcare issues?

9. What are your thoughts about having any further children?
    - What would you do differently/the same?

10. What is your understanding of the place of depression in your life now or in the future?

11. What other plans do you have for the future?

Appendix I

Transcription Conventions

The interviews were transcribed complete verbatim. That is, including;

- All filler words such as ums, ahs and ers and "meaningless" statements such as "I mean", "you know"
- Words that are started but not completed
- Sentences that are started but not completed
- Word repetitions e.g. "So I said, I said, I said to him ..."

(pause)	Long pauses only, short pauses are indicated with a comma
(laughter)	Laughter
(recording change)	Change of recording within a single interview
(interruption, description, time)	For actual interruptions such as person entering the room or an unrelated telephone conversation
(interview ends, time)	Only used when an interview is clearly finished but the recording continues
(noise made)	Where a "strange" noises are made e.g. raspberries, whooping noises, banging fist on table
. . .	To indicate the trailing off and/or "picking back up" of a sentence
"-" e.g. inter-	Indicates a word has been cut-off midway through speech