New mothers creating their well-being: A hermeneutic study

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PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

and the best possible result has been obtained.
Certificate of originality

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma of a university or other institute of higher learning, except where due acknowledgement is made in the text.

(Signed)........... 25.9.78
Rose Cole
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Dedication

I dedicate this thesis to my father Victor Gilbert Cole who died on the 22nd April, 1996. *OM MANI PADME HUM.*
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THE SUMMARY OF THE THESIS

This hermeneutic study explores the experience of well-being of eight new mothers who live in the Blue Mountains of N.S.W. The experiences were analysed to illuminate definitions, meanings and practices which create their well-being.

This study transcends existing notions of health and motherhood. I argue that mothers resist the social expectations created by the ‘ideology of motherhood’ by; defining their well-being, redefining and resisting the notion of being the ‘good mother’ by creating practices to achieve their well-being. Social support is integral to this.

This study is grounded in hermeneutics incorporating the Heideggerian ideas of being-in-the-world, co-constitution and the hermeneutic circle and also the Gadamerian idea of fusion of horizons. I adopt a post-structuralist feminist perspective incorporating Foucault’s ideas on power, knowledge, truth and resistance.

I use my metaphor ‘hermeneutics as dance’ to highlight the creative process of imaging in the literal, visual and kinesthetic sense for discovering and understanding new mothers’ well-being. The hermeneutic analysis was preceded by the transcription of taped, unstructured conversations with eight new mothers exploring their experiences of well-being. Eight definitions of these new mothers’ well-being are presented. Three patterns of meaning of these new mothers’ well-being are described and interpreted; adapting personal expectations; adapting to societal expectations and being supported. These new mothers’ well-being practices including going out, my time, being in control, being confident, normalising and ways of knowing are described. Implications for nursing practice, education and research are discussed.
CHAPTER 1: INTRODUCTION

Tiddas
You are my sisters, you ask nothing of me
In return, love is the gift, given easily

You are the colors of the rainbow
You are the happiness we seek
In return, truth is the gift, given easily

You are the quiet at night
You are the shelter we seek
In return, comfort is the gift, given easily

You will always be my sisters
You ask nothing of me
In return, understanding is the gift
given easily ...........

(Tiddas, 1995, Track 5)

MY CONCERN FOR NEW MOTHERS

From my experiences, in hospitals and communities, as a midwife, community nurse
and women’s health nurse has evolved my concern for new mothers. As a community
nurse I have supported mothers in their homes, at baby clinics and at new mothers’
groups. Although their infant was the client, the mothers themselves expressed their
concerns about being mothers and turned to me as a source of advice not only on infant
care but more importantly on how they could cope with motherhood.

When I reflected upon my facilitation of ‘preparation for parenthood’ classes, I realized
that the focus of these classes was on birth, and although postnatal depression was
mentioned, normal lifestyle and role changes were not considered. My facilitation of
‘new mothers’ groups’ also validated my interpretation that there was a focus on infant
care and a lack of discussion of problems new mothers experienced and strategies they
adopted in order to cope.
Poor self concept, poor body image, lack of confidence and isolation due to lack of social networks are commonly acknowledged. However there are subtle effects of compromised well-being which are not acknowledged by new mothers. The end result of compromised well-being is reflected in the incidence of women's mental disorders and postnatal depression which are as high as 40 per cent in N.S.W. (Australian Bureau of Statistics, 1992; NSW Health Department, 1994a).

When well-being is compromised a range of effects on new mothers can result. Promotion and maintenance of new mothers' well-being is vital in order to prevent the severe consequences of postnatal depression, as well as commonly acknowledged problems such as poor self concept, poor body image, lack of confidence and isolation due to lack of social support networks.

POSTNATAL DEPRESSION LITERATURE

Although there is a plethora of quantitative literature on postnatal depression there is a paucity of qualitative studies. Nicolson (1990) proposes a model of loss and bereavement to explain postnatal depression. She explains that the experience of loss and bereavement is normal for women making the transition to motherhood.

In an anthropological review of the literature on childbirth, Stern and Kruckman (1983) found that mild postnatal depression is undocumented in the cross-cultural literature. They suggest that it is a 'culture bound' syndrome and propose that social structuring of the postpartum period prevents postnatal depression. These factors in the social structuring of the postpartum period include:

(1) structuring of a distinct post-partum time period;
(2) protective measures and rituals reflecting the presumed vulnerability of the new mother;
(3) social seclusion:
mandated rest:
(5) assistance in tasks from relatives and/or midwife:
(6) social rituals through rituals, gifts, etc. of the new social status of the mother.

(p. 1039)

The anthropological literature indicates that postnatal depression is a western phenomenon because we do not have a suitable social structure of the postpartum period in order to prevent postnatal depression. Because postnatal depression is prevalent in Australia it is useful to know what new mothers need for their health and well-being in order to prevent the dire consequence of postnatal depression.

NURSING’S QUANTITATIVE RESEARCH ON MOTHERHOOD
My initial review of the quantitative nursing literature on motherhood showed that maternal role was a significant theme. There exists considerable research which identifies variables affecting the maternal role such as demographic (Walker, Crain & Thompson, 1986) and psychosocial variables (Mercer, 1981).

Health variables, such as parity [number of live viable births], postpartum and neonatal complications, physical energy and type of delivery are linked to functional status of the mother. Tulman, Fawcett, Groblewski and Silverman (1990) explored changes in functional status defined as women’s readiness to assume infant care practices and usual (household, social, community, self care, work) activities after childbirth. A finding from their research indicated that at six months postpartum, women had resumed only 17.5 per cent of full functional ability in self care activities. This suggests a notion of a self role which is contrary to role theory’s (the predominant theoretical framework adopted in nursing quantitative research) interpretation of role which perceives self in relation to others. What then are mothers’ practices in relation to themselves?
These nursing quantitative studies identify numerous variables affecting the maternal role, however they concentrate on maternal role only, ignoring the context of mothers’ multiple roles, such as marital and domestic and the social and environmental influences on mothering. On further exploration of the literature outside purely nursing sources I found it is important to consider marital status because married women in comparison to single, divorced or widowed women experience detrimental health effects (Kane, 1991). The home role is important for new mothers as it often results in low social status and poor self esteem (Knapman, 1991). The social context is also important for new mothers because of the availability or accessibility to social resources such as adequate housing (WHO, 1986). Research emphasises the stress, psychological distress and depression that results from women’s social roles such as maternal, marital, occupational and household (Brown & Harris, 1978; Kandel, Davies & Raveis, 1985; Gore & Mangione, 1983).

The literature identified focuses on roles in relation to others, that is maternal, marital and domestic roles. This sex role stereotyping image of women whereby the social role of deferring to others and articulating needs in relation to others undermines women’s well-being through self depreciation (Milne-Home, 1992).

The nursing literature exploring an aspect of mothers’ well-being, that is maternal role, has been primarily quantitative where researchers have attempted to objectify and quantify mothers’ experiences. A multitude of variables have been identified, however they are reductionist in nature because they decompose mothers’ experiences. Since their experience has been separated into parts and studied objectively, their own meanings about motherhood have been decayed, that is decomposed. In quantitative research on motherhood, mothers have been objects rather then participants. This objective stance has ignored the concerns of new mothers from their own perspective. How can their concerns be measured and why would we want to?
**What** are the concerns of new mothers from their perspective? **What** is well-being for them? **What** affects their well-being? **What** do they do for themselves to achieve well-being in order to prevent postnatal depression?

**THE PURPOSE OF THE STUDY**

The information, knowledge and understanding obtained from this study will inform nursing practice. This study's findings will be disseminated to Australian nurses, in particular midwives, community nurses and women’s health nurses. These nurses can inform mothers of the findings of this study and use recommendations in their practice.

**RESEARCH QUESTIONS**

This study attempts to answer the following four questions:

- How do new mothers define their well-being?
- What are the common patterns of meaning in their definitions?
- What practices are necessary for new mothers to create their well-being?
- What can we [as nurses] do for new mothers?

**EXPLANATION OF KEY TERMS**

**Definition of ‘well-being’**

Well-being can only be known through personal description (Parse, 1987). Well-being is more than health which incorporates a holistic view (physical, mental, social, spiritual) because it is a term that refers to a lived experience. Well-being is a subjective experience of being healthy. Well-being means being well and therefore living a life of healthiness but it also means becoming well, the ability to envision and create well-being.
Well-being is a lived experience which incorporates practices of well-being. Benner and Wrubel (1989) offer a definition of well-being as:

... congruence between one's possibilities and one's actual practices and lived meanings ... based on caring and being cared for. (p. 160)

This definition suggests that well-being is a lived experience which incorporates envisioning and becoming one's own possibilities through practices of well-being and the reciprocal nature of caring.

**Definition of ‘personal meaning’:** What well-being means to each mother in the study.

**Explanation of ‘patterns of meaning’**

What emerged from my conversations with the new mothers were ‘patterns of meaning’ in relation to their well-being. A ‘pattern of meaning’ is my (as the researcher) interpretation of the new mother’s personal meaning. Each pattern was a flexible structure that was formed from the commonalities in the personal meanings for the new mothers in this study. Each of these patterns of meaning consists of parts, what I term subpatterns. I would like the reader to keep this in mind whilst reading this thesis.

**OVERVIEW OF CHAPTERS**

Chapter 2 examines notions of health in nursing and nursing strategies currently used with new mothers. I provide a historical analysis of baby health services in N.S.W. I describe the philosophies of primary health care and discuss nurses' role in primary health care. I show how the concepts of the ‘The Ottawa Charter for Health Promotion’ have been applied to mothers. I critique ‘empowerment’ in the nursing literature from a post-structuralist feminist perspective incorporating Foucault's ideas on power.
Chapter 3 explores and interprets some meanings of motherhood from a post-structuralist feminist perspective incorporating Foucault’s ideas on power, knowledge, truth and resistance. I integrate Erikson’s life stages and Gilligan’s model of moral development to provide a framework for understanding the developmental and moral issues affecting new mothers. I critique the ideology of motherhood from a post-structuralist feminist perspective. I critique the myth of motherhood by exploring the following three questions:

Is motherhood instinctive?

Is a mother the best provider of care for her child?

Does having a child fulfil a woman?

I explore meanings of motherhood from mothers’ own perspective concentrating on Australian studies. I discuss relationships associated with motherhood and social support. I critique the portrayal of motherhood in the media.

Chapter 4 describes why I chose a hermeneutic phenomenological approach to understand new mothers’ well-being. I describe phenomenology and its historical evolution from Husserlian to Heideggerian phenomenology. I examine and compare the two schools of thought. I discuss the Heideggerian ideas; being-in-the-world, co-constitution and hermeneutic circle as well as the Gadamerian idea of fusion of horizons. I review phenomenological studies on health, motherhood and nursing.

Chapter 5 explains why I created my metaphor ‘hermeneutics as dance’ and what are the benefits of applying the metaphor to nursing practice. I describe the hermeneutic research process and data analysis.
Chapter 6 answers the following questions:

What are new mothers' definitions of their own well-being?
What are the common 'patterns of meanings' of new mothers' well-being?
What are the practices necessary for new mothers to create their well-being?

I present the findings of this study using the new mothers' words and ideas. I interpret the findings. I compare the findings and my interpretations with previous literature. I state whether the findings and my interpretations confirm, challenge or expand previous research.

Chapter 7 answers the question: what can we [as nurses] do for new mothers? I discuss the implications of this study for nursing practice, education and research.

This study illuminates the ways in which new mothers create their own well-being through their practices. Their well-being practices balance the losses they experience and resist the notion of being the ideological 'good mother'.
CHAPTER 2
NURSING NEW MOTHERS: CHANGING NOTIONS OF HEALTH AND POWER

Discern the Past
Understand the Present
Declare the Future

Socrates

CONCEPTUALISATIONS OF HEALTH IN NURSING
What is this thing called health? The Australian Pocket Oxford Dictionary (Turner, 1976) defines health as “soundness of body or mind” (p. 323). “Sound” is further defined as “healthy, not diseased or injured or rotten” (p. 671). This clinical definition points to a dichotomous view in which people are perceived physically as either being healthy or diseased. Consequently, this biomedical interpretation fails to consider people’s mental and social health.

At the beginning of my nursing career, the Encyclopedia and Dictionary of Medicine, Nursing and Allied Health (Miller & Keane, 1978) was a major resource for defining knowledge and the vocabulary related to nursing. Health was defined as “a state of physical, mental and social well-being” (p. 443). This definition was adapted from the World Health Organisation’s definition in its constitution (1946, cited in Benner & Wrubel, 1989) which stated “Health is a state of complete, physical, mental and social well-being and not merely the absence of disease or infirmity” (p. 151). This provided an international definition of health and is the most familiar to nurses.

This definition of health of 1946 extends the interpretation of health from a biomedical perspective to include a social perspective. This holistic view integrates the notion of interaction of the whole person with their world, that is their living environment. There is an interplay between physical, mental and social aspects of being. Physical being
includes the biochemical factors pertaining to the body. Mental being refers to
cognition (thoughts and perceptions) and affective (emotions and feelings) experiences.
Social being refers to relationships with others as well as the environment.
Accordingly, nursing affirms the holistic view of people in which they are perceived as
a living unity (Parse, 1981). The Australian Nursing Council (1994) endorses this
philosophy:

Nurses provide care, simultaneously attending to the biological, psychological,
social and spiritual needs of the person, and by being acutely aware of the inter-
relationships between these needs. (p. 2)
Nursing addresses the complexity and uniqueness of the person in the
environmental context. (p. 2)

The ideal state of health calls for ‘complete’ well-being. This suggests an ultimate
point which all can reach. However, each individual has different physical, social and
emotional capacities which may make such a state unattainable. This view is further
contested by Benner and Wrubel (1989) who criticise it for being a perfectionist,
utopian, static, acontextual view which fails to recognise the resources required for
health from a personal and social perspective. For example, personal attributes such as
knowledge and skills in relation to health as well as social resources such as access to
health services, employment and adequate housing, are necessary for achieving health.
Health is not static, as it is a dynamic concept. It is not solely the absence of disease or
infirmity. Health is affected by people’s social environment. This includes the social,
political, economical as well as physical environment.

How do people gain such a complete state of physical, mental and social well-being
when social inequalities exist? For example, racism and sexism are prevalent in
contemporary Australia. Racism is evident in acts of discrimination and violence
(covert and overt) against Aboriginal people. Sexism is seen in the stereotypical
portrayal of women in the media as well as in acts of violence against women prevalent
through the incidence of domestic violence and sexual assault.
There also exist inequities to access for health whereby some disadvantaged people do not have the personal resources (knowledge, skills, attitudes, beliefs, values), nor the availability or accessibility of social resources (employment, adequate housing, a healthy environment) to promote their health. For example, this is reflected by differing cardiovascular disease morbidity and mortality rates between men and women, differences in mortality rates between Aboriginal/Torres Strait Islanders and the remaining Australian population and differences in lifestyle behaviours between high and lower socioeconomic status groups in Australia (Nutbeam, Wise, Bauman & Leeder, 1992). These indicate that there exist gross inequalities in health status between various groups in society. The most at risk are those people who are socioeconomically disadvantaged. Personal as well as social resources are needed to combat inequities in social conditions between disadvantaged and privileged groups in Australia in order to ensure social justice.

How do new mothers achieve a complete state of physical, mental and social well-being when they experience physical, mental and social disadvantages? Physically, women have been reported in the pilot time use survey of 1000 Sydney households conducted by the Office of the Status of Women (1991), as doing 70 percent of unpaid work when compared to men in the home which increased to 91 percent when they became new mothers. Between 10 to 40 percent of new mothers will experience postnatal depression. Socially, a risk factor for postnatal depression is social isolation (NSW Health Department, 1994a). Many new mothers are socially isolated in the home because of the lack of geographically close extended family and friend support which has arisen from them moving to affordable, developing residential areas. These new residential areas are often a distance from regional centres and are also disadvantaged by lack of transport and community facilities. If new mothers experience social isolation and this is compounded by poverty, which can occur as a result of a low income family or being a single mother, they are at great risk for developing postnatal
depression. The complete (ideal) state of health is therefore unattainable for many new mothers as many lack social resources for health.

What do new mothers do to be healthy? How do new mothers feel when they are healthy? How do they cope and adapt to a social environment which is not conducive to their health? What kind of supports are needed to aid this process of adaptation? What are their needs for health?

The rest of this chapter will explore past and present notions of health in nursing in order to discover other conceptualisation's of health apart from the illusory, ideal state. Its aim is to find a relevant conceptualisation of health for new mothers which will be a useful framework to aid analysis for this study. I begin with a discussion of concepts of health which have informed nursing theory, then go on to examine how these have been translated into practice in Australian nursing history.

Health as a state

In nursing, conceptualisations of health as a state fail to agree on the nature of the state. Some such conceptualisations focus on the physical, psychological and social states combined (Johnson, 1968), whereas others focus on the developmental aspects of the variables (Neuman, 1980). Yet others define state in terms of the whole (Orem, 1971). These variations seem to derive from the varying beliefs of each theorist. Some, such as Johnson (1968) take an individual, static view of the state, whereas others, such as Neuman (1980) take a social view of the state. Of these, the social conceptualisation is the most useful conceptualisation for this research because it recognises the importance of social resources for promoting and maintaining health.

However, these static views, even the socially defined states, do not account for the changes which can occur as a result of the physical and socioeconomical environment,
availability and accessibility of services as well as healthy lifestyle practices. The conceptualisation of health as a process provides a more complete view of health as it recognises this dynamic, developmental as well as interactive nature of health.

**Health as a process**

In this conceptualisation of health as a process, the environment, both social and physical, can promote or restrain the development of human potential and health by affecting the degree of adaptation required. This view is quite popular in nursing (King, 1981; Newman, 1979; Parse, 1981; Payne, 1983; Pender, 1987).

The view of health as a process involves health as being; dynamic, developmental, relative as well as behavioural. By this, the theorists mean that the health of a person is relative, that is it is continually changing because of their development and behaviour. It is described by many nurses as involving growth and adaptation (Parse, 1981; Payne, 1983). Other nurses refer to this same general concept as the actualising and stabilising development of human potential (Johnson, 1968; King, 1981; Payne, 1983; Pender, 1987; Rogers, 1991 in Hugh, 1991).

The ability to adapt, is in itself a personal resource for promoting change (Jones, 1991). However, there is a need for personal resources, for example knowledge and skills as well as environmental resources, for example a healthy environment to maintain a sense of equilibrium especially in times of stress (Antonovsky, 1979). This is of particular relevance to this study of women becoming mothers as it is a mammoth life change for women; stressful and requiring adaptability on the part of women but also support from society.

This conceptualisation of health as a process is more appropriate than health as a state because it allows for individual differences in social and personal resources. The
conceptualisation of health as an equilibrium has similarities to health as a process, however health as equilibrium focuses on the outcome of adaptation rather than the process.

**Health as an equilibrium**

In this conceptualisation of health as an equilibrium there is recognition of interaction of the person with their environment as well as the adaptability aided through the use of resources to achieve stability, the goal for health (Jones, 1991; King, 1981). Some nurses, like Fawcett (1989), adopt an open systems view which recognises feedback of energy between the person and the environment. In contrast, others like Payne (1983), focus on the adaptive processes of the body to maintain constancy of the internal environment. This appears to be a limited view of equilibrium, one which does not recognise the effects of the environment nor the level at which equilibrium can be achieved. People adapt to achieve equilibrium or stability in order to be healthy.

**Health as a goal**

Health is described by numerous nurses as being the goal of nursing (Fitzpatrick, 1983; Henderson, 1991; King, 1981; Newman, 1979; Orlando, 1961; Parse, 1981; Paterson & Zderad, 1976; Rogers, 1991 in Hugh, 1991). This goal is for individuals to achieve their maximum human potential (Benner & Wrubel, 1989; King, 1981; Paterson & Zderad, 1976; Pender, 1991 in Hugh, 1991). Some nurses, such as Payne (1983) focus on the individual responsibility of self care and healthy lifestyle practices whilst other theorists, such as Pender (1991, cited in Hugh, 1991) focus on the need for interpersonal relationships. However, these views, although including both the individual and interpersonal levels, still fail to recognise the social context for health. Resources, both personal and social, are required for people to achieve the goal of health. Because the
goal of nursing is health, nurses need to be cognisant of what resources are required for people, in this instance new mothers.

If the view that health for new mothers is best described as an adaptive process is accepted, then the goal of nursing the mothers should entail efforts to support individual new mothers in the adaptations required. It is therefore useful to explore historically the supports that have been offered to new mothers. I will therefore discuss and critique the development of baby health services in N.S.W.

NURSING STRATEGIES WITH NEW MOTHERS

Historical analysis of baby health services in N.S.W.

Historically, baby health services and clinics have been known in precisely those terms. They have not been known as mothers’ health services nor clinics. Mothers were perceived as agents for their infants (Knapman, 1993). Fortunately, with the growth of the social view of health, there has been a change in focus from the mother as an agent to a client in her own right, with needs that need to be met by support. Note that I refer to the people that I nurse in the community context as clients. This more active term is used in preference to the term patients which is used in hospital settings.

I have provided a mothers’ advisory service (advice and support) in my role as community nurse as well as run women’s health clinics in my role as a women’s health nurse which, although not specifically targeted for mothers, did involve considerable clinical, support, counselling and referral services for mothers. The following discussion highlights the development of these changes from an infant focus to a more client-centred focus which aims to support mothers as well as infants.

N.S.W. was the first area in Australia to commence infant welfare work. The focus of infant welfare work in the early part of this century was to improve infant health and
mothercraft. Infant mortality rates were caused by poor domestic conditions, for example; high urbanisation, no sanitation, inadequate housing, inferior water and milk supplies. Legislation by the Public Health Act in 1886 resulted in improvements in relation to sanitation, water and garbage services (N.S.W. Department of Health, 1989a). Also, the middle class model of childrearing which was endorsed, was unachievable for many working class mothers. This was a result not only of poor domestic conditions but also of poverty and lack of education in relation to health (Knapman, 1993).

As well as a high infant mortality rate there existed a reduced birth rate primarily as a result of abortion, contraception, illegitimacy and infanticide. These concerns alerted politicians and in 1903 the N.S.W. Government’s Royal Commission into the fall in birth rate found the following causes of infant mortality especially pertinent to the lower class; artificial feeding, defective care by midwives, ill health of mothers, lack of maternal knowledge, inexpert infant feeding, poor infant food substitutes, poor domestic hygiene, misuse of drugs, infanticide and baby farming (N.S.W. Department of Health, 1989a, p. 13).

Consequently, the N.S.W. Department of Health prioritised the need for correct feeding and hygienic care of infants as well as mothercraft education. This was an individualistic approach in which mothers assumed responsibility for their infant’s health. There was a lack of consideration given to mothers’ needs as well as the social influences on health. Mothers were perceived as lacking mothercraft knowledge and skills.

The focus of education on mothers emphasised acquiring mothercraft knowledge and skills in order to reduce infant morbidity and mortality. Mothers were perceived as requiring scientific, medical motherhood knowledge (Knapman, 1993). This view was
clearly stated in Our Babies (Department of Health, N.S.W., 1940's cited in N.S.W. Department of Health, 1989a):

Experience, too, has demonstrated that maternal instinct alone is insufficient equipment for a mother to undertake the responsibility of feeding and caring for a baby. Mothers are slow to accept this. This tendency is to regard maternal instinct as all-sufficient. But in every sphere of human endeavour it is training that counts. Motherhood is no exception to the rule. (p. 117)

Why? Because the Medical Journal of Australia (1917, cited in N.S.W. Department of Health, 1989a) stated “Infants will live and thrive in spite of poverty and bad sanitation, but they will not survive bad mothercraft!” (p. 29). In the Australian publication of the Ladies’ Handbook of Home Treatment first published in 1912 (Richards, 1956) this responsibility of being a good woman, wife and mother was described:

Good women are a nation's chief asset. Hear what a soldier and statesman had to say on the point - Colonel Theodore Roosevelt:- "Unless the average woman is a good wife and mother, unless she brings up her children sound in soul and mind and body - unless this is true of the average woman, no brilliancy of genius, no material prosperity, no triumphs of science and industry, will avail to save the race from ruin and death. The mother is the one supreme asset of national life; she is more important by far than the successful statesman or business man, or artist or scientist". A successful marriage, we may conclude, is one in which “the average woman”, inspired and aided by a true and faithful husband, is enabled to maintain a happy home and rear her children in soundness of body, mind and soul. (p. 35)

Hence, mothers were held solely responsible for the health of their infants and the state of health of the nation. The Maternity Allowance introduced in 1912 emphasised mothers’ contribution to national service (Holmes & Lake, 1995). This payment of five pounds was given to every woman for the birth of a child. Payment was given to married and unmarried women, however not to indigenous nor Asian born women.

To ensure this national service occurred, trained health visiting in the home began in 1904. Baby clinics provided the venue for the surveillance of mothers and infants as early as 1914 at Alexandria, an industrial inner urban suburb of Sydney. A medical officer and trained triple certificate nurses ran the clinic as well as provided a district
nursing service. Nurses were always under medical supervision (N.S.W. Department of Health, 1989a). Standardised, scientific knowledge resulted in the professionalisation of mothering which was perceived as requiring a full time commitment (Knapman, 1993). This commitment reinforced the cultural expectation of mothers being solely responsible for the provision of care to their infants. Women at this time however were still relegated to the domestic sphere and were consequently subservient to men in a male dominated society.

However due to the rise of the suffragette movement in Australia at the beginning of the century and the effects of women’s right to vote there were major social changes occurring which were recognising the need for social equality for women. The legislation for the Maternity Allowance (1912) was perceived by feminists as a recognition of maternal rights and the foundation for the growth of their economic independence (Holmes & Lake, 1995).

The baby health clinics were initially intended for lower class mothers, however by the late 1920’s all mothers were included, irrespective of class. This occurred despite medical opposition. It is interesting that although a middle class model of mothercraft was in operation, higher class mothers were also perceived as being ignorant and lacking basic mothercraft education. Matthews (1984) asserts that this type of social control existed until the 1950’s.

Also at this time, maternal and baby welfare came under the division of the Department of Health and subsequently, the government subsidised baby health clinics. By 1944 the infant welfare centre was a community service under the control of the Commonwealth Department of Health (N.S.W. Department of Health, 1989a).

Prior to World War II there was a shift in focus from the physical to include monitoring of the mental and intellectual health of infants. Post war, due to European migration,
translations of infant care practices occurred, however these were according to white, middle class standards (Knapman, 1993). There was a developing concern for Aboriginal health. Fortunately, the government was beginning to realise that culturally appropriate services were needed. This resulted in the provision of multilingual nurses and interpreters. In addition, there was an increase in the birth rate, ‘the postwar baby boom’, urbanisation and temporary dwellings as well as the formation of new suburbs with the compounding problems of lack of transport and no support (N.S.W. Department of Health, 1989a). Isolation, lack of support and inadequate housing developed a social awareness of the need for personal and social resources to ensure health.

The government was beginning to realise that health services alone could not provide these necessary resources. For example, transport was needed to decrease isolation experienced by people for them to access services and resources required. In addition community facilities were required to provide venues for meeting community needs such as social networking.

In the 50’s there was a focus on educating parents. Fathers were being involved and education was extended from purely infant care. For example, issues in relation to family finance and budgeting were discussed.

A social support model was developing which provided not only personal resources such as knowledge and skills in relation to mothercraft but also a form of social support for mothers. By the early 1960’s mothers’ discussion groups and classes had commenced in the outer west of Sydney (N.S.W. Department of Health, 1989a). Also since the introduction of Doctor Spock’s instructions for child care, an increase in focus on the emotional health of infants by proper management and discipline occurred (Knapman, 1993). However, mothers’ groups were changing the focus of infant care from the infant to the recognition of mothers’ needs. This was supported by the rise of
feminism which was voicing women’s needs for equality in the domestic as well as public spheres. In 1964 there were 415 baby health clinics in N.S.W. In 1965, health districts were formed. The focus of health was changing to a greater family orientation (N.S.W. Department of Health, 1989a).

By the 1970’s, at the baby health clinics, although mothers experienced freedom from routines and standardisation, they experienced an increased responsibility for the physical, mental, social and emotional development of their infant. Bonding with infants was encouraged and women were increasingly blamed for maternal deprivation. Since World War II women had entered the workforce and many women experienced a sense of guilt leaving their infant. As a result of gender inequities in paid and unpaid work women experienced an increased workload (Knapman, 1993). This has major implications for social justice in relation to women’s health.

In 1970 the attention of the baby health clinics was extended to include maintenance of the health of the family as well as the community. By the 1970’s, the baby health clinics were beginning to be utilised for other purposes apart from infant monitoring and mothercraft advice (N.S.W. Department of Health, 1989a). The development of the physical environment was being supplemented by social resources which reduced some of the problems experienced by mothers.

A sociocultural awareness developed necessitating innovative programs (Knapman, 1993). Aboriginal and migrant health were given priority with substantial financial commitment from the government. In 1973 the N.S.W. Department of Health became the Health Commission of N.S.W. There were 14 government regions. The Community Health Program was initiated by the Whitlam labour government which followed the principles of the baby health centres by focusing on preventative measures and going into the community in order to meet its needs. A tertiary Diploma of Community Health Nursing course commenced which increased the focus on the need
for community resources because of increased urbanisation, the breakdown of the extended family and the varying types of families (N.S.W. Department of Health, 1989a). The development of the Community Health Program occurred alongside the application of primary health care which was first articulated in 1978.

Primary Health Care

The concept of primary health care gained International recognition as a result of the Alma Ata (USSR) Conference (WHO, 1978). Primary health care was defined by the World Health Organisation (1978) as follows:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (p. 3)

Primary health care adopts a social view of health incorporating philosophies of social justice, equity and self reliance (South Australian Health Commission, 1986). Social justice recognises that social, environmental and economic factors influence health. Mahler (1981) stated “The health of the poor is largely the result of a combination of unemployment (and underemployment), poverty, poor housing, poor sanitation, malnutrition, and lack of will and initiative to make changes for the better” (pp. 7-8). Therefore these repressive characteristics need to be removed to improve the health of the poor. Social justice strategies attempt to balance inequities in society by redistributing resources to the most at need. Equity as a philosophy means equity in health status by the provision of equal opportunities for health. This especially applies to the disadvantaged (South Australian Health Commission, 1986). If people are to be self reliant, at the individual, family, community or national level, detrimental factors
which influence their health must be alleviated in order to promote their health. To be self reliant in health involves people acquiring resources if needed.

Primary health care is perceived as a strategy for achieving the health of people. This commitment is known as the 'Health for all' strategy. Mahler (1981) who was Director-General of the World Health Organisation from 1973 to 1988, asserts that the three prerequisites of primary health care include a multi sectoral approach, community involvement and appropriate technology. A multi sectoral approach recognises that the health sector alone cannot improve the health of a community. Contributions are also required by government and non government sectors including education, agriculture, industry, housing, finance, and voluntary groups. Community participation involves community members planning and implementing health care. Appropriate technology Mahler (1981) defined as being “technically sound, culturally appropriate and financially feasible” (p. 10).

The Australian Nursing Federation adopted the position statement: primary health care (1990). Mahler (1985) advocates that nurses should perform a significant role in the shift of health care to primary health care. He states this involves; a change in role from the hospital into the community, being resources for people especially in relation to health education, nurse leaders initiating innovative programs which can result in increased interpersonal and intersectoral health development, and being a source of guidance for non-professional community health services.

Health Promotion

'The Ottawa Charter for Health Promotion' (WHO, 1986), which evolved from the Alma Ata declaration, provides a framework for action in health settings. The charter emphasises the need for resources in promoting health:
... to reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. (p. 1)

The charter provides an action framework for achieving 'health for all'. There are five action areas which include building a healthy public policy, creating supportive environments, strengthening community action, developing personal skills as well as reorienting health services (WHO, 1986). Healthy public policy refers to diverse approaches including government and non-government organisational changes to promote health. Creating supportive environments refers to the creation of a physical and social environment conducive to health. Strengthening community action means promoting community participation in the planning and implementation of services to promote health. Developing personal skills refers to the acquisition of knowledge and skills (education, information) to promote health. Reorienting health services relates to changing the focus of health services towards prevention.

So, how were these concepts applied to mothers?

**Building a healthy public policy**

Building a healthy public policy means ensuring social justice by allocating resources for health to the most in need. At the policy level, the National Women's Health Policy (Commonwealth Department of Community Services and Health, 1989) stated as a goal “to improve the health and well-being of all women in Australia, with a focus on those most at risk, and to encourage the health system to be more responsive to the health needs of women” (p. 6). Knapman (1993) emphasises that this policy stressed the vulnerability of mothers before, during and after birth and of mothers with young children.
Furthermore, the publication of *Maternity Services in New South Wales: Final Report of the Ministerial Task Force on Obstetric Services in New South Wales*, commonly known as the Shearman Report, occurred in 1989 (N.S.W. Department of Health, 1989b). Of particular relevance to mothers for this study were the following recommendations:

**Recommendation 5.6**
That the distribution of community based postnatal family support services be planned on a geographic area and population basis to ensure that all families with babies and young children have access to a tiered referral network of services including Early Childhood Nurses providing primary care in co-operation with General Practitioners, family care cottages providing day centre mothercraft and support services, and one residential family care unit per area/region providing 24 hour intensive supervision and assistance for vulnerable and stressed mothers and families referred by family care cottages. (p. 219)

**Recommendation 5.7**
The role of the Early Childhood Nurse be extended to include team work with ethnic health workers, Aboriginal health workers, general practitioners, youth workers, etc., in order to respond to identified special needs in their areas. Continuing professional education be made available to enable Early Childhood Nurses to maintain and develop the skills and knowledge essential to their role. That senior community nurses / N.U.M's should be responsible for the day to day management and continuing education of early childhood nurse teams. (p. 220)

**Recommendation 5.11**
Maternity units and area health services should establish and adopt protocols for the effective identification, care, referral and treatment of postnatal depression and provide appropriate inservice training for maternity unit midwives and community based health care staff including Early Childhood Nurses, Generalist Community Nurses, General Practitioners and family care workers. (p. 228)

Women and families were identified as having special needs because of physical, medical, social or emotional factors. Social or emotional problems were defined to include “postnatal depression, isolation, previous infant death; low socio-economic status, poverty; history of domestic violence or child abuse as well as some Aboriginal or immigrant women who may lack family support and fail to utilise mainstream health services” (p. 220).
Creating supportive environments

In the 1980’s, a social support model developed which focussed on the needs of the mother. In the late 1970’s, due to the increasing effects of urbanisation, lack of extended family support and information, and the different forms of families, the Health Education Officer for Maternal and Child Health in 1979 recommended mothers’ groups to enable women to socially network as well as receive mothercraft education in order to increase their coping skills (Degeling, 1979).

In the NSW Department of Health’s Baby Health Activity Survey in 1984 (cited in Knapman, 1993), group activities were identified as being a positive approach to meet the changing needs of women. Isolation was identified as a major problem for women. Also, fathers involvement in the care of their infant and domestic support (excepting the middle class) was found to be limited.

Some negative aspects of these group activities included; inability to access those most at need, lack of public transport and lack of child care facilities. It was recommended that special needs groups be targeted “... young single mothers, isolated mothers, families under stress and lacking support, migrant mothers with language difficulties, low income/unemployed families, working mothers and those with drug/alcohol/psychiatric problems” (Milne, 1984, cited in Knapman, 1991, p. 9).

The Shearman Report (1989), stressed the importance of community based postnatal care and family support services. The report also indicated that there needed to be changes in parenting education to enable parents “to adjust to their roles and relate to other parents in order to form supportive social networks” (p. 238). ‘New mothers’ groups’ were identified as a strategy. These groups provide education and advice on mothering but also more significantly provide a form of social support by developing interpersonal relationships (Lawson & Callaghan, 1991).
In a study by Knapman (1991) of five diverse mothers’ groups at Early Childhood Centres in the Sydney metropolitan area the following reasons for attendance were identified; reassurance and advice with children, justification in terms of the needs of their infants, a lack of other social engagements, desiring friendships and having a rest from their other children. Knapman (1993) identifies that many mothers’ groups become self sustaining. This highlights the positive nature of mothers’ groups for creating supportive environments.

*Strengthening community action*

Voluntary groups have supplemented government and non government services. For example, the Childbirth Education Association and Nursing Mothers Association have provided valued support and education for parents. Also, the government has consulted with women and mothers in order to develop their health policies. For example, the Community Consultation on Post Natal Stress and Depression in NSW has been used as a framework for the development of postnatal depression support policies (NSW Women’s Consultative Committee, 1994).

*Developing personal skills*

Early Childhood Services have provided the knowledge and support for the development of personal skills for parenting. Nurses have used individual and group approaches to parenting education following the recommendations of The Shearman Report’s (1989) outline of content for postnatal education:

*Understanding the emotional, physical, nutritional and developmental needs of their baby.
*Develop and practise basic ‘parenting’ and baby care skills.
*Debriefing and sharing the experience of pregnancy, the birth, and early parenting concerns.
*Increasing the self confidence and independence in the management of their new family situation.
*Identifying available and appropriate support networks, services and facilities.
Identifying the lifestyle issues relevant to the maintenance of the family unit well-being, health and stress management. Differing ways of dealing with their changing roles within the family and their social network. (p. 117)

Also, the Postnatal Depression Services Review (NSW Health Department, 1994b), recommended that parenting education coordinators be appointed in all Health Services Areas and Districts. This has resulted in greater monitoring, coordination and collaboration amongst government and non-government health professionals concerning parenting education as well as identifying the needs of particular groups (for example, Aboriginal, Non English Speaking Background, adolescent) within the community.

Reorienting health services

In the 1980’s a more family orientated service was offered in which the focus was on advice and support. The generalist community nurse was required to have additional qualifications for running baby health clinics. By the 1980’s there were 500 community health services to parents of babies (N.S.W. Department of Health, 1989a). In a Baby Health Activity survey by the Department of Health (1984, cited in Knapman, 1993) nurses identified their need for education in relation to interviewing, counselling, coping with emotional problems, the dynamics of families, parenting styles and increased cultural awareness. This education was needed because of increasing single parent families, isolation, depression, low income, increasing unemployment rates, drug and alcohol problems and cultural significance.

This resulted in nurses recognising the need for supporting mothers and their families. The Shearmun Report (1989) noted the changes in the role of Early Childhood Nurses in the 1980’s:

Early Childhood Nurses, formerly known as Baby Health Sisters, have traditionally played a primary care role in relation to mothers and babies or families with young children. Originally the role focused on educating mothers about health and hygiene in order to reduce the infant mortality rate. This role
has undergone significant change in the past decade, and now encompasses education, health promotion, health and developmental screening, monitoring family well-being, and providing guidance, counselling and support to families with young children. (p. 217)

It is estimated that between 80 to 90 percent of mothers attend Early Childhood Centres in N.S.W. at least once (Knapman, 1993). Therefore the majority of mothers in N.S.W are attending baby health clinics for advice as well as support.

The World Health Organisation’s (WHO, 1986) definition of health promotion as “the process of enabling people to increase control over, and to improve, their health” (p. 1) recognises that personal and social resources are necessary for health. It follows that the nurse, because he/she is involved in health promotion activities, is perceived as somehow enabling this process.

Enabling means empowering, but a central question of this thesis is can nurses empower new mothers? How do new mothers increase control over their lives in order to improve their health? What are their needs for health? What is needed for them to meet their needs? To answer these questions I will explore the notion of empowerment/enablement and its implications for women and mothers in particular.

THE PROBLEM OF ‘EMPOWERMENT’

Empowerment in the nursing literature

The Australian Pocket Oxford Dictionary (Turner, 1976) defines empowering as enabling or giving authority and ability to do something. The concept of empowerment is discussed in diverse areas of nursing practice. Gilbert (1995), in a review of the Cumulative Index to Nursing and Allied Health literature, identified in a 10 year period that 378 papers listed empowerment as one of the topics discussed. Gilbert reasons that empowerment implies an unequal power relationship between the person empowering who has greater authority than the person being empowered. Her review identified that
only a few papers discussed the relationship between empowerment and the notion of power. This concern highlights the need for nurses to discuss empowerment along with power in order to develop nursing knowledge and practice.

Empowerment as a concept has been described by Gibson (1991) as being a process, an outcome, transactional, positive problem solving, dynamic, dialectical as well as being developmental. Empowerment as a process and outcome refers to the developmental process which occurs for people as they interpret their situation (positive problem solving) in order to gain mastery of their lives (Simmons & Parsons, 1983, cited in Gibson, 1991). Empowerment as transactional recognises the importance of people's interactions and relationships with others as well as the environment in the process of empowerment. Empowerment as dynamic refers to the shared nature of power in which power is given as well as taken. Empowerment as a dialectical concept refers to the diversity in process and outcome. Empowerment as being developmental refers to the process of becoming (Keiffer, 1984, cited in Gibson, 1991).

Gibson (1991) asserts “Health care professionals cannot empower people; people can only empower themselves” (p. 357). In order to achieve this, Gibson claims the role of the nurse needs to be one of facilitator and resource as opposed to a service provider. Consequently, Gibson redefines empowerment as “a social process of recognizing, promoting and enhancing people’s abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives” (p. 359). Unfortunately, this definition still fails to recognise the social context of people's lives which was so clearly articulated in the Alma Ata and 'Ottawa Charter' discussed previously in this chapter. Also, this definition has formed a foundation for other nurses development of the concept of empowerment. For example, Jones and Meleis (1993) propose empowerment as a model for health. They state “In this model, health is being empowered to define, seek, and find conditions, resources, and processes to be an effective agent in meeting the significant needs perceived by individuals” (p.
12). This model still implies that nurses are the agent which contradicts Gibson’s (1991) assertion that people empower themselves. This highlights the confusion in the nursing literature in regards to the concept of the term empowerment and therefore its relevance to the formulation of nursing models and consequently nursing theories.

The World Health Organisation’s (WHO, 1986) definition of health promotion affirms that health care professionals ‘enable’ people’s health. However, as the term empowerment implies, to enable implies that health professionals have greater authority than consumers of health care. This form of arrogance needs to be avoided if nurses are to subscribe to an empowerment model at all. As I have argued in this chapter, people need personal and social resources for their health. I believe that if people have the necessary resources for their health, they are empowered, that is they have control of their lives. How can nurses empower clients when they do not possess these resources? How are nurses the authority on how and where people live and what people do when their exists so many social inequalities? Because their exist so many social inequalities it is useful for nurses to explore further the notion of empowerment and power.

**Foucault’s ideas on power**

Foucault (1977) asserts that power is productive: “... power produces; it produces reality; it produces domains of objects and rituals of truth” (p. 194). Power and knowledge are inextricably linked. Power produces knowledge and knowledge exercises power. Power/knowledge operates everywhere to produce truth, reality and normality.

Foucault (1980a, cited in McHoul & Grace, 1993, p. 59) contends that power is exercised by a network of power relations which is dependent upon the production, accumulation, circulation and functioning of a discourse. Foucault (1977) defines discourse as a set of common assumptions and practices which provide the basis of
conscious knowledge. Discourse, then refers to a set of statements which are circulated in society which consequently shape the meanings we ascribe to our experiences.

He describes power in the following way:

Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target. They are always also the elements of its articulation. (Foucault, 1980a, cited in McHoul & Grace, 1993, p. 89)

Foucault (1977) describes power as exercised through disciplinary techniques such as surveillance, categorization and intervention by experts in the human sciences. These are a form of social control and normalization which create the divisions healthy/ill, sane/mad and legal/delinquent (Sawicki, 1991).

Foucault (1980a, cited in McHoul & Grace, 1993) advocates an ascending rather than a descending analysis of power. He claims that it is useful to discern power relations at the micro level of society in order to understand how mechanisms of power have been able to function along with the production, accumulation, circulation and functioning of a discourse. Foucault (1980) describes the link between power and truth in relation to these discourses:

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

He (1980) further clarifies this meaning in the following way:

'Truth' is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements. 'Truth' is linked
in a circular relation with systems of power which produce and sustain it, and to
effects of power which it induces and extend it. A 'regime' of truth. (p. 133)

Foucault asserts that wherever there are these power relations there is also resistance.
Resistance according to Foucault refers to resistance to power/knowledge. Luke and
Gore (1992) stipulate that individuals are the vehicles of power, not its point of
application.

The post-structuralist critique of ‘empowerment’
Gore (1992) provides a post-structuralist analysis of empowerment in critical and
feminist educational discourses drawing on Foucault’s ideas on power. She identifies
three suppositions in regards to the term empowerment. First, an agent of
empowerment. Second, a notion of power as property and third some kind of vision or
desirable end state. Gore critiques these suppositions and identifies the following
shortcomings. Conceiving empowerment as requiring an agent ignores the context of
the agent. Conceiving power as property implies that the agent of power can control,
give and take power from the person being empowered. Conceiving a vision of
empowerment implies a dichotomy of empowerment and oppression.

I do not embrace post-structuralist feminism entirely. My view of the person is
incompatible with the post-structuralist view of the subject which denies authenticity to
individual experience (Gavey, 1989). I do recognise diversity and that there can be
multiple meanings derived from people’s experiences, however, I believe that common
meanings, interests and concerns need to be articulated through language and other
forms of communication in order to ensure social justice. I also believe that it is
imperative to incorporate contextual influences, that is social, cultural and historical
contexts into understanding people’s experiences. I do subscribe to the post-
structuralist interpretation of power, knowledge, discourse, and resistance which asserts
that knowledge is socially constructed and is indicative of power relations in society.
What can we do for new mothers?

To rethink the problem of empowerment utilising Gore’s post-structuralist analysis and Foucault’s ideas on power and attempt to apply empowerment to nursing practice, I question whether nurses can empower their clients at all. Nurses need to rethink the concept of empowerment and change their practice to incorporate a more egalitarian stance.

How can we know what new mothers’ needs and practices are unless we listen to them. By listening to new mothers, they reveal their needs to us which allows us to be there with them through their motherhood experience. Therefore, we need to ask what can we [as nurses] do for new mothers? To answer this question, nurses need to know what are new mothers’ needs and practices for their health and well-being.

The question I therefore ask is, what are new mothers’ needs and practices for their health and well-being?

CONCLUSION

I have adopted the view that since the health of new mothers is best described as an adaptive process, the goal of nursing them should entail efforts to support them. The historical analysis of baby health services in N.S.W. showed the development of a social model of health which incorporated the philosophies of primary health care and the concepts of the ‘Ottawa Charter’. The main question which arose from this discussion was about ‘empowerment’. Can nurses empower their clients? In drawing on Foucault’s ideas on power and the post-structuralist critique of ‘empowerment’ a central question for this thesis was derived: what can we [as nurses] do for new mothers? To answer this question, nurses need to also ask what are new mothers’ needs and practices for their health and well-being?
CHAPTER 3: RE-VISIONING MOTHERHOOD

Re-vision - the act of looking back, of seeing with fresh eyes, of entering an old text from a new critical direction - is for us more than a chapter in cultural history: it is an act of survival. Until we can understand the assumptions in which we are drenched we cannot know ourselves. And this drive to self-knowledge, for woman, is more than a search for identity: it is part of her refusal of the self-destructiveness of the male-dominated society. (Rich, 1972, cited in Reason & Rowan, 1981, p. 457)

Feminism and Foucault

I adopt a post-structuralist feminist perspective incorporating Foucault’s ideas on power, knowledge and truth in order to critique the concept of motherhood. Diamond and Quinby (1988, p. x) outline the “four convergences” of feminism and Foucault. First, both identify the body as the site of power and domination. Second, both point to “the local and intimate” operations of power rather than the power of the state. Third, both discuss discourse as its capacity to produce and maintain dominant power as well as resistance to these discourses by marginalised and unrecognised discourses. Fourth, they both criticise the ways in which western humanism has privileged the masculine elite as it proclaims universal truth, freedom and human nature. In drawing on the fourth convergence, I will discuss Erikson’s life-span theory to highlight how women’s experiences have been neglected in its formulation and what this means for women.

MODELS OF DEVELOPMENT

Erikson’s Eight Stages of Life

Erikson’s life-span theory identified eight stages of life which represent the dilemmas that people face at stages in their life. Each stage of development is marked by a choice between two conflicting characteristics which need to be resolved in order to negotiate the next stage (Erikson, 1963). Erikson’s (1963) sequence of phases of psychosocial development, the ‘Eight ages of Man’ are; basic trust versus basic mistrust, autonomy versus shame and doubt, initiative versus guilt, industry versus inferiority, identity
versus role confusion, intimacy versus isolation, generativity versus stagnation and finally, ego integrity versus despair.

Developmentally, most new mothers in this study fall into the stages of ‘intimacy versus isolation’ (young adulthood) and ‘generativity versus stagnation’ (adulthood) in Erikson’s theory based on their age, and consequently these need further clarification. In regards to the sixth dilemma ‘intimacy versus isolation’ (young adulthood), Erikson (1963) wrote:

Thus, the young adult, emerging from the search for and the insistence on identity, is eager and willing to fuse his identity with that of others. He is ready for intimacy, that is, the capacity to commit himself to concrete affiliations and partnerships and to develop the ethical strength to abide by such commitments, even though they call for significant sacrifices and compromises. Body and ego must now be masters of the organ modes and of the nuclear conflicts, in order to be able to face the fear of ego loss in situations which call for self abandonment: in the solidarity of close affiliations, in orgasms and sexual unions, in close friendships and in physical combat, in experiences of inspirations by teachers and of intuition from the recesses of the self. (pp. 263-264)

Unfortunately, this excerpt highlights how Erikson has excluded women from his theory. He does not use the word woman, for example “... willing to fuse his identity with that of others. He ...” nor does he represent their experiences, for example in referring to the call for self abandonment in close affiliations, in orgasms and sexual unions he fails to recognise mothers’ diverse experiences of self abandonment which occur whilst breastfeeding and caring for their infants and children. Intimacy is a prerequisite for the seventh developmental dilemma ‘generativity versus stagnation’ which involves people demonstrating concern for others and the world in general.

The meaning of intimacy involves mutuality, reciprocity and self disclosure. Erikson (1959) outlined how ‘intimacy versus isolation’, psychosocially involves losing and finding oneself in another. Since a prerequisite to intimacy is identity, it appears contradictory that one can find oneself by connecting to another. I believe that an
evolved identity cannot lose itself willingly and abnegate when it is striving to self-develop.

The possible outcomes of the ‘intimacy versus isolation’ stage include first, non-commitment to the relationship at hand which results in isolation as well as second, the possibility of losing one’s own identity by merging into the partner’s identity. There exist gender differences in relation to the likely outcomes of this stage, in which women suffer due to social inequities exemplified in women’s higher incidence of mental illness than men (A.B.S., 1992).

In regards to not committing to a relationship, a study by Brown and Harris (1978) found that for working women, lack of an intimate partner or intimacy in the primary relationship was found to be a major theme in their experiences of depression, along with poor socioeconomic circumstances. This is not explained by Erikson’s model and highlights that men are actually not being intimate with women whereas women regard intimacy as being important for their well-being.

The second possible outcome concerns loss of self which arises from losing one’s personal identity through merging of identities. It is a social expectation for women to care for others. This loss of self is felt by many women as a result of socialisation in which they are encouraged to defer, even negate their needs when caring for others, particularly men and children. This results in self-depreciation and a lowered self esteem which consequently can lead to depression. Women need to be socialised to care for themselves.

Many people use Erikson’s model in order to understand human development. Since women are excluded from its formulation their experiences can be pathologised. Also, Erikson’s model focuses on persons in isolation from their social context. As I felt dissatisfied with this individualistic perspective on development and on the male gender
bias it seems to be based on, I turned to Gilligan's (1982) theory of moral development which considers morals, gender and the self in a broader context.

**Gilligan's theory of moral development**

Gilligan (1977) argued that developmental models, especially Kohlberg's theory of moral development, ignore women's particular experiences. Gilligan studied 29 women of diverse cultural and socioeconomic backgrounds, who were contemplating an abortion decision, to derive the nature and development of women's moral judgements. Although this study may appear removed from my present study into new mothers' well-being, it is useful as a framework for understanding the social sanctions which are imposed on women when they decide how to act morally in any given context.

The six moral stages proposed by Kohlberg (1981) derived from a study of 84 boys are summarised as follows. What is morally right in Stage One to Six respectively concerns; the egocentric importance of a person's physical actions, the mutual needs and purposes of both self and others, shared feelings and expectations of self and others, conforming to social values, the rational maintenance of rights and finally (in Stage Six) actions based on agreement to universal moral principles, in particular the universal principle of justice. This model proposes that a person can free moral decisions from their needs and social conventions in order to abide by principles of justice.

Gilligan's (1977; 1982) main argument concerning Kohlberg's (1981) invariant sequence of moral development is based on the following three premises. Firstly, that it was gender biased as his study did not include girls and women. Secondly, that there exist gender differences in moral orientation. Thirdly, Gilligan asserted that moral reasoning needs to be understood in context.
In Kohlberg's model, because Stages One to Four do not involve principled reasoning, they are considered morally inferior to Stages Five and Six. Because the lower levels are concerned with feelings, sentience, care and friendship which are attributes of femininity, Gilligan argued that according to Kohlberg's model women are consequently perceived as being morally undeveloped and immature. Gilligan (1987) asserted that women's roles in men's life cycle as nurturers and carers has been devalued by this model. Women were predominantly perceived as being in Stage Three in Kohlberg's model which relates to pleasing others through one's actions (Kohlberg, 1981, p. 115).

Unlike Kohlberg's model, which is an invariant sequence moving toward autonomy and individuation, Gilligan (1982) argued the importance of attachment and relationships in women's lives. She wrote:

> The elusive mystery of women's development lies in the recognition of the continuing importance of attachment in the human life cycle. Woman's place in man's life cycle is to protect this recognition while the developmental litany intones the celebration of separation, autonomy, individuation and natural right. (p. 72)

Gilligan (1982) asserted that the core problem experienced by women concerns conflict between self and others which needs to be settled with care and responsibility in order to reconcile femininity and adulthood. Gilligan (1982) proposed levels of moral reasoning which she described as the 'different voice', a feminine perspective on female moral development. She argued that there are both female and male perspective's in moral reasoning. The female perspective involves an ethic of care where they demonstrate interdependence with others whilst still being able to maintain their own integrity, whereas the male perspective incorporates an ethic of justice. Her model espoused a hierarchical developmental sequence of women's moral judgement consisting of three levels with transitions between them. Initially there is a concern with survival, then a concern for goodness and finally an ethic of care.
‘The first level: orientation to individual survival’

In 1977, Gilligan stated “... at the first level, morality is seen as a matter of sanctions imposed by society of which one is more subject than citizen ...” (p. 496). This interpretation highlights that society imposes rules on how women should act. At the first level is the concern with self survival. Gilligan (1977) noted:

... the abortion decision centers on the self. The concern is pragmatic and the issue is individual survival. At this level, “should” is undifferentiated from would, and other people influence the decisions only through their power to affect its consequences. (pp. 492)

At the first level, self interest is the basis for moral judgement. From my personal experiences of diagnosing women’s pregnancies and discussing how they feel prior to consideration of their options, many have echoed this self interest stance of individual survival. In so doing women resist and reject social sanctions. ‘The first transition: from selfishness to responsibility’ involves moving from selfishness to assuming responsibility for self and others (Gilligan, 1977). Self concept is perceived as being influenced positively by socially acceptable moral actions (Gilligan, 1982).

‘The second level: goodness as self sacrifice’

‘The second level: goodness as self sacrifice’ involves moral judgements being dependent upon shared norms and expectations. Goodness is equated with the feminine trait of caring for others by self sacrificing actions. Feminine stereotypes of gentleness, easy expression of feelings and tact are integral to this meaning (Broverman et al., 1972, cited in Gilligan, 1977). An example given by Gilligan to illustrate this notion is when a woman who does not want an abortion has one because her lover wants her to. The intention is not to hurt others, with no consideration given to not hurting oneself.
Consequently, women sacrifice their own needs to care for others. This feminine trait is prevalent amongst mothers because they are socialised to negate their own needs whilst caring for their infants.

'The second transition: from goodness to truth' concerns being responsible for not hurting others as well as oneself in the morality of care. Women's own needs are recognised as being important as they assume responsibility for their own and another's needs as well as considering the realities of personal intentions and consequences. This level highlights how women's own needs are met in the morality of caring for themselves.

Gilligan (1977) wrote that honesty is essential for women's self concept:

To be responsible for oneself, it is necessary first to acknowledge what it is that one is doing. The criterion for judgement thus shifts from "goodness" to "truth" as the morality of action comes to be assessed not on the basis of its appearance in the eyes of others, but in terms of its intention and consequence. (p. 498)

_The third level: the morality of nonviolence_

'The third level: the morality of nonviolence' involves the injunction against hurting as well as the condemnation of exploitation as being the major principle guiding moral judgements and actions. This involves egalitarian principles in relation to self and others. Thus an ethic of care becomes the universal obligation in which women resolve femininity and adulthood.

In summary, Gilligan's theory of moral development re-images the notions of autonomy and individuation to cede to the importance of attachment and relationships in women's lives. The model notes the effects of the sanctions of society upon women. The issue of femininity which I believe is socially constructed is transcended in order for women to recognise their own needs, intentions and the consequences of their
actions. The injunction against hurting others; condemnation of exploitation and an 
ethic of caring for oneself and others are the universal principles underpinning women’s 
moral decisions. This theory thankfully recognises the importance of women caring for 
themselves when deciding how to act morally.

Gilligan’s (1982) theory of moral development offers a useful framework for studying 
morals, gender and self in context. Research has found that women and men 
incorporate both models, where women focus on care whilst men focus on justice (Ford 
& Lowery, 1986; Gilligan & Antanucci, 1988). There is a need to explore further 
mens’s subscription to Gilligan’s theory of moral development. There is also a gap in 
the nursing literature in relation to women’s moral decision making in nursing contexts 
and consequently to the use of Gilligan’s theory.

The developmental peak of Gilligan’s theory of moral development is the morality of 
nonviolence, the injunction against hurting and the condemnation of exploitation as 
being the principles of women’s moral actions. I have discussed in Chapter 2 gender 
inequalities in relation to women’s unpaid work in the home. Postnatal depression is a 
significant problem for new mothers. Women experience overt forms of violence as 
evident from the high incidence of sexual assault and domestic violence in Australia 
amongst other countries. In this chapter I presented the fact that women experience a 
higher incidence of mental illness when compared to men. These facts show that 
although women subscribe to the moral principles of non violence and the 
condemnation of exploitation, these principles are not reciprocated from a male 
dominated society. I will attempt to explore further the contextual, that is social, 
influences on new mothers since I believe women do not experience social justice.

The next section defines the structures of the oppression of women by exploring the 
Marxian concept of ideology and how this has been applied to motherhood. I will
discuss, describe and critically analyse feminist debates regarding this ideology, as part of the discussion of the power relations operating in the social oppression of mothers.

THE IDEOLOGY OF MOTHERHOOD

The feminist critique of the ideology of motherhood

Feminists have utilised, revised and extended the Marxist interpretation of ideology as a framework for understanding the oppression of women in society. Ideology is defined by The Australian Pocket Oxford Dictionary (Turner, 1976) as “ideas characteristic of some class etc. or at the basis of some economic or political theory or system” (p. 344). Marx’s basic argument regarding ideology is that there exist a system of illusory or false ideas operating in society which supports the interest of the dominant class. The dominant class is determined by the existing mode of production and the division of labour it requires. Consequently, for Marx, these dominant needs support the materialist gains of capitalism. This results in a division of labour according to class (Marx & Engels, 1974).

Feminists have used this Marxian ideology in understanding women’s oppression in a patriarchal society. Firestone (1971) in The Dialectic of Sex claimed that patriarchy, which she defined as the systematic subordination of women, is rooted in the biological inequality of the sexes. She offered a feminist revision of the materialist theory of history offered by Marx and Engels. However, Firestone focuses on sex class rather than economic class. For her, the relations of reproduction not of production are paramount. Consequently, reproductive roles are perceived as causing the division of labour where it suits capitalism to confine women to the domestic sphere where they can provide unpaid work which ultimately stimulates capitalism. Firestone argued that by getting rid of the family, gender distinctions and reproductive differences power is redistributed away from patriarchy towards women’s personal power. However, there are some problems with adopting Firestone’s arguments. For example, her assertion of
getting rid of the family fails to recognise the value of mothering and the family in society.

This interpretation has been extended by Mitchell (1971), Oakley (1974, 1980), Rich (1976), and Wearing (1984) from an economic and a biologically based view of domination to a more socially constructed view of domination based on gender which favours men. Rich (1976) argued that the institution of motherhood as opposed to the experience of motherhood resulted from a patriarchal society:

How have women given birth, who has helped them, and how, and why? These are not simple questions of the history of midwifery and obstetrics: they are political questions. The woman awaiting her period, or the onset of labor, the woman lying on a table undergoing abortion or pushing her baby out, the woman inserting a diaphragm or swallowing her daily pill, is doing these things under the influence of centuries of imprinting. Her choices - when she has any - are made, or outlawed, within the context of laws and professional codes, religious sanctions and ethnic traditions, from whose creation women have been historically excluded. (p. 117)

Rich (1976), like Firestone, adopted a biological perspective in regards to the inequalities between men and women. She asserted that the female reproductive organs which have been the target of patriarchy result in women being passive to the male medical profession. She defined women's opponents as "individual men, the welfare system, the medical and psychoanalytic establishments, or the organised network of drug traffic, pornography, and prostitution" (p. 289). Rich (1976) argues that women need to repossess their bodies in order to obtain power.

Mitchell (1971), like Firestone and Rich argued that women's oppression has been biologically based. She claimed that the gender based ideology consists of four structures of women's oppression which include: production, reproduction, sexuality and the sociology of children. The core premises of her argument are that because of their physical limitations women are more suited to the domestic sphere, are defined by their reproductive abilities (which is seen as an indication of women's natural role) and consequently are destined to being responsible for child rearing.
Oakley (1974; 1980) argued that the capitalist ideologies of femininity justified the restriction of women to the home. Oakley argued against the psychological and psychoanalytical perspectives of motherhood which focuses on the biological constructs of reproduction and feminine behaviour. The syllogism of this biological argument was outlined by Oakley (1980); only women can give birth, only women look after children and therefore only women can look after children (p. 80). She alleged that with reduced family size and increased geographical mobility experienced by mothers, difficulties result from a lack of the apprentice-type learning of motherhood skills which had traditionally been available. In addition, with increasing labour force participation rates compounded by women continuing to take the major responsibility for domestic chores, women suffer multiple role strain. Because of these social influences Oakley adopted a social perspective in her studies on motherhood which incorporate cultural interpretations of their first hand accounts of their concerns. These concerns will be discussed later in this chapter.

The Australian sociologist Betsy Wearing (1984) affirmed that class as well as gender is important for the investigation of ideology in motherhood. Like Oakley, Wearing interpreted class as being responsible for women’s relegation to domestic labour as well as for the reproduction of labour power. Also, like Firestone, Rich and Mitchell she asserted that gender power relations suit the patriarchy. However, she questioned whether motherhood was ideologically or utopian based. She distinguishes between the Marxian concept of ideology and Mannheim’s concept of utopia “indicating ideas and values which transcend the existing order while arising out of it, and representing the interests of a subordinate but ascendant group within it ... ” (Wearing, 1984, p. 15). From her research, which took place between 1977 and 1979, involving 150 women with preschool children, she presents their core beliefs concerning ideology and utopian ideas of motherhood.
Table 1: Ideology and utopian ideas

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<tr>
<th>IDEOLOGY</th>
<th>UTOPIAN IDEAS</th>
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<tr>
<td>1. Motherhood and womanhood are intermeshed; to be considered a mature, balanced, fulfilled adult, a woman should be a mother.</td>
<td>1. Motherhood isn’t necessarily for women’s fulfilment, nor is it inevitable, but it does ‘build character’.</td>
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| 2. a A ‘good’ mother is always available to her children, she spends time with them, guides, supports, encourages and corrects as well as loving and caring for them physically. She is also responsible for the cleanliness of their home environment.  
   b A ‘good’ mother is unselfish, she puts her children’s needs before her own. | 2. A good parent is all of (a) but is also attempting to fulfil his/her own needs by developing individual potentialities, apart from parenthood. |
| 3. Children need their mothers in constant attendance at least for the first 3-5 years of their lives. | 3. Children need to relate to a number of adults, both male and female. The quality of the relationship with a carer is more important than quantity. |
| 4. The individual mother should have total responsibility for her own children at all times. | 4. The individual mother is primarily responsible for her children, but this responsibility should be shared with other adult carers, both male and female. The community and the state should take more responsibility for the rearing of children. |
| 5. Mothering is a low status but important, worthwhile and intrinsically rewarding job in our society. The non-material rewards outweigh the lack of financial and status rewards. | 5. Mothering is a low status, worthwhile and intrinsically rewarding job in our male dominated society. If men participated more it’s status would be raised. Changes in the employment structure are needed to enable men as well as women to participate in parenting and in the workforce. |

Wearing’s study identifies a number of ideological ideas concerning motherhood. For a woman to be considered a mature adult by society, she needs to be a mother. Her social definition and status as well as personal development is derived from this role.

According to the ideology of motherhood, a woman needs to be a ‘good mother’, that is, to be always available and unselfish. Diligence and maternal sacrifice are important. Although motherhood is considered a low status occupation the ideology proposes that women feel rewarded by assuming responsibility for the care of their infant.

The notion of altruism is significant in these ideological ideas. Mothers are deemed to have a sense of responsibility for the care of their child which is to be demonstrated through selfless actions. The consequences of this altruism is ‘good’ is equated with ‘caring’ by mothers. This is to result in them feeling personally rewarded and satisfied.
These ideological ideas, ‘good mother’, diligence in care and maternal sacrifice are social expectations which affect mothers’ thoughts, feelings and behaviours. These ideas relate to Gilligan’s (1982) second level of women’s moral judgement ‘goodness as self sacrifice’ which emphasises feminine traits of caring which results in women sacrificing their own needs to care for others. Mothers need to consider their own needs and care for themselves.

Wearing (1984) asserted that these ideological ideas restrained women’s independence and participation in public (work) life and suggested that this could be overcome if the state assumed responsibility for child care. She argued that if all women are free to work, one’s work status would become more important and highly valued and hence caring for an infant at home would become obsolete. This interpretation unfortunately ignores the valuable aspects of full time and part time mothering.

Matthews (1984), in a feminist critique of the history of femininity in twentieth century Australia, argues that standards of femininity are defined by abstract ideals which are historically created. Subsequently, these ideals become a value or an ethic of duty dictating how mothers ought to act. They are therefore prescriptive. If mothers do not carry out these duties, feelings of guilt can result (Greenspan, 1994).

The utopian ideas identified by Wearing’s study are different to the ideological views. The utopian views recognise that a mother’s needs must be met as well as her infant’s. Also, the quality of the relationship between the carer and the infant is perceived as being more important than the quantity of time spent in caring. Caring is regarded as a responsibility shared between parents and carers.

My previous discussion has shown the development of the feminist analysis of the ideology of motherhood from an economic to a biological, then a social analysis of
gender. A further point which needs to be discussed is addressed by post-structuralist feminists who challenge the sex/gender and mind/body distinctions (Wearing, 1996).

**Post-structuralist feminism and Foucault**

An Australian philosopher, Gatens (1983), argued for a critique of the construction of female experience which considers the female body. In her critique of the sex/gender distinction, she states that this is necessary in order to recognise and act upon social values to change patriarchal social relations. She interprets the assumptions underlying degendering as being both rationalist and a-historical because they view the body and consciousness as being neutral. She suggests that it is useful to understand how the body is culturally inscribed.

Grosz (1994), like Gatens (1983) argues that we need to explore how the body is culturally inscribed. She refers to the body as the site of cultural inscriptions and the cultural product:

> The body must be regarded as a site of social, political, cultural, and geographical inscriptions, productions, or constitution. The body is not opposed to culture, a resistant throwback to a natural past; it is itself a cultural, the cultural, product. (p. 23)

Post-structuralists have drawn on Foucault’s description of social power on bodies:

> The body is molded by a great many distinct regimes; it is broken down by the rhythms of work, rest and holidays; it is poisoned by food or values, through eating habits or moral laws; it constructs resistances ... Nothing in man - not even his body - is sufficiently stable to serve as a basis of self recognition or for understanding other men. (1977b, cited in Grosz, 1994, p. 148)

The body is the site of power and domination. Foucault (1980) asserts that the body is molded by many regimes, that is systems of power. He argues against the marxist notion of ideology which focuses on superstructural forms of power such as capitalism and patriarchy. Instead he contends that we need to understand how power is exercised
on the body and its mechanisms which permit time and labour to be extracted from bodies at the infrastructural, that is at the micro level of society (McHoul & Grace, 1993).

Foucault (1980) argues that power is exercised by a network of power relations, which is dependent on the production, accumulation, circulation and functioning of a discourse. Dominant discourses support existing power relations. These power relations in turn produce the cultural product, that is they define what is the culturally appropriate body and exert power on the body in order to extract time and labour.

Foucault (1980) claims that it is useful to know historically how effects of truth are produced within discourses which may or may not be true or false in themselves. In drawing on Wearing’s ‘ideology of motherhood’ and Foucault’s ideas on power and knowledge, I will now critique the discourses on motherhood, what I refer to as the myth and meanings of motherhood.

THE MYTH AND MEANINGS OF MOTHERHOOD

I will initially critique the myth in relation to motherhood as outlined by Braverman (1990) who asserts that the core elements “dictate that motherhood is instinctual, that having a child fulfills a woman in ways that no other experience can, and that mother is the best care provider for the child” (p. 228). The following three questions will be discussed to highlight and distinguish between the myths (which are not completely true) and the meanings derived from a discourse that represents truthfully, mothers’ experience:

Is motherhood instinctive?
Is a mother the best provider of care for her child?
Does having a child fulfil a woman?
Is motherhood instinctive?

Do mothers naturally know how to mother or do they learn how to mother? What does mothering really mean when it is not even defined in dictionaries? Motherhood, culturally across the world, signifies a celebration of the pageantry of birth to welcome an infant into a family and community. Mothers generally care for and protect their infants.

The cultural, social and structural construction of motherhood, however, presents it as being natural and instinctive, that is mothers are seen to possess a maternal instinct. Badinter (1981) wrote in regards to this in her book The Myth of Motherhood:

Mother love has been discussed as a kind of instinct for so long that a “maternal instinct” has come to seem rooted in woman’s very nature, regardless of the time or place in which she has lived. In the common view, every woman fulfils her destiny once she becomes a mother, finding within herself all the required responses, as if they were automatic and inevitable, held in reserve to await the right moment. Because reproduction is a natural function, surely - or so it has been assumed - the biological and physiological fact of pregnancy must carry with it a corresponding battery of predetermined maternal attitudes and patterns of behavior. (p. xx)

This excerpt succinctly explains the ideological myth which asserts that being a mother is a necessary criterion for womanhood and that mothers are able to innately love and care for their infant. Badinter argues that these myths derive from Freudian psychoanalytic concepts in relation to women’s personalities; the qualities of passivity, masochism and narcissism. Badinter (1981) refutes the notion of the maternal instinct by presenting evidence showing that women have abortions, marry and do not become mothers, and do not marry, all of which indicate that some women reject motherhood outright.

In relation to those women who choose to become mothers, the maternal instinct is accepted by many women as being true, that is they believe in it and therefore it becomes an expectation. However there are some mothers who find the maternal instinct the antithesis of their reality. A study by Oakley (1979) found that:
The myth of the maternal instinct has been a long time dying, and is not even dead yet. Of a sample of mothers interviewed in 1975-6, 61 percent believed in it, although 36 percent of these found that in practice they did not have ‘it’ when they came face to face with their babies. (p. 243)

The majority of the women in Oakley’s study did naturally know how to mother. This finding needs further exploration to determine if mothering is genetic in nature.

However, many mothers in Oakley’s study did not possess ‘it’, the maternal instinct. Historically, the notion of maternal instinct has resulted in serious implications for women who have been under medical control. Ehrenreich and English (1979) in For her own good: 150 years of the experts’ advice to women wrote:

As psychoanalytic attention shifted from the normal to the deviant, from the “healthy” to the pathological, the theory of instinctual motherhood quickly lost whatever comfort it might have held for women. The instinct theory asserted, at best, that women did know something about child raising independently of the experts. They did not have to master techniques and methods formulated in the psychologists’ lab or clinic. But with the new emphasis on pathology, “instinct” proved to be a harsher taskmaster for women than discipline and study had ever been. If anything should go awry in the mother-child relationship or in the child’s development the finger of blame would no longer point at the mother’s faulty technique, but at her defective instincts. What really mattered now was not what the mother read or thought, what she wanted to do or tried to do, but what her unconscious motivations were. And instincts couldn’t be faked. (p. 226)

I discussed in Chapter 2 how historically this view of maternal instinct has been eroded as mothers were deemed ignorant and in need of scientific training in order to improve the infant mortality rate at the beginning of this century. This discourse on motherhood has been derived from medical, scientific knowledge, notably of a patriarchal origin. This has resulted in the medicalisation and professionalisation of motherhood. As I also discussed in Chapter 2, as well as being disseminated through baby clinics and baby health services this discourse is circulated in popular literature even today.

There appear to be contradictory messages in regards to the notion of the maternal instinct. On the one hand is the notion that it exists, that is it is a natural part of being female and on the other hand mothers need to be trained and controlled by medical,
scientific and legal authorities. The notion of a maternal instinct because it is contradictory is confusing for mothers.

What about the notion of mother love, can it be an instinct?

**Is mother love an instinct?**

What is this thing called mother love? Mother's Day is celebrated in many western countries on the second Sunday in May to honour motherhood (Bram, Phillips & Dickey, 1971). It is interesting that we honour motherhood although Wearing’s (1984) study has shown that mothers in fact experience low social status.

Mother love is like any unconditional love which is mutual and reciprocal in nature. However, it is different to other forms of love (partner, father, sibling) in that it is a societal expectation and responsibility for mothers to demonstrate love for their infants. Gilligan (1982) argued that women's definition of morality is centred on relationships, responsibility and an ethic of caring for oneself and others. Mother love involves not only the responsibility of caring for an infant but also the development of a reciprocal relationship in which the needs of both mother and infant are considered. How can this be an instinct?

To refer to the notion of instinct conjures up images of animals and some kind of primal instinct. Beauvoir (1972) contended that women’s inferior status was rooted in man’s conception of woman as ‘other’. It can be surmised that by comparing women to animals certainly decreases their status in society further.

Whitbeck (1984) reasoned against the notion of innate maternal behaviour by citing studies of monkeys which showed that sexual and maternal behaviour is learned (Schier, Harlow & Stollnity, 1965, cited in Whitbeck, 1984). Whitbeck proposes that
the biological experience of pregnancy, labour, childbirth, nursing and the postpartum period affect women’s attachment to their infant by enhancing feelings of caring. This biological interpretations fails to recognise contextual influences such as whether the mother has adequate housing, food for survival and supportive relationships (WHO, 1986; Brown & Harris, 1978).

The psychological interpretation of mothering indicates that mothering is learned by a process of trial and error. The assumptions are that infants possess bio physiological needs which are met by mothers and consequently emotional interactions between mother and infant are biological in nature (Everingham, 1994). This interpretation unfortunately fails to consider the notion of co-constitution, that is mothers’ and infants’ history and experiences being-in-the-world.

The notion of co-constitution, one of the most important Heideggerian philosophical assumptions, is noteworthy for its acknowledgement of the fusion between the person and their world (Heidegger, 1962). Koch (1995) describes this meaning as “... being constructed by the ‘world’ in which we live and at the same time constructing this world from our own experience and background” (p. 831). Context and experience are therefore important for understanding mothering.

The sociological interpretation of mothering indicates that maternal love and care is learned through social experience (Oakley, 1979; Crouch & Manderson, 1993). Oakley (1979) found from her study that mothers’ relationships before the birth of their baby, the ways in which they were mothered, their concerns about their own upbringing, as well as messages received in childhood and adulthood about mothering affected the way they mothered. This importance of relationships for women supports Gilligan’s (1982) theory of moral development. A mother’s life history, incorporating the experiences of pregnancy, birth and the motherhood period also influences mother love and care.
An Australian study by Crouch and Manderson (1993) of 93 first time mothers between 1982 to 1987 discussed the development of mothers' love for and attachment to their infants. A major finding was that mothers bonded with their infant as early as at conception. This bond develops during pregnancy and motherhood. Some mothers expected to bond instantly with their infant at birth and felt disillusioned and surprised when this did not occur. This lack of bonding was affected by perceived negative physical experiences of labour and birth which resulted in some women feeling emotionally separated from and ambivalent towards their infant. Consequently, for some mothers it took time to attach whereas others fell in love with their infant instantly at birth. Confidence in infant care affected their attachment. Mothers believed that breastfeeding would establish bonding and enhance attachment. The achievement of a reciprocal relationship was important, from the mother’s point of view, for example a mother responding to her infant’s smile.

Crouch and Manderson (1993) concluded from their study:

Our study suggests that the surge of feeling at birth is neither a ‘natural part’ of labour (even where the mode of delivery is entirely “natural”), nor a pre-condition for the growth of maternal feelings over time. Nevertheless, the idea of “bonding” is part of the modern folklore about birth and many women feel disappointment and guilt in relation to the perceived shortcomings of their own birth experience and their accomplishments in this respect. (pp. 122-123)

So how do mothers know how to mother?

Women’s ways of knowing

It is useful to discuss Belenky, Clinchy, Goldberger and Tarule’s (1986) views on Women’s ways of knowing in order to provide a framework for understanding maternal knowledge and practice. This framework incorporates ideas derived from Gilligan’s (1982) theory of moral development. Belenky et al. (1986) interviewed 135 women about their experiences as learners and knowers. From their study, they define
women's ways of knowing; silence, received knowledge, subjective knowledge, procedural knowledge, and finally, constructed knowledge.

Silence refers to women "feeling deaf and dumb" (Belenky et al., 1986, p. 24). They are obedient to authorities, perceive themselves powerless and passive as well as incompetent in learning. This way of knowing was predominant amongst young, socioeconomically and educationally disadvantaged women. Historically, maternal incompetence has been monitored by Baby Health Centres and child health authorities, in particular the Department of Community Services. This has resulted in the removal of the child from the mother if the child is considered at risk, that is, in danger of being abused or in need of care. It can be deduced that this silent form of knowing is ineffective for learning.

Received knowledge refers to women depending on others for their knowledge. They regard themselves as recipients of information. Sources of knowledge are friends and authorities. This received knowledge is not scrutinised nor critiqued but regarded as the truth. Consequently, because they depend on others for knowledge, their own self definition is derived from others. This type of knowledge was predominant amongst the young women who were not educated at tertiary levels. Historically, as I have discussed in Chapter 2, Baby Health Clinics monitor the competence of mothers. Infant's growth and health has been monitored and mothers, because of their ignorance, have been scientifically trained in an effort to improve infant mortality. Mothers, however, obtain knowledge from friends, other women and mothers. This was discussed in Chapter 2 - 'new mothers' groups'.

Subjective knowledge refers to "the inner voice" (Belenky et al., 1986, p. 52), that is an intuitive form of knowledge. Unlike received knowers who depend on external sources of knowledge and authorities, subjective knowers depend on and assert their own personal authority. They recognise that their own personal needs must be met rather
than meeting any stereotypical expectations related to women providing care for others. In addition, their actions need to feel appropriate. Half of the participants in Belenky and colleagues' study, were 'subjectivists'. Their study found that mothers' confidence increased with experience. Subjective knowers recognise that personal experience is a valuable source of knowledge. It is personal and intuited. Historically, subjective knowing has been squashed by scientific knowing. Because child health authorities have monitored maternal competence and because mothers have been deemed incompetent, mothers have had to resist external sources of authority in order to promote their own subjective knowing. I will discuss later how the mothers in this study resist external sources of authority in order to promote their own subjective knowing which consequently enhances their well-being.

Procedural knowledge refers to "knowing how" through the "voice of reason" (Belenky et al., 1986, p. 87, 95). It involves gaining and applying procedures for getting and imparting knowledge. Unlike the silent and subjective knowers who do not depend on logic and reason, these procedural knowers rely on objective thought and logic. Amongst the procedural knowers there are two types of knowing; separate and connected.

Separate knowing is a form of impersonal reasoning which depends on standards and techniques to aid analysis. Historically, mothers' separate knowing has involved education in the form of antenatal and postnatal education which has been facilitated by nurses or parenting educators. Mothercraft standards used in education have been derived from Tresillian methods as well as from standards endorsed by child psychiatrists, psychologists and doctors.

Connected knowing is interpersonal and involves personal experience as well as the ability to empathise with others in order to approximate and understand other peoples ideas. An environment which permits women to share personal experiences in a non
judgemental manner is necessary for this form of knowing. In the Belenky et al. (1986) study, these women knowers were tertiary educated. Mothers’ connected knowing has primarily been achieved in mothers’ group settings where mothers learn from other mothers. Mothers learn in an informal environment of collaboration.

Constructed knowledge refers to the ability of women to integrate both subjective and objective types of knowing. They are ‘passionate knowers’ (Belenky et al., 1986, p. 141) which refers to the understanding of the inextricable relationship between the knower and the known:

To see that all knowledge is a construction and that truth is a matter of the context in which it is embedded is to greatly expand the possibilities of how to think about anything, even those things we consider to be the most elementary and obvious. Theories become not truth but models for approximating experience .... (p. 138)

These types of knowers in the Belenky et al. (1986) study needed to remove themselves psychologically and geographically from all they had known in order to self reflect and analyse before they could speak in their authentic voices. This study identified only a few women who were constructivists and they were also tertiary educated. Constructed knowledge recognises that subjective feelings and objective rational understanding needs to be integrated. The past is re-examined for important subjective, personal meanings as well as for consideration of realities about past and present life situations.

So is there a maternal instinct? Women’s ways of knowing indicate that knowledge is subjective as well as objective. Women and therefore mothers possess an innate way of knowing which is subjective, personal and intuited. Constructed knowledge affirms subjective, instinctive forms of knowledge. Women learn from personal experience as well as from external sources of knowledge. Wisdom is gained by experience. And what is the experience of motherhood? It is about responsibilities, relationships and the ethic involved in caring for an infant as well as themselves.
This leads me to discuss the next question:

Is a mother the best provider of care for her child?

The sense of responsibility in motherhood

I have previously outlined the ideology of motherhood (Wearing, 1984) which suggests a mother should have total responsibility of her own children at all times. The strength of this ideology was confirmed by Everingham’s (1994) research which found “In every instance in the study it was the mother who initially took the personal responsibility for her child’s care, even if the father was prepared to share the care, or became the primary carer at a later date” (p. 64). Because mothers feel personally responsible for their infants’ care and because infants cannot speak their needs, mothers obviously feel they must know and interpret their infants’ needs in order to provide care.

What are mothers’ thoughts, feelings and behaviours? Ruddick (1982) claimed that ‘maternal thinking’ involves the discipline of judging one’s own success or failure in maternal practice. The four main interests governing maternal practice include; preserving the life of the child, fostering the child’s growth (physical, emotional and intellectual), shaping a socially acceptable child, as well as having a capacity for attentive love. Protection of an infant and the provision of nourishment, including a nourishing environment, are necessary to foster the child’s growth in order for them to develop into socially acceptable beings. The capacity for attentive love, empathy, means that mothers are sensitive to the needs of their infant which they place ahead of their own needs.

Would these four main interests be pertinent to remote Aboriginal women who clearly exhibit poor health status as evidenced by high morbidity and infant mortality rates? Would the interest of shaping a socially acceptable child be important for poor Aboriginal mothers when they do not have enough food for survival? No, because first
is the issue of what cultural standard is being used and second, the interest is one of survival! One of my main arguments in this thesis is that people are inextricably linked with their world in a historical, social and cultural sense. Consequently, a sociocultural interpretation is necessary in order to understand the concerns of mothers.

Everingham (1994) claims that since Ruddick’s ‘maternal thinking’ lacks sociocultural analysis the moral dimensions of nurturing need to be analysed. Everingham attempts to reconstruct the notion of autonomy to consider the ‘agency’ of women performing nurturing (p. 4). She asserts that nurturing is an interpretive action of the mother whereby she interprets and judges the needs of the child in order to construct cultural meanings and forms of subjectivity of both the child and herself. It can be deduced from this line of argument that men can also nurture.

Everingham (1994) reconceptualised Ruddick’s term ‘maternal thinking’ to describe how ‘maternal attitudes’ involves mothers assuming responsibility for meeting their child’s needs as well as being responsible for their social behaviour. Everingham, like Ruddick, posits that the main responsibility of mothers is to meet their child’s needs - that is their child’s physical, mental and social needs. These areas of needs have been historically influenced by popular child-raising techniques. Techniques to meet infants’ needs have been advocated primarily by male doctors, principally psychologists and psychiatrists who have focussed on the child’s need for love and a loving, nourishing environment in order to become an acceptable member of society (Ehrenreich & English, 1979). It is generally agreed that the main responsibility of motherhood entails mothers meeting their infant’s needs (Braverman, 1990; Bergum, 1989; Crouch & Manderson, 1993; Wearing, 1984).

Bergum, (1989) in a hermeneutic phenomenological study of the transformation of woman to mother, enunciated a number of critical stages. These transformative experiences involve; the decision to have a child, the presence of the child, birth pain,
the transformative sense of responsibility, the giving body and having a child on one's mind. The relationship of knowledge to self-understanding is also discussed.

In relation to "the transformative sense of responsibility" Bergum discusses the notion of "taking responsibility" which commences during pregnancy when women assume healthy practices in order to produce a healthy baby. "Taking responsibility" relates to preparing for the birth and the baby's presence. Consequently, women assume responsibility for their expectant baby as well as for themselves. Due to the effect of socialisation processes, the focus of attention is on the baby. The theme, "the transformative experience of having a child on one's mind" relates to "the giving body" in which mothers provide nourishment and love to their children.

The theme of expectant mothers "taking responsibility" for their health practices has been historically endorsed in popular literature. It is useful to discern the changes in the health practices which have occurred this century. In the Ladies Handbook of Home Treatment, first published in 1912 (Richards, 1956) topics discussed in regard to the health of the expectant mother are; fresh air and sunlight, exercise, rest, clothing, diet and personal hygiene. In this handbook the care of the baby is discussed, however, there is no mention at all of the care of the mother.

In Natural Pregnancy: A practical holistic guide to wellbeing from conception to birth (Balaskas, 1990) the contents page lists the following chapters; emotions, nutrition, yoga and exercise, massage, natural therapies, holistic healing. Emotions, that is feelings, are now regarded as being just as important for wellbeing as body care. Balaskas advocates holistic healing:

Your body is designed to accommodate the dynamic physical changes of pregnancy and you may experience this period as a time of great health and vitality. Eating well, taking plenty of exercise, and staying in touch with your feelings will help to ensure physical and emotional wellbeing. (p. 68)
Matthews (1984) argues that the ideal of physical fitness for maternity in the twentieth century has been socially controlled by the medical profession. Mothers however attend to their skin, receive massage, exercise, get in touch with their own breathing, are touched and touch, dance and relax. Caring for themselves also involves relationships with others and the environment in which they live.

Apart from the theme of ‘taking responsibility’, ‘the giving body’, that is the concern for nourishing the child has resulted in many concerns for mothers, especially in relation to breastfeeding (Crouch & Manderson, 1993; Nicolson, 1990). Crouch and Manderson (1993) describe how for the mothers in their study, concern about the care of their infant centred on feeding. They experience a loss of control which is affected by prescriptive views on breastfeeding. Breastfeeding is represented as being natural and suited to demand feeding practices. The notion of nurturing involves patterns of feeding, duration and quality. Mothers identified a lack of confidence initially with feeding and this was exacerbated by conflicting advice from people, especially Baby Health Clinic nurses. Also their breastfeeding was under surveillance by Baby Health Centre nurses who monitored their baby’s weight. If the baby’s weight gain was poor, the mother was blamed for having an inadequate milk supply. This study affirms that breastfeeding is an important issue for mothers.

A study of postnatal depression by Nicolson (1990) found that women felt that they had failed and reported feeling depressed if they were unable to breastfeed when they desired to do so. Also problems such as sore nipples, engorgement or breast infections resulted in depression if breastfeeding was regarded as a high priority. This highlights some implications for mothers of breastfeeding.

In summary, ‘taking responsibility’ means expectant mothers assuming healthy life practices according to medical standards, especially body care practices, in order to prepare for and produce a healthy child. The prime responsibility of mothers involves
meeting their infants' needs. The infants' needs include the need for protection and nourishment in the nutritional and environmental sense. These maternal practices are perceived as fostering the growth of a socially skilled child. Through empathy, the capacity for attentive love, mothers are able to recognise their infants' needs. These themes of 'taking responsibility' and 'the giving body' focus on the physical dimensions of mothering.

However, it seems that the time and location dimensions in which these responsibilities are to be performed are limited. As I have already discussed in Chapter 2, women have been reported as doing 91 percent of unpaid work when they became new mothers (Office of the Status of Women, 1991). This coupled with mothers’ responsibilities for infant care indicates that mothers work hard (Oakley, 1974). Consequently, they feel exhausted (Crouch & Manderson, 1993) and they need to rest (Brown, Lumley, Small & Astbury, 1994).

Physical isolation and social confinement have been elucidated by feminist research as being a major concern for mothers (Brown et al., 1994; Crouch & Manderson, 1993). Many mothers also experience postnatal depression (NSW Health Department, 1994a). It is with this understanding of mothers experiencing exhaustion, isolation and postnatal depression that I ask the next question.

**Does having a child fulfil a woman?**

Motherhood involves a metamorphosis of being a woman to becoming a mother as well. Her self concept changes and grows in order to accommodate her new role as mother. Prior values and roles change. Previous priorities, goals and purposes in life also change. Mothers experience motherhood, learn, reconceptualise their past and present life situation and evolve.
The previous discussion has highlighted concerns of mothers. They feel enormously responsible for the care of their infant - feelings which are socially expected. Historically, Ehrenreich and English (1979) argue that the discourse on mothers finding fulfilment in child care has been constructed by psychoanalysts in order to create the ideal mother. Mothers are expected to feel fulfilled whilst performing these responsibilities.

Brown et al. (1994) describe how the rewards of motherhood promote mothers' emotional growth and maturity. They found from their study that this was achieved by observing and interacting with their child whilst the child developed, feeling needed by their child, moulding their child's life, having their child's company and generally feeling satisfaction. Unfortunately this interpretation outlines the rewards being derived from their infant, what are the rewards derived from themselves? Also, Wearing's (1984) study pointed out that although many mothers find motherhood intrinsically rewarding it is of low social status. Because the social and financial rewards of employment are the basis of one's self worth, Oakley (1980) argues that mothers' self esteem is impaired because of the loss of social status.

Mothers' experience of their decline in life satisfaction is well documented by Oakley's studies (1974; 1980). Her studies show that many mothers experience hard working conditions, social isolation, monotony, are tied down, do not have time for self, experience feeding problems, are sleep deprived and generally find baby care hard. Mothers' time and labour are certainly extracted from them.

The Australian researchers Barclay, Everitt, Rogan, Schmied and Whyllie (1997), in their study using focus groups of 55 first time mothers identified 'loss' to be one of the six categories in their analysis of the experience of early motherhood. The main concepts included; unpredictability, lifestyle, relationship, out of control, loss of sense of self, time, freedom, loss of confidence, resentment and grieving.
The NSW Health Department (1994a) report incidences of postnatal depression as high as 40 percent. Many of the signs and symptoms of postnatal depression such as loss of energy, confidence and control are, as I have discussed, common experiences of motherhood. This highlights the way in which mothers’ normal experiences are being pathologised and affirms Ehrenreich and English’s (1979) argument that the medicalisation and professionalisation of motherhood has resulted in the pathologisation of motherhood.

Barclay and Lloyd (1996) support my interpretation and argue that there is a ‘misery of motherhood’ as Australian research is revealing that unhappiness after childbirth is prevalent. They claim that the postpartum period is a period of distress because of a decline in life satisfaction and the experience of loss.

Can mothers feel fulfilled when they experience a decline in life satisfaction? To feel fulfilled implies that mothers feel satisfied, that their needs are being met. The previous discussion alludes to the fact that they are in some ways and they are not in others.

If we are to understand what mothers need to be fulfilled it is useful to understand their needs from their own perspective. The literature review indicates negative images of motherhood; hard work, exhaustion, social isolation and postnatal depression. However, there exists what Maushart (1997) describes as the “Mask of Motherhood”:

The Mask of Motherhood is the outward and visible sign of this silent conspiracy - the public face of motherhood which conceals from the world, and from ourselves, the momentousness of our common undertaking. The Mask of Motherhood is what mutes our rage into murmurs, and softens our sorrow into resignation. The Mask of Motherhood is the semblance of serenity and control that enables women’s work to pass unnoticed in the larger dramas of human life. Above all, the mask keeps us quiet about what we know, to the point where we forget that we know anything at all - or anything worth telling. (pp. 14-15)
The 'mask of motherhood' refers to the cultural invisibility of motherhood. Mothers are expected to cope, but how do they? They cope because of their relationships with their world, that is because of social support.

*Relationships associated with motherhood: Social support*

The experience of motherhood is constituted through relationship with one's own infant, partner and social network - in other words, motherhood is co-constituted. The environment in which mothers live affects them. Their interpersonal relationships, including with their infant, affects them personally. This leads me to discuss the relationships associated with motherhood. I believe it is social support which can overcome the negative aspects of motherhood, the hard work and social isolation - to result in mothers feeling satisfied with their lives.


Schaefer et al. (1981, cited in Oakley, 1992) distinguish between emotional, informational and instrumental forms of social connections:

*Emotional* support includes intimacy and attachment, reassurance, and being able to confide in and rely on another - all of which contribute to the feeling that one is loved or cared about, or even that one is a member of a group, not a stranger. *Tangible* support involves direct aid or services and can include loans, gifts of money or goods, and provision of services such as taking care of needy persons or doing a chore for them. *Informational* support includes giving information and
advice which could help a person solve a problem and providing feedback about how a person is doing. (p. 29)

Studies of social support during motherhood have found that partner's emotional support as well as tangible support have positive effects on women's well-being (Gjerdingen, Froberg & Fontaine, 1990). A mother's own mother's emotional and tangible support has also been proven beneficial (Everingham, 1994). Fathers, siblings, relatives, friends colleagues, neighbours and health care professionals also provide support. However, partners, close friends and relatives are indicated as being the main social network during pregnancy and childbirth (Tarkka & Paunonen, 1996).

Also Mauthner (1995) describes the role of social contacts between mothers experiencing postnatal depression. Her research suggests that mothers who are depressed feel that they have lost their personal voice as well as connection with others. Talking to other mothers about their feelings was seen to be the most important step towards moving out of depression.

I have previously discussed in Chapter 2 the benefits of 'new mothers' groups' which provide reassurance, advice, justification in terms of the needs of their infants, social interaction and friendships (Knapman, 1993). These venues provide an opportunity for mothers to discuss and confirm their maternal practices and judgements in a nonjudgemental environment, that is collaboratively (Everingham, 1994).

Social relationships however can also be unsupportive. Parks, Lenz and Jenkins (1992) describe that these negative effects result from demands on women's time as well as from unwanted advice, criticism and meddling, all of which can reduce the confidence of women. Everingham (1994) confirms this by discussing the negative effects on mothers of unsolicited advice.
Social relationships can influence women’s health both positively and negatively, however mothers need other forms of social support besides interpersonal relationships. I have discussed in Chapter 2 community sources of support. I have also discussed earlier in this chapter the cultural invisibility of mothers because of the ‘the mask of motherhood’. This ‘mask of motherhood’ is perpetuated by the media. The media as a conveyor of cultural values can also support mothers but this leads to my next question:

Does the media support mothers?

RE-IMAGING MOTHERHOOD

Motherhood in the media

The media provide images of the ideology of femininity. Winship (1978) asserts that women have become a capitalist commodity, a media product and the provider of the ideology of femininity. What the media portray are stereotypical images, for example exaggerated images of ‘superwoman’. The ‘superwoman’ images which have been circulating since the 1980’s are contradictory messages about women being able to combine professional careers and fulfil the myth of motherhood (Lafia, 1993).

In an Australian study by Martin (1991) of Aussie mums and television ads the messages identified were about motherhood and being female, the correct domestic relations and the division of labour in the home which favours men. These unrealistic stereotypes about motherhood are circulated by a male dominated media (Gough, 1996).

The problem is that there is little or no correspondence between the image of women in the media and women’s real life experiences. Also because images are stereotypical and women are represented as sex objects, research by Lanis and Covell (1995) has shown that men exposed to sex object advertising are accepting of rape.
Kaplan (1992) in *Motherhood and representation: The mother in popular culture and melodrama* analysed representations of the mother in popular culture from 1830 to the present time. Mother representations indicate; the too doting mother, the fusional mother-child bond and the concept of joyfulness. These representations depict an image of blissful motherhood.

These images become expectations for mothers to be loving towards their infant, bonded and happy in the process. The problem is that the images can become absorbed at an unconscious level and consumers, especially mothers themselves try to measure up to these unrealistic, unachievable ideals and can fail to achieve this kind of bliss. The reality of mothers’ lives, as I have discussed previously, is not bliss because many mothers experience postnatal depression, social isolation and exhaustion. These images are not depicted by the media. Therefore the media is perpetuating the ‘mask of motherhood’.

This reality has become a national issue and the then Ministry for the Status and Advancement of Women in 1994 in the *NSW government working for women* publication formulated a goal “Changing the portrayal of women” (p. 12). Through collaborative efforts with women, the government recognised that women wanted more realistic representations of their experiences in advertising, the arts and in sport. Aims included encouraging positive and diverse images of women in all government advertising. Many projects have occurred since this goal was formulated to change the portrayal of women in the media.

The reality is that media are still male dominated and are still portraying unrealistic, stereotypical images of motherhood. To answer the question, do the media support mothers? They do not because the current images depicted are unreal; they do not represent mothers’ realities.
The real experiences of motherhood elucidated by mothers themselves are negative. Do we want to portray negative images which will also have a detrimental effect on women because the media form public opinion and influences the way women see themselves? Do we want mothers to see themselves negatively? No. Re-imaging motherhood towards positive, realistic images and meanings is necessary to promote mothers’ health and well-being.

What this thesis is attempting to understand is the experience of well-being of new mothers. What is it? How do they achieve it? Phenomenology describes the nature of an experience (van Manen, 1990). It seeks to describe and understand the meanings individuals place on their every-day experiences (Cohen, 1987). I have stressed in the literature review my values in relation to people being-in-the-world which recognises the contextual influences on their health. Because of this world view, I adopt Heideggerian phenomenology as an appropriate methodology for this study because it is concerned with what it means to be a person as well as recognising the inseparable relationship of the person to their world (Leonard, 1989). This type of phenomenology transcends description to include interpretation of phenomena in social, cultural and historical contexts (Allen, Benner & Diekelmann, 1986).

Heideggerian phenomenology offers an appropriate methodology for this study into the well-being of new mothers. This chapter has outlined my post-structuralist feminist interpretation of motherhood which will be incorporated into this understanding of new mothers’ well-being.

CONCLUSION

Re-imaging motherhood is necessary in order to create positive, realistic images which will enhance mothers’ health and well-being. In this chapter, I analysed Erikson’s life span theory to provide a framework for understanding the developmental dilemmas that
mothers face and to point out how women's experiences have been neglected in his theory. I discussed Gilligan's model of moral development to provide a framework for understanding morals, gender and self in context. I critically analysed the ideology and discourses on motherhood and concluded that there exists a myth of motherhood which is perpetuated by the media. The research on motherhood from mothers' own perspectives indicates negative images of motherhood. I argued for the re-imaging of motherhood. I introduced Heideggerian phenomenology as an appropriate methodology for this study which will be informed by a post-structuralist feminist perspective.
CHAPTER 4: RESEARCH METHODOLOGY (1): PHENOMENOLOGY

GENERAL DESCRIPTION OF PHENOMENOLOGY

Phenomenology as a methodology focuses on describing the lived experiences of people, that is the everyday meanings of life in an everyday context (Davis, 1978; Oiler, 1982; Omery, 1983; Ray, 1990; van Manen, 1984, 1990; Wilkes, 1991). It aims to understand the nature or meanings which people ascribe to these experiences (Taylor, 1993). Omery (1983) emphasises that phenomenology includes the objective and subjective realms of experience for an understanding of this perspective to occur. Phenomenology seeks to understand the total meaning of people's lived experiences and is particularly relevant for contemporary nursing practice which reciprocally connects with people, living their own lived experiences, with a view to ultimately promoting and maintaining their well-being. Phenomenology as a type of qualitative methodology evolved as a reaction to the positivist ideals of science.

Positivism as described by Koch (1995) involves the notion of meaning being understood in terms of an independent reality. Positivists test theory by a process of deductive reasoning and study in controlled contexts (Allen, Benner & Diekelmann, 1986). Lincoln and Guba (1985) point out that positivists assume that the whole is simply the sum of its parts. Benner and Wrubel (1989) describe this as reductionism where the complex is understood basically by its components which are not related intrinsically to each other. This positivist paradigm is derived from the view of Descartes who argued that perception and subsequently knowledge was derived from the conception of the subject being in the world of objects (Magee, 1987).

Phenomenology challenges these positivist notions of objectivity and of part/whole relationships (Lincoln & Guba, 1985). Whereas positivists focus on the objective view,
phenomenologists focus on the subjective view (Davis, 1978). Omery (1983) asserts that phenomenologists focus on the total experience, that is both the objective and subjective views. What is studied in phenomenology are phenomena, the appearance of things from a subjective point of view (Cohen, 1987). Cohen (1987) distinguishes phenomenology from positivist ideals of science by asserting that study is initiated by going "to the things" themselves, that is phenomena, instead of theories.

Van Manen (1984) emphasises that phenomenology is the study of the lifeworld, the world as we immediately experience it rather than as we conceptualise, categorize, or theorize about it. By going to phenomena initially, instead of theories, phenomenology aims at describing and explicating the meaning structures of everyday life (van Manen, 1990). These meanings may be different to the way we conceptualise and theorize about them. The aim of phenomenology is to gain insight into these practical experiences. Van Manen (1984) states this poignantly:

> Phenomenology differs from almost every other science in that it attempts to gain insightful descriptions of the way we experience the world. So phenomenology does not offer us the possibility of effective theory with which we can now explain and/or control the world but rather it offers us the possibility of plausible insight which brings us more direct contact with the world. (pp. 37-38)

Phenomenology focuses on everyday practical experiences and this approach incorporates a relational view of people with their world. Allen, Benner and Diekelmann (1986) describe this as "pragmatic activity, that is everyday understanding and practices, and the study of relational issues, [which] are distinctly different from the study of objects, as in the natural sciences ... " (p. 28).

**Husserlian phenomenology**

The first of the two main phenomenological schools of thought, Husserlian phenomenology, is best described with reference to its core notions of 'intentionality' and 'bracketing'. Husserlian phenomenology firstly conceives the person
independently of the world and this is evident in its approach to research. This school of thought detaches the researcher's interpretive framework from the phenomena under study through 'bracketing'.

Husserl is known as the father of modern phenomenology (Leonard, 1989). Husserlian phenomenology as a descriptive phenomenology is concerned with epistemology, that is how people know things (Benner & Wrubel, 1989). Walters (1994) describes Husserlian phenomenology as "the culmination of the Cartesian tradition" (p. 136) where people's relationship to the world is thought of in terms of detached subjects knowing objects. Husserl conceived the term 'intentionality' for this conception of the mind as being directed towards things (Molina, 1969). Benner and Wrubel (1989) describe this approach as being a mental, cognitive representation view. Ihde (1974) points out that the Cartesian mind/body dichotomy is maintained in Husserlian phenomenology where the mind is viewed independently of the body. In addition, the Cartesian subject/object view of the person being independent of their world is also advocated (Benner, 1985; Hekman, 1986; Ihde, 1974; Koch, 1995).

Koch (1995) argues that this notion of an independent reality supports positivistic notions of objectification and detachment. From this point of view, reality is objectified as is the representation of phenomena in the mind in separation from the physical body. That is, it is treated as an objective conception that people can be independent of their world. Benner (1985) questions this view of reality as it fails to recognise the relational qualities of the person. Allen, Benner and Diekelmann (1986) describe relational qualities as those needed to recognise a person as a participant in cultural, social, and historical contexts. In Husserlian phenomenology, what is described are phenomena as they appear through consciousness (Thompson, 1990). Despite this Cartesian basis, Husserl was one of the first philosophers to study lived experiences.
Lived experiences refers to the experience of people in events, situations and circumstances (Parker, 1994). Husserlian phenomenology involves describing this lifeworld or this world of lived experiences to disclose intersubjective or common, shared meanings (Cohen, 1987). Thus, it aims to explicate the lived experience of these phenomena as they appear through consciousness. In order to achieve this, Husserl introduced the research procedure of ‘bracketing’ which he advocated as essential in the description of these lived experiences.

This procedure involves suspending judgement or “holding in abeyance one’s preconceptions” (Ray, 1994, p. 119) to allow a true form of the things to be understood. Oiler (1982) describes this as a process of the researcher holding at bay facts, knowledge and theory. Cohen (1987) points out that this involves describing a phenomenon without interpretation. The researcher demonstrates neutrality by not interpreting the researched phenomena. This was believed to result in an accurate portrayal of people’s reality (Koch, 1995; Swanson-Kaufmann & Schonwald, 1988). In Husserlian phenomenology, researchers bracket their preconceptions in order to reflect on described experiences and describe the essential structures of the experience being studied.

This approach, however, can be criticised as being reductionist as it attempts to separate the person from their world. Ideals of positivism are maintained with the focus on the subjective point of view. With Husserlian phenomenology, reality is perceived as being separate or independent of the person. This view fails to recognise interaction of the person with their world and promotes the positivist ideal of objectification as the person is viewed as being in a world of objects. Also it artificially detaches the researcher from the research through the process of ‘bracketing’. I believe that it is impossible to bracket my knowledge and experience of new mothers in order to study their well-being. My experiences and knowledge were the impetus for this study. My understandings were reflected upon to comprehend and explicate the findings of this
study. Contrary to the view of Husserlian phenomenology which advocates ‘bracketing’, I refute this notion as I am an integral part of this study.

**Heideggerian phenomenology**

Heidegger shifted phenomenological thinking from Husserl’s epistemological view to an ontological view. Whereas Husserl was interested in epistemology, that is how people know things, Heidegger was interested in the meaning of existence, that is what it means to be a person in historical, cultural and social contexts (Leonard, 1989). One of the core concepts this entails is ‘Dasein’.

Dreyfus (1991) describes ‘Dasein’ as a way of being which is characteristic of all people. Leonard (1989) presents the Heideggerian view of the person as having a world, as a being for whom things have significance and value, as self-interpreting, as embodied and as a person in time. The notions of the person as having a world and as being self-interpreting are of particular relevance to this study which focuses on women’s interpretations of their well-being in their everyday world of living.

Dreyfus (1991) describes Heidegger’s term ‘being-in-the-world’ as referring to the lived ‘Dasein’, that is ‘Dasein’ as it occurs in everyday life activities. Dreyfus (1987, cited in Koch, 1995) describes this as “from the beginning the person is amongst it all, being in it, coping with it” (p. 831) and should not be understood in subject/object terms. Leonard (1989) points out that this view advocates an inseparable relationship of the person to their world, a major contrast with the earlier Husserlian version of phenomenology.

Leonard (1989) defines the person-world relationship as: “world is the meaningful set of relationships, practices, and language that we have by virtue of being born into a culture” (p. 43). Leonard adds that this world is ‘a priori’, that is it is given in our
linguistic and cultural practices as well as in our history. Koch (1995) defines this notion of 'co-constitution' as referring to Heidegger's notion of the person and the world co-constituting each other. This philosophical assumption refers to the "indissoluble unity" (p. 831) of the person and world, meaning that we are constructed by the world and simultaneously we construct this world from our own background and experience.

Allen, Benner and Diekelmann (1986) succinctly state this Heideggerian view of the person as follows:

... to be human is to be-in-the-world, to participate in cultural, social, and historical contexts. This is a relational view of the person, and "human nature" is not considered fixed. The person is self-interpreting through and through, and these self interpretations are not individually generated, but are handed down in the language and cultural practices. (p. 28)

This indissoluble unity leads to an interpretive approach to phenomena, whereby phenomena are only ever viewed and understood as constructed socially. This is a major difference between Husserlian and Heideggerian approaches to phenomenology.

Benner and Wrubel (1989) point out that people's backgrounds provide them with cultural meanings which are incorporated into their lives from birth. Allen, Benner and Diekelmann (1986) further add that meaning is shared and passed on culturally through language, skills and practices. Heidegger (1962) coined the term 'the historicality of understanding' to denote the incorporation of pre-understandings (historical, cultural, social) of a person's background into an interpretation and understanding of their lived experiences. This understanding for Heidegger is derived from the 'hermeneutic circle':

This circle of understanding is not an orbit in which any random kind of knowledge may move; it is the expression of the existential fore-structure of Dasein itself. ... The 'circle' in understanding belongs to the structure of meaning, and the latter phenomenon is rooted in the existential constitution of Dasein - that is, in the understanding which interprets. (Heidegger, 1962, p. 195)
The ‘hermeneutic circle’ thus refers to the process where the whole is understood from its parts and the parts from the whole (Scheiermacher, 1977, cited in Reeder, 1988). This involves pre-understandings being used as a framework for further interpretation and understanding. Koch (1995) describes the process of reevaluating and modifying pre-understanding as a part of a ‘hermeneutic circle’. Gadamer, a pupil of Heidegger’s, developed his conception of this process to include prejudices being incorporated into understanding and the ‘hermeneutic circle’.

Gadamer introduced the term ‘effective historical consciousness’ to denote an awareness by people of prejudices ruling their own understanding. When one’s horizon, that is one’s point of view is used to understand another’s point of view or horizon, the horizon’s are said to ‘fuse’. The act of ‘fusion of horizons’, that is the fusion of the two horizons is an act of understanding (Gadamer, 1975).

Heideggerian phenomenology as an ontology transcends description to include interpretation of phenomena in historical, cultural and social contexts. It involves incorporating an interpretation of ‘being-in-the-world’, ‘co-constitution’, the ‘hermeneutic circle’, and the ‘fusion of horizons’ in order to understand people’s experiences. It does this through language, by hermeneutics.

**Hermeneutics**

Hermeneutics comes from the Greek word "hermeneia" which consists of three directions of meaning: to express/expression, to interpret/interpretation as well as to translate/translation (Reeder, 1988). The writings of both Heidegger (1962) and his pupil Gadamer (1975) describe hermeneutics as an interpretation of Being, an understanding of Being through language. Hermeneutics is further explicated in chapter five.
Justification for hermeneutic study of new mothers’ well-being

Heideggerian phenomenology, as an ontology, is concerned with what it means to be a person, as well as recognising the inseparable relationship of the person with their world (Leonard, 1989). This type of phenomenology transcends description to include interpretation of phenomena in social, cultural and historical contexts (Allen, Benner & Diekelmann, 1986). Heideggerian phenomenology offers an appropriate methodology to transcend current notions of health to incorporate the notion of well-being of new mothers. This understanding will be derived through language, by hermeneutics. Hermeneutics is language that will express, interpret and translate meanings about new mothers’ well-being.

As the main aim of this thesis is to understand the well-being of new mothers, I searched the phenomenological literature for studies on health and motherhood. Since I was also interested in knowing what nurses can do for new mothers, I reviewed phenomenological research about nursing.

RELEVANT PHENOMENOLOGICAL RESEARCH

Phenomenological descriptions of health

Parse (1987) argues that health which is central to nursing practice can only be known through personal description. I was interested in understanding about the experience of health or well-being of new mothers’ and since phenomenology purports to include objective and subjective realms of experience I reviewed a number of studies to elicit meanings of health.

Parse, Coyne and Smith (1985) in their study The Lived Experience of Health used a Husserlian phenomenological approach, known as van Kaarn’s method (1969, cited in Parse et al., 1985) to evolve through description (descriptive expressions, common elements) the structural definition of the lived experience of health. For the 400
subjects in the study between the ages of seven and sixty five, the structural definition of the lived experience of health was “harmony sparked by energy leading to plentitude”(p. 34). The results of this study identified many concepts of health which have also been identified in other studies. Consequently some space below is devoted to discussing the results and other phenomenological studies supporting their results.

**Harmony**

In the Parse et al. (1985) study, ‘harmony’ meant ‘resonating clarity’ (feeling happy, relaxed, being with others), ‘symphonic integrity’ (feeling of worth, loved, at peace), ‘serene unity’ (feeling at peace), and ‘synchronous contemplation’ (having good health, feeling at peace with decisions).

This concept was described in Payne’s (1986) study of the lived experience of health which identified ‘health as spatial harmony’ (feeling harmony, balance and control interacting with the environment) as well as ‘health as a sense of unity’ (feeling whole and relating to the world).

This concept was also described in Rose’s (1990) study of the psychological health of women as ‘centering’ (focusing and balancing between outside and the inner self), ‘quiescing’ (becoming, seeking and being calm and at rest), ‘apprehending intrication’ (knowing, seeing and understanding complexity) and ‘introspecting’ (having an inner awareness of psychological processes). The concept also includes ‘interrelating’ (having mutual, intimate, reciprocal and open relationships), ‘having capacity’ (having the ability to heal, problem solve, be present, to face pain and to recognise when one does not have capacity), as well as ‘embracing vulnerability’ (process of accepting, acknowledging and integrating imperfections as valid parts of self).
Furthermore, this concept of harmony was described by Beck (1991) as ‘peaceful contentedness’ (feeling a sense of satisfaction with life in relation to self, family and friends) and is also evident in Hanna’s (1989) structural definition of the health of graduate nursing students which included the concepts of happiness, contentment and clarity of thinking. The second concept, in addition to ‘harmony’ identified by Parse et al. (1985) was ‘energy’.

Energy

In the Parse et al. (1985) study, ‘energy’ meant ‘invigorating force’ (feeling alive, feeling good after exercise), ‘spirited intensity’ (being enthusiastic and energetic), ‘exhilarated potency’ (feeling great, alert, enjoying, participating, having energy), and ‘transcendent vitality’ (feeling alive, vibrant, active, euphoric).

This concept was discussed in Payne’s (1986) study as ‘health as a possession in time’ (personally controlling lifestyle to promote health) and ‘health as body congruity’ (feeling in tune with one’s body). Also, this concept relates to Rose’s (1990) concept of ‘using humor’ (having the ability to laugh to release energy, to distance self to keep focussed, to feel light, to freshen the perspective and to see both sides or the paradox of life). The concept of energy correlates with Beck’s (1991) theme of ‘perpetual vigilance’ (striving to achieve a positive lifestyle physically and mentally). This concept is also found in Hanna’s (1989) structural definition of health “health is an awareness of a physical state related to abilities, appearance, and energy level as well as a mental state of happiness/contentment, anticipation/excitement, and clarity of thinking”(p. 375). In addition to ‘harmony’ and ‘energy’, Parse et al. (1985) identified ‘plentitude’ as the third concept of health.
Plentitude

In the Parse et al. (1985) study, ‘plentitude’ meant ‘constructing successfullness’ (feeling creative and productive, accomplishing), ‘fulfilling inventiveness’ (accomplishing), ‘creating triumphs’ (accomplishing) and ‘generating completeness’ (accomplishing, participating, being able).

This concept is similar to Payne’s (1986) concept of health as ‘belonging to life’, ‘becoming’ and ‘transcendence’. Health as ‘belonging to life’ meant having energy to participate in life. Health as a sense of ‘becoming’ meant achieving goals and developing personal potential. Health as ‘transcendence’ meant the dynamic interplay of experience which involved facing reality, anticipating as well as being hopeful.

Also, this concept was described by Rose (1990) as ‘quintessencing’ which referred to the process of becoming and being the most perfect embodiment of self. Recognizing, becoming, accepting as well as being were identified as subcategories of this theme. Furthermore, this concept relates to Beck’s (1991) concept of ‘optimum unfolding’ which meant experiencing the highest levels of functioning.

These Husserlian phenomenological studies describe health as being a state, a goal, as well as an equilibrium. These studies are meaningful for nursing as they provide new conceptualisations of health which have been advocated by nurses (Payne, 1983; Meleis, 1990; Pender, 1990). Unfortunately, Husserlian phenomenology as an epistemology views reality as being independent of the person (Koch, 1995). The previous discussion of Husserlian phenomenological studies (Beck, 1991; Hanna, 1989; Parse et al., 1985; Payne, 1986; Rose, 1990) have therefore not considered the context of health, nor the resources required. This view is the antithesis of the nursing holistic notion of the person interacting with the environment, the philosophy of primary health care as well as health promotion strategies which recognise the significance of social, cultural, political as well as environmental determinants of health.
Also, because these studies are Husserlian phenomenological studies which advocate ‘bracketing’, the researcher’s interpretive framework (that is the conceptual leanings and the interpretive background of the researcher) has not been included. Therefore, they have not incorporated the notions of the ‘hermeneutic circle’ and the ‘fusion of horizons’ for understanding the lived experience of health.

As the goal of nursing is the promotion of health, contextual needs must be made explicit to ensure health. Benner and Wrubel (1989) define well-being “as congruence between one’s possibilities and one’s actual practices and lived meanings and is based on caring and being cared for” (p. 160). There is a need to explore further this notion of health, the lived experience of well-being, particularly the experience of well-being of new mothers.

**Phenomenological research on motherhood**

Bergum (1989) states: “by gathering the fragments and threads from the stories of women it may be possible to weave a fabric that displays the transformation of women who become mothers” (p. 17). She utilised van Manen’s (1984) and Gadamer’s (1975) hermeneutic approach to provide a description and interpretation of the transformation of women to mothers. She coined the term “thematic moments” to highlight certain aspects of their stories. Bergum explicates a number of transformative experiences which I have previously outlined in Chapter 3. Of particular significance to this study are the themes of ‘taking responsibility’ and ‘the giving body’. Bergum’s study is particularly relevant to this study as it explores the transformation of woman to mother. Another area of phenomenological research I explored concerned nursing.
Phenomenological research on nursing

Riemen's (1986) Husserlian phenomenological study investigated the essential structure of a caring nurse-client interaction. Colaizzi's phenomenological analysis (1978, cited in Riemen, 1986) was utilised to describe the essential structure of the phenomena of a caring nurse-client relationship. Both caring and non-caring interactions were analysed to explicate meanings of the clients' descriptions. The total of the meanings were clustered to represent themes common to the subjects' descriptions. The Riemen (1986) exhaustive description of a caring nurse-client interaction was summarised as follows:

In a caring interaction, the nurse's existential presence is perceived by the client as more than just a physical presence. There is an aspect of the nurse giving of oneself to the client. This giving of oneself may be in response to the clients' request but it is more often a voluntary effort and is unsolicited by the client. The nurse's willingness to give of oneself is primarily perceived by the client as an attitude and behavior of sitting down and really listening and responding to the unique concerns of the individual as a person of value. The relaxation, comfort, security that the client experiences both physically and mentally is immediate and direct result of the client's stated and unstated needs being heard and responded to by the nurse. (p. 101)

This study highlights that a caring nurse/client relationship involves the nurse listening to the client and responding to their needs. Taylor's phenomenological study (1991, cited in Taylor, 1994) emphasises that there are other aspects of nursing apart from just listening and responding to client's needs. Taylor studied the concept of ordinariness in nursing framed within the phenomenological concepts of 'lived experience', 'Dasein', 'being-in-the-world' and 'fusion of horizons'. Hermeneutic analysis of interviews and observation revealed evolved activities and qualities indicating aspects of the ordinariness in nursing. These included; facilitating coping, facilitating learning, facilitating independence, appreciating skilful nursing care, appreciating helping and many more (Taylor, 1994).

My discussion of phenomenological studies on health has highlighted that they are Husserlian in nature and therefore do not include the Heideggerian ideas of 'being-in-the-world', 'co-constitution', the 'hermeneutic circle' nor the Gadamerian idea of the
‘fusion of horizons’. Bergum’s (1989) study is particularly relevant to this study because it is about the transformation of woman to mother and, because it is a Heideggerian study, interpretation has been incorporated into understanding this transformation of woman to mother. Also, Taylor’s study (1991, cited in Taylor, 1994) has congruent Heideggerian concepts to this study and can therefore be utilised to explore what we [as nurses] can do for new mothers.

CONCLUSION

In this chapter I described the historical evolution from Husserlian to Heideggerian phenomenology to highlight the transformation in phenomenological thought from being purely descriptive to being interpretive. I discussed the Heideggerian ideas of ‘being-in-the-world, ‘co-constitution’, the ‘hermeneutic circle’ and the Gadamerian idea of ‘fusion of horizons’ to emphasise that interpretation includes incorporating historical, cultural and social contexts in order to understand the lived experiences of people. I justified my choice of a hermeneutic approach for this study because hermeneutics is interpretive and considers historical, cultural and social contexts in order to understand new mothers’ well-being. I reviewed relevant phenomenological studies on health, motherhood and nursing and concluded that descriptions of health, because they have been derived from Husserlian approaches, are descriptive in nature and have not included interpretation nor the context of people’s lives.
CHAPTER 5: RESEARCH METHODOLOGY (2):
HERMENEUTICS AS DANCE

INTRODUCTION

My identities as a nurse, dancer and feminist have all informed the research process of this study. From my initial contact with the new mothers, I interpreted hermeneutics as dance. The following discussion will explain my metaphor ‘hermeneutics as dance’ by answering the following two questions:

1. Why have I created the metaphor?
2. What are the benefits of applying the metaphor to nursing research?

Rose: My being-in-the world

My being-in-the world involves, amongst other things, being a nurse, a dancer and a feminist. The understandings derived from these experiences are inextricably linked with the way I am and how I live. When people ask me what I am, depending on the context, there are times I reply, I’m a nurse, and other times, I’m a dancer. As the researcher in this study, my history affects the lens with which I view the research process and its interpretation.

I began nursing in 1978. I have been a certified midwife, community nurse, youth health nurse, women’s health nurse practitioner, nurse academic and research assistant. These roles have developed my nursing practice and research, a feminist way of being as well as my commitment to social justice.

I began dancing when I was four years of age. I have experienced diverse forms of dance. I was classically trained in ballet (Royal Academy of Dance) for 14 years. This
training also included modern, jazz and character (cultural) forms of dance. More recently, my dancing and creativity has been rejuvenated by contemporary forms of dance, Aboriginal dance, African dance and Belly Dancing.

My dancing is evolving along with my nursing. I have linked the two seemingly different domains of hermeneutics and dance by creating the metaphor ‘hermeneutics as dance’. To understand this metaphor it is initially necessary to have some knowledge of both domains.

**HERMENEUTICS**

The philosophy of hermeneutics used in this study is founded on Heideggerian phenomenology. I have already described phenomenology and its historical evolution from Husserlian phenomenology to Heideggerian phenomenology in the previous chapter. To refocus: Heideggerian phenomenology is an ontology concerned with what it means to be a person. “For Heidegger, hermeneutics begins at home in which an interpretation of the structure of everydayness in which *Dasein* dwells” (Dreyfus, 1991, p. 34). This type of phenomenology transcends description to include interpretation of phenomena in social, cultural and historical contexts (Allen, Benner & Diekelmann, 1986). The writings of both Heidegger (1962) and his pupil Gadamer (1975) describe hermeneutics as an interpretation of Being, an understanding of Being through language.

Hermeneutics is language that expresses, interprets and translates people’s meanings about being-in-the-world. It does this by systematically interpreting text:

> The hermeneutic method aims at a progressive uncovering and explication of the researcher’s practical understanding of what is being studied. This in turn involves becoming more aware of some of the interests, habits and practices that form the background against which the phenomena appear and take form.

(Packer, 1985, p. 1089)
For van Manen (1984), phenomenological research is the attentive practice of thoughtfulness described as “a minding, a heeding, a caring attunement - a heedful, mindful wondering about the project of life, of living, of what it means to live a life” (p. 38).

Themes are the essence or the structure of the lived experience:

Themes are the stars that make up the universe of meaning we live through. By the light of these themes we can navigate and explore such universes. (van Manen, 1990, p. 90)

Hermeneutics involves discovery of these themes, which represent the structure of the lived experience. Van Manen (1990) suggests that “theme analysis refers ... to the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the work” (p. 78).

Hermeneutic analysis involves the interpreter’s interaction with the text. This analysis also involves the ‘hermeneutic circle’ (Heidegger, 1962). Hermeneutic analysis “consists of circular and spiral relationships between whole and parts, between what is known and what is unknown, between the phenomenon itself and its wider context, between the knower and that which is known” (Reason & Rowan, 1981, p. 135). In hermeneutics, not only is the person perceived as having a world but the researcher also has a world which is integrated into the research process to understand a lived experience.

Gadamer coined the term ‘effective historical consciousness’ to denote an awareness by people of prejudices, that is of pre-conceptions or pre-understandings ruling one’s own understanding. Gadamer asserts the structural elements of this ‘effective history’ includes: an awareness of one’s hermeneutic situation and horizon; the dialogical relationship between interpreter and text; the dialectic between question and answer and openness for tradition. An awareness of one’s hermeneutic horizon includes an
awareness of one’s prejudices. A dialogical relationship between interpreter and text involves keeping the dialogue open between the interpreter and text through the dialectic of question and answer which incorporates the ‘hermeneutic circle’. This relationship involves the interpreter interpreting, questioning and conversing with the text. An openness for tradition considers the historicality of understanding, when the interpreter’s historical and ideological views are relaxed whilst interpreting the historical and cultural horizon’s of participant’s or the object under study. Gadamer refers to widening one’s own horizon so that it can integrate the other’s horizon. Thus, an awareness of prejudices, the dialogue of question and answer and the ‘hermeneutic circle’ results in the fusion of horizons, that is in understanding (Gadamer, 1975).

Allen and Jensen (1990) describe interpretation and understanding as being in a dialectic, interactional relationship with one another. Consequently, historical, cultural and social pre-understandings are incorporated into an understanding of lived experience. Koch (1995) describes the process of reevaluating and modifying pre-understanding as a part of the ‘hermeneutic circle’.

In hermeneutics, the researcher is the instrument for the research process. The researcher interacts with the researched and their words by incorporating and modifying pre-understandings to result in understanding lived experiences.

Van Manen (1990) gives the most complete description of an approach for phenomenological research. He describes it as the dynamic interplay between the following six activities:

(1) turning to a phenomenon which seriously interests us and commits us to the world;
(2) investigating experience as we live it rather than as we conceptualise it;
(3) reflecting on the essential themes which characterise the phenomenon;
(4) describing the phenomenon through the art of writing and rewriting;
(5) maintaining a strong and orientated pedagogical relation to the phenomenon;
(6) balancing the research context by considering parts and whole. (pp. 30-31)
What, then is the relationship between hermeneutics and dance?

HERMENEUTICS AS DANCE

Dance is a language which aims to express, interpret and describe symbolic meanings people have about being-in-the-world (Hawkins, 1964). Dance is also a form of art. Art has a variety of meanings. Art is beauty. Art is intuition, a vision or imagination. Art is expression, an image, a form. Art is also a form of communication, a language (Ellfeldt, 1976). Moreover, art is an experience, as meaning is derived from the relationship between people’s actions and the consequences of them (Dewey, 1959).

I discovered, from my immediate contact with the new mothers, ‘hermeneutics as dance’. I felt at a gut level that my involvement, my interaction with them, as well as my interpretation of their meanings of well-being, was a dance. I turned to the literature to reinforce the validity of my thinking. In particular, I searched for academic validity and I encountered the work of Janesick (1994) whose way of thinking was similar to mine.

Janesick (1994), a dancer (modern dance techniques), choreographer, ethnographic researcher and academic, relates the Deweyan sense of art as experience to dance by creating the inspiring metaphor: ‘The Dance of Qualitative Research Design’. Janesick selected the metaphor because of her devotion to dance which is about lived experiences and because of the inherent power of the metaphor achieved by the artistic use of language.

Janesick (1994) describes qualitative research design as choreography: “Just as the dancer begins with a warm-up of the body, follows through with floor exercises, and then moves to a cool-down period, I like to think of qualitative design as consisting of three stages” (p. 211). The first, the warm up stage refers to beginning decisions which
are made prior to entering the field. The second, refers to the total workout stage which involves decisions in relation to pilot study, participant, researcher and time issues. The third, cool down stage, refers to decisions which are made at the end of the study, that is after leaving the field. This involves data analysis by a process of constant comparative analysis to develop categories which are then incorporated into a model to explain behaviour. Theoretical interpretation is perceived as being integral to this process.

There are some problems with Janesick’s metaphor. I feel ambivalent about her interpretation of the first warm up stage which she describes as a preparatory stage. In this study I perceived the warm up stage to be the prelude to my conversations with the new mothers when social introductions warmed us up, that is, opened us up to our conversations. I agree that the researcher warms up by making decisions prior to entering the field. However, from my understanding derived from doing this thesis, the literature review can in fact be a workout along with the data analysis. I therefore do not agree with her cool down stage. In this study, I felt the cool down stage was after I had finished my conversations with the new mothers and we were able to chat. Although there are some problems with Janesick’s metaphor, the power of her metaphor is its creative ability to describe qualitative research design as a choreography. What it also emphasises is that the purpose of qualitative research as the choreography is to communicate people’s meanings about being-in-the-world.

Dance is a creative art experience. The choreography of the dance expresses the intent of the dance, that is its purpose. The choreographer uses imagination to act as a creative instrument of discovery by illuminating or imaging symbolic meanings. Therefore, in dance, the choreographer is the instrument for the process of dance. Movements are artfully related and integrated to result in organisation and unity of the dance composition (H’Doubler, 1940). The choreographer interacts with the dancers as well as the dance composition by using imagination for creativity and discovery of lived experiences. The dance as a language describes meanings people have being-in-the-
world. Dance, like hermeneutics, communicates people’s meanings about being-in-the-world.

In addition to seeking academic justification of my metaphor, I analysed hermeneutics and dance and found the following similarities or relationships between the two domains.

**Table 2: Hermeneutics as dance**

<table>
<thead>
<tr>
<th>Hermeneutics</th>
<th>Dance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Language:</strong> to express, interpret and translate people’s meanings being-in-the-world.</td>
<td><strong>Language:</strong> to describe and interpret symbolic meanings people have being-in-the-world</td>
</tr>
<tr>
<td><strong>Hermeneutics is a creative experience:</strong></td>
<td><strong>Dance is a creative art experience:</strong></td>
</tr>
<tr>
<td><em>The researcher is the instrument for the research process.</em></td>
<td><em>The choreographer is the instrument for the research process.</em></td>
</tr>
<tr>
<td><em>The researcher interacts with the researched and their words using creative thought for discovery of lived experiences.</em></td>
<td><em>The choreographer interacts with the dancers and the dance using imagination (imagery), creativity, for discovery of lived experiences.</em></td>
</tr>
<tr>
<td><strong>Creative Process:</strong> (van Manen, 1990)</td>
<td><strong>Creative Process:</strong> (Blom &amp; Chaplin, 1988)</td>
</tr>
<tr>
<td>1. Turning to a phenomenon which interests us.</td>
<td>1. <strong>Preparation:</strong> ?/ aim / purpose / background understanding</td>
</tr>
<tr>
<td>2. Investigating lived experience</td>
<td>2. <strong>Exploration:</strong> Examining concepts, ideas</td>
</tr>
<tr>
<td>3. Reflecting on the essential themes which characterise the phenomena</td>
<td>3. <strong>Illumination:</strong> Imaging, images created</td>
</tr>
<tr>
<td>4. Describing the phenomenon through the art of writing and rewriting</td>
<td>4. <strong>Formation:</strong> Choreography</td>
</tr>
</tbody>
</table>

I have embraced the metaphor ‘hermeneutics as dance’ because hermeneutics like dance is a creative experience. Hermeneutics, like dance, has the same purpose which is to discover and communicate lived experiences. Hermenutical research like dance involves creativity. The hermeneutic researcher is like the creative choreographer who aims to communicate lived experiences.
The choreographer, like the researcher, is the creative instrument for discovery of people's lived experience. Just like the choreographer who interacts with the dancers and the dance using their imagination, the hermeneutical researcher interacts with the researched and their dialogue using their creative thought.

Just like the choreographer who prepares, explores, illuminates, forms and projects images of symbolic meanings, the researcher in hermeneutics undergoes the same process. First, there is the preparation stage in which the researcher initially poses a question to frame the purpose of the research. Second, there is the exploration stage which refers to the process of examining concepts and ideas. Third, is the illumination stage in which images are articulated. Fourth, is the formation stage of a dialogue, that is "a literary genre in which 'characters' discuss a subject at length" (Cuddon, 1982, p. 186).

Preparation

Preparation includes developing an aim for the study. The researcher asks a question or a number of questions to provide a purpose or an intent for the study. This forms foundation for discovery, analysis and synthesis. The aim of this study is to explore and discover new mothers' well-being by defining, describing and identifying practices which create their well-being.

Preparation also involves the researcher having some background understanding. I prepared for this study by researching relevant literature and research. This literature review has been incorporated into this thesis.

This literature review also involved knowing about the environment, the context of the new mothers who lived in the Blue Mountains area. This area is known for its national heritage status, Australia's highest bushfire risk and its climate being one of the coldest
and wettest in N.S.W. There is enormous geographic diversity with highly urbanised as well as isolated rural communities. There is a high rate of population growth because of the combination of the suburban spread westward from Sydney and the influx of families into newly released housing areas. There are also compounding problems of isolation due to the lack of transport and access to services (Blue Mountains City Council, 1994; Wentworth Area Health Service, 1994).

There is one local hospital, Blue Mountains District Anzac Memorial Hospital which provides maternity services, and another smaller hospital, Springwood Hospital which provides postnatal care. The Domiciliary Midwife Program is offered from the main hospital for a period from postnatal day one to day seven. There are community nursing services based at the two Community Health Centre’s in the area which offer early childhood services and support to women. This service includes Family Care Nurses, Lactation Consultants and allied health services. Postnatal depression support groups are offered in this area, however women need to travel to the regional centre to receive Tresillian family care support.

This knowledge of the services offered in the area highlights the support available to women through the area’s health services. However, residents rely on regional services for birth and family problems. There is, therefore, a lack of comprehensive services provided at the local level which is exacerbated by the environmental influences previously discussed.

Preparation also involves the researcher gaining access to participants who fit a set of selection criteria. Approval for this study was granted by the Human Ethics Review Committee of the University of Western Sydney Nepean. The criteria for inclusion in this study were for mothers to be new mothers and able to speak English.
There were eight participants. The first mother was referred to me from an independent Homebirth Midwife, and the remaining seven came from a 'new mothers' group' at one of the community health centres in the Blue Mountains area. Interestingly, all the new mothers in the group wanted to participate, so I included them irrespective of their baby's age. However, to keep the sample homogenous, one woman was not included as she had returned to work.

Preparation, also involves the researcher gaining informed consent from participants. The new mothers were invited to participate after a verbal and written explanation (Appendix A: INFORMATION/CONSENT FORM) of the purpose of the study, the procedure and ethical considerations.

**Exploration**

Exploration refers to the researcher exploring concepts and ideas relating to the aim of the study. As the researcher I explored the lived experience of new mothers’ well-being through conversation. As a feminist I prefer to use the term conversation rather than the term interview which Oakley (1981) and Reinharz (1983) assert conjures up images of a hierarchical, exploitative relationship. I respected the new mothers in this study by considering them to be the experts. Since all the new mothers invited me into their homes for the conversation to occur, I also respected the idea that I was a guest in their home.

The conversation with each new mother consisted of a number of phases. Initially the warm up phase involved a social introduction by sharing food and drink. During this time I would describe why I was doing the study, the procedure and ethical considerations. I then gained written consent from them.
The second phase involved me gaining some background information regarding the mother. This was achieved by discussing her age, career, partner, social context and review of her pregnancy, labour, delivery, and postnatal period. I took notes during this phase. During this time we tried to create an environment conducive to conversation. The conversations occurred primarily in the lounge or kitchen. We were usually seated comfortably on chairs or a lounge or on the floor.

The third phase was the recording of the conversation. This was opened by me saying “Can you tell me about your experiences of well-being?”. I would offer my personal notion of well-being for clarification if requested. I described it as “a positive notion of health, health not only being the physical, but also the mental, the social, the emotional, looking at it from a whole perspective”. During the conversation, the mother would describe what well-being meant for her as well as her practices she created for her own well-being. Consequently, she identified essential needs for her own well-being. These identified needs I compiled by taking notes during the conversation.

The fourth phase refers to the conclusion of the conversation when I presented to her her own individual definition of well-being which we had evolved and compiled through our conversation. In the fifth and final phase, we cooled down from the experience of the conversation by sharing food and drink again, walking around her house and garden and generally chatting.

Because thoughtfulness is integral to an understanding of a lived experience, I reflected on the experience of the conversation and in particular the mothers’ spoken words. I listened to the taped conversation twice prior to transcription. At this time, I jotted down words or phrases that stood out for me. Their words were then transcribed into text.
Illumination

Illumination refers to the researcher imaging symbolic meanings. I illuminated meanings by entering into a dialogue with the text and seeking themes. ‘Patterns of meaning’ were derived from conversations with the eight new mothers. I ceased conversations at the eighth new mother because I felt that there were no new ‘patterns of meaning’ being revealed.

A verbatim transcript of each conversation was typed using a computer. The first five were typed on my behalf and the last three I typed myself. I valued the experience of transcribing as I could hear the new mothers’ words when writing and analysing. Even though I did not transcribe all of the transcripts myself, analysis has involved thorough interpretation in which I have had to reheat, reread, reflect and interpret the women’s words. I therefore feel that there is no difference in my depth of understanding between the transcripts.

As well as the transcript I had written background information on each mother which was obtained prior to the recording of the conversation with her. This information provided a history of her pregnancy, birth and postnatal period. This history was essential to understand the new mothers present experiences. The following, for example is Lisa’s background information.

Lisa was 25 years of age; her partner Matthew, a carpenter, was 27 years old. Lisa worked in a bank and left when she was six months pregnant. They moved to their new house in the Blue Mountains one week prior to the birth. The birth was a planned homebirth, however Lisa was transferred to the regional hospital for failure to progress during labour. Lisa “sobbed” as a result of this transfer. Hospital meant drips, monitors and an epidural anaesthetic. Brendan’s birthweight was 8lb 1oz and he was 51cms long. Whilst in hospital Lisa felt she was overtly discriminated against because she had decided to birth outside the system. This was perceived whilst in the postnatal ward because she was not seen by a midwife and her baby was not checked by a paediatrician. She felt “disappointed”. Brendan was nine weeks old when Lisa and I had our conversation.

This history informed my understanding of Lisa’s well-being by emphasising the fact that because she chose to give birth outside the system, she felt that she was
discriminated against and disadvantaged by lack of support services postnatally. A summary of all the new mothers background information is provided in Appendix B.

I analysed each transcript separately. I made notes of my thoughts in the margin of the text. Initially, I performed a detailed line by line analysis of the transcripts searching for themes, visualising the text like a stage. I found that particular descriptive expressions were highlighted, that is certain words and phrases stood out for me just like a spotlight captures dance images on stage. To illustrate this process I will provide an example of how the catchphrase “sussing out” was derived from the following excerpt.

Probably because now I’m sussing out like what a particular cry is, when you first had him, it was like if he cried he was hungry, and I would just put him on the boob and that pacified him whether he was hungry or not, just breastfeeding them will calm them down you know, but now I know like that’s a tired cry.

In order to provide a conceptual framework to describe the new mothers’ well-being, commonalities in their personal meanings were formed into a structure, what I call a pattern of meaning. I composed a table to summarise the ‘personal meanings’ derived for each new mother. Table 3, beginning on the following page is the summary of my conversation with Lisa. The header is Lisa’s definition of well-being which concluded my conversation with her. The first column represents the catch phrases of significant descriptive expressions. The second column refers to her ‘personal meaning’ derived. The third column refers to my interpretation.

When I had made a summary of each conversation, I sought commonalities in meanings and practices. I cut and pasted using a card system as well as my computer. I then compiled a table to represent the common patterns of meaning. This process involved ongoing hermeneutic analysis by continual, never ending literature review, reflection, analysis, writing and rewriting. There were three patterns of meaning identified, these
being; ‘adapting personal expectations’, ‘adapting to societal expectations’ and ‘being supported’, which will be discussed in the next chapter.

Table 3: Summary of Lisa’s conversation

<table>
<thead>
<tr>
<th>CATCH PHRASES</th>
<th>PERSONAL MEANING</th>
<th>INTERPRETATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I am doing well”</td>
<td>Achieving in relation to baby tasks as well as household tasks</td>
<td>Personal expectations - ability to achieve baby tasks as well as household tasks/being capable</td>
</tr>
<tr>
<td>“getting things done”</td>
<td>Work signs</td>
<td>Household tasks - sign of productivity/hard work</td>
</tr>
<tr>
<td>“it's like nonstop, you never seem to get everything done”</td>
<td>Being organised</td>
<td>Infant care - nothing to show for work</td>
</tr>
<tr>
<td>“I don't have anything to show for it”</td>
<td>DIFFICULTIES</td>
<td>Being able to get out - doing well, achieving.</td>
</tr>
<tr>
<td>“you have to be organised”</td>
<td>Boredom with baby</td>
<td>Infant’s development increases satisfaction with time spent with baby</td>
</tr>
<tr>
<td>“there is not a lot I can do with him ... I can talk to him ... give him massage ... you can't do that all day”</td>
<td>Feeling tired</td>
<td>Being tired because of work of mothering.</td>
</tr>
<tr>
<td>“I just don't want to get out of bed”</td>
<td>Crying baby</td>
<td>Baby crying prevents getting things done</td>
</tr>
<tr>
<td>“the baby crying nonstop”</td>
<td>Visitors</td>
<td>Need to know how to settle baby &amp; cope with crying baby.</td>
</tr>
<tr>
<td>“I think you feel you have to entertain them”</td>
<td>Visitors</td>
<td>Visitors hindrance to getting things done</td>
</tr>
<tr>
<td>“sussing out”, “time on our own”</td>
<td>Knowing how to mother</td>
<td>Learning/adjusting in order to fulfill baby’s needs</td>
</tr>
<tr>
<td>“you want to learn to cope on your own”</td>
<td></td>
<td>Need secluded time with baby in order to learn mothering and develop relationship with baby.</td>
</tr>
<tr>
<td>“you are learning and adjusting to how and what your baby wants and how to give him that”</td>
<td>Maintaining appearances</td>
<td>Learn to cope on your own</td>
</tr>
<tr>
<td>“I feel healthy, I have lost all my weight”, “if my hair feels good I feel good”, “makes you look like you are coping”, “looking good”</td>
<td>Difficult to have time for self</td>
<td>Weight and personal appearance boosts self image confidence, and external affirmations of coping</td>
</tr>
<tr>
<td>“it is hard to even have a bloody shower”</td>
<td></td>
<td>Need time for self</td>
</tr>
<tr>
<td>‘its ok to ask for help*</td>
<td>Support-seeking</td>
<td>Need to ask for help</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>‘they go on about it’, “you want to learn to do it on your own”, “I am ashamed of it”</td>
<td>Having support from partner, mum, mother in law, Sr, family, friends,</td>
<td>Feel ashamed if seek help reluctant to seek help-desire to cope</td>
</tr>
<tr>
<td>‘my family are quite supportive’</td>
<td>Support of community nurses</td>
<td>Support from family</td>
</tr>
<tr>
<td>“I chose to go outside the system” [homebirth] “They [community nurses] should make the first move to me ...we are here to help not for me to have to go in and say I need help”</td>
<td>Support of new mothers</td>
<td>Community nurses need to introduce themselves and offer support to all mothers irrespective of birthplace</td>
</tr>
<tr>
<td>“kinship”, “we are first time mothers we are doing it together” “no-one was trying to give each other a hard time”, “help each other out”</td>
<td></td>
<td>New mothers not intimidating, equal, same experiences</td>
</tr>
<tr>
<td>“you feel you should cope”</td>
<td>Coping</td>
<td>Disappointed and frustrated if not coping</td>
</tr>
<tr>
<td>“you do cope but then you have days when you feel you don’t”,</td>
<td>Coping strategies</td>
<td>Resort to cigarettes/alcohol to calm down in order to cope</td>
</tr>
<tr>
<td>“I feel a bit disappointed”, “it is just so bloody frustrating”</td>
<td>Go out</td>
<td>Escape from house - space</td>
</tr>
<tr>
<td>“I feel like I want to have a cigarette ... I have a glass of wine”</td>
<td>Rest</td>
<td>Access support, someone else to cope</td>
</tr>
<tr>
<td>“getting out of this house ... where he screams”, “someone else there to cope”</td>
<td>Compares self to others</td>
<td>Need to rest</td>
</tr>
<tr>
<td>“manage to get by with rest”</td>
<td></td>
<td>Rationalises experience by comparing to others</td>
</tr>
<tr>
<td>“it is a bit upsetting when you see your younger sister coping and she has two”,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“he is just sort of a very demanding baby”</td>
<td>Adapting personal expectations</td>
<td>Letting go of old expectations/goals</td>
</tr>
<tr>
<td>“I used to do a lot of cross stitching, I don’t get much of a chance to do those things now”</td>
<td>Difficulty - time</td>
<td>Unable to achieve prior expectations due to time spent on mothering</td>
</tr>
<tr>
<td>“you want everything to be the same as it was before so it is hard to adjust to realising...”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* ‘its ok to ask for help’ refers to the sentiment expressed by the individuals that it is acceptable to seek help and support.
<table>
<thead>
<tr>
<th>“you feel you should cope”</th>
<th>Societal expectations - coping</th>
<th>Expected to cope</th>
</tr>
</thead>
<tbody>
<tr>
<td>“you should naturally know”</td>
<td>Naturally know</td>
<td>Expected to naturally know how to mother</td>
</tr>
<tr>
<td>“doing all these set things”</td>
<td>Doing set things</td>
<td>Society rules</td>
</tr>
<tr>
<td>“I am sick of trying to justify to them”</td>
<td>Justify actions</td>
<td>Feels need to explain, defend decisions</td>
</tr>
<tr>
<td>“they don’t respect my opinion, its up to me, it is my baby”</td>
<td></td>
<td>Need to have decisions respected</td>
</tr>
</tbody>
</table>

**Formation**

In hermeneutics, the researcher presents a dialogue, that is a literary text of meanings, from her interaction with the subjects of the research and with their words. I will be presenting these patterns of meaning in the following chapter. It is through projection, a reaching out and contacting the reader in some way that understanding of the lived experience of new mothers’ well-being results.

In summary, I have highlighted the similarities and relationships between hermeneutics and dance. I emphasised the creativity of hermeneutics which is like the creativity of dance. I transferred the elements of the process of dance onto the process of hermeneutics. Hermeneutics involves the researcher undergoing the stages of preparation, exploration, illumination and formation. The researcher, like the choreographer is the creative instrument for creativity, discovery and communication of people’s lived experiences. Hermeneutics as dance creates, discovers and communicates meanings people have being-in-the-world.

**What are the benefits of applying the metaphor hermeneutics as dance to nursing research?**

Metaphor is derived from the Greek word ‘metaphora’ whereby ‘meta’ means over and ‘pherein’ means to carry. Metaphor refers to the linguistic processes where elements of
one object are transferred to another object (Hawkes, 1972). Metaphors have always been used to find similarity or relationships between two domains. The domains may be related in structure, hence the term structural metaphor or they may be related in function or a plethora of other ways. However, what results from this form of analytical thought is the formation of a new domain consisting of the relations between the two domains of the metaphor (Sticht, 1993).

I created the metaphor ‘hermeneutics as dance’ to highlight the creativity of hermeneutical research which is like the creativity of dance. ‘Hermeneutics as dance’ is a structural metaphor. I have highlighted the similarities in aims, interaction and process. Hermeneutics and dance have similar aims which are to communicate via language people’s meanings being-in-the-world. I transferred the elements of dance; preparation, exploration, illumination and formation to the process of hermeneutics. What results from this form of communication is clarification and close examination of the elements of the process of dance and its relationships, its similarities in structure and pattern to the process of hermeneutics. Thus analytical thought is enhanced (Sticht, 1993) which is desirable for nurse researchers because research is discovery, analysis and synthesis of people’s meanings about being-in-the world and because nursing itself is an art form.

Hermeneutics as dance is a creative process of discovery about lived experiences. Creative thought is integral to this process. Intons-Peterson (1993) asserts that imagery has a role to play in the creative process. In particular the dance notion of illuminating, that is of imaging which results from the choreographers imagination has great potential for creativity and discovery in hermeneutics. Imagery, creativity and discovery are inextricably linked. What is needed for understanding to occur is imaging people’s lived experiences not only in a literal sense but also in a visual and kinesthetic sense. The richness of this kind of imagery can be used to discover the vividness of the lived experience of the well-being of new mothers.
RIGOUR

Since I created the metaphor ‘hermeneutics as dance’, I also created unique standards of rigour incorporating qualitative research and dance standards. My aim is to in give direction to future hermeneutical studies. The evaluation framework used in this study is guided by tenets from Burns (1989), Munhall (1994), Sandelowski (1986), and dance evaluations from my personal Royal Academy of Dance examinations reports, University of Western Sydney Nepean (UWS Nepean), Department of Dance objectives (1995) and dance evaluations (Blom & Chaplin, 1988; Hawkins, 1964; H'Doubler, 1940).

The first standard is ‘technique’ with the criteria of ‘careful approach’, ‘harmonious form’ and ‘fluidity of movement’. The second standard is ‘projection’ with the criteria of ‘responsiveness’ and ‘appreciation’. These standards will now be briefly explained.

The first standard of ‘technique’ is defined as the ability to artistically communicate this study in a unique way (UWS Nepean, Department of Dance, 1995). ‘Technique’ relates to the whole research process, that is composition as well as expression. Technique was maintained in this study by fulfilling the three criteria ‘careful approach’, ‘harmonious form’ and ‘fluidity of movement’.

A ‘careful approach’, defined as a respect for the research process, was maintained by expressing respect and concern for participants as well as maintaining ethics. This was demonstrated in my approach to conversations and the ethical procedures I adopted.

A ‘harmonious form’ is defined as a balanced organisation of the dialogue which shows the interrelatedness of parts to the whole. The form is therefore of solid structure with well placed descriptions and interpretations. A sense of cohesion and balance of patterns results revealing harmonious organisation as well as unity (H’Doubler, 1940).

A ‘harmonious form’ results from rigour of the entire research process. Burns (1989)
states this kind of rigour to be ‘methodological congruence’. This involves rigour in documentation, procedural rigor and ethical rigor.

Rigour in documentation requires explication of all of the stages of the research. I have described previously the stages of this research which have included; the purpose, the research questions, the literature review which has informed the study, my interpretive framework and also the research process and analysis.

Procedural rigour refers to what the researcher does in the research process. The researcher demonstrates logic in what she does. I have demonstrated procedural rigour by describing the research process including analysis previously in this chapter.

Ethical rigour was achieved in this study by adherence to ethical considerations outlined in Appendix C and approval for the study by the Human Ethics Review Committee of the UWS Nepean. All participants were given a copy of the information/consent form which detailed their rights in the study. Their consent was voluntary, informed and required in writing. They had a right to withdraw at any time.

‘Fluidity in movement’ involves reporting the decision making process so other researchers can follow the researcher’s reasoning. This criteria is congruent with Burn’s (1989) fourth dimension of auditability in ‘Standard 11: Methodological Congruence’ (p. 48) and ‘Standard 111: Analytical Preciseness’ (p. 49). I described the process of research and gave examples of the raw data and illustrated how I interpreted the data previously. The following chapter will describe the ‘patterns of meaning’ derived from this process of thematic analysis. I use raw data to show how I interpreted participants’ meanings.

The second standard for rigour in this study is ‘projection’. ‘Projection’ is defined as a reaching out and touching the reader in some way (Minton, 1984). This involves the
criteria ‘responsiveness’ and ‘appreciation’ (Munhall, 1994). Munhall (1994) states a “rich study is a full, embodied, multifaceted, multi layered, sensitive, impassioned description of a human experience; it will stir people” (p. 193). ‘Responsiveness’ (Munhall, 1994, p.193) refers to the reader and participants responding to the study through reflection or being moved to act in some way. This study aims for such ‘responsiveness’ and an ‘appreciation’ of the value of the findings.

In summary there are two standards of rigour demonstrated in this study. These include ‘technique’ and ‘projection’. These standards guide the scholastic explication and appreciation of this study.

CONCLUSION

I have explained why I have created the metaphor ‘hermeneutics as dance’.

Hermeneutics and dance are similar because they are both language which aim to communicate meanings about people’s being-in-the-world. Both hermeneutics and dance are interactive. In hermeneutics there is interaction between the researcher, the researched and the discourse whereas in dance, there is interaction between the choreographer, dancers and the dance.

Hermeneutics as dance highlights the creativity involved in doing hermeneutics which is like the creativity of dance. It is with this sense of hermeneutics as dance being a creative process of imagery, creativity and discovery that I will present in the following chapter new mothers’ discourse about their well-being and how they create it.
CHAPTER 6: FINDINGS: HOW NEW MOTHERS CREATE THEIR WELL-BEING

METAMORPHOSIS: Things new mothers need

Life’s changed!
As I, first time mother
Make you, a new soul,
We create one another.
Support.

Realisation, achievement,
Knowing -
I transcend
And I am coping.
Support.

Realisation, letting go
I accept
And I have goals
The past is gone.
Support.

Realisation
Organisation
Feeling it’s working
Having, ‘my time’
Support.

Sense of knowing,
Trial and error,
Mastering mothering,
And positive attitude,
Support.

Maintaining appearances,
Boosting self-image,
Being seen to be coping,
And feeling confident,
Self realisation,
Knowing as process.

The sense of coping,
Of being rejuvenated,
Energy restored
By simple luxuries.
Supporting myself,
By making my own time.

The sense of being here,
Partnership, kinship,
Sharing experiences,
Respite sometimes needed,
Being supported
By empathetic relationships.

All with a sense of joy,
Trusting my own authority,
All new mothers are sisters to me,
Self realisation.
Support.

INTRODUCTION

This chapter will answer the following three questions:

1. What are new mothers’ definitions of their own well-being?
2. What are the common patterns of meaning of new mothers’ well-being?
3. What are the practices necessary for new mothers to create their well-being?

I will relate the findings of this study to previous literature and research. The patterns of meaning identified in this study illuminate concepts of health and well-being specific to new mothers. In comparison with the phenomenological descriptions of health outlined in chapter 4, the findings from this study show many similarities and some differences. These findings go beyond and are more detailed and explicit then current phenomenological descriptions of health.

THE NEW MOTHERS’ DEFINITIONS OF WELL-BEING

The new mothers’ definitions of their own well-being were compiled during my conversation with each of them individually (refer to page p. 94 for conversation discussion). To conclude my conversation with each new mother, I presented her own definition of well-being to her which in turn she affirmed and voiced loudly herself to me.

The new mothers’ definitions refer to well-being as a positive, upward state where new mothers feel good, healthy, happy, joyful, delighted and rested. Well-being meant coping, achieving, that is “doing well”; “looking good” and having my time. It also meant having a relationship with their “happy, healthy baby”; a sense of “partnership” with partners and a sense of “kinship” with other new mothers. The following are these new mothers’ definitions of their own well-being:
Lisa: Well-being: Feeling healthy, looking good and coping.

Dianne: Well-being: Being coping and being on top of things.

Kathi: Well-being: I’m on the road to well-being - feel rested, feel confident, up
to date, doing OK with my baby and have time for myself to do what I want to do.
I’ve got coping: I’m coping, I am healthy and so is my baby but I still feel I have
got a fragile self esteem. I don’t really have a plan and I still have a lot of anxiety
about different things but I am getting there.

Jo: Well-being: Everyone healthy - me, baby and husband, being happy,
spending time together, being close to husband.

Julie: Well-being: Partnership with husband, unravelling your mind, untangling
knots (your way through things), unravelling until you’re straight, release anger,
time to yourself, ego boost - identity, response from baby, confidence with my
baby, relaxed and confident - (doing well).

Michelle: Well-being is happiness, joy and delight. The things that I need for my
well-being are; relationship with my baby, supportive husband, sharing of
experiences - with mothers’ group and other women, feeling of achievement,
looking well, being confident, being positive and having my needs met as
well as my baby’s - (things are quite fine).

Kim: Well-being for me means being in control, organisation, support,
understanding, openness with my partner, support and relationship with my sister,
no routines, no pressure, getting out and proving myself and thinking about
getting back into shape physically.

Nicola: Well-being: Feeling good, being happy and it means; a happy healthy
baby, having time for yourself, adequate sleep, feeling of achievement, good self
esteem and support.

PATTERNS OF MEANING

Three patterns of meaning were revealed, these being ‘adapting personal expectations’,
‘adapting to societal expectations’ and ‘being supported’. Each of these patterns of
meaning also consist of parts, what I term subpatterns of meaning which also has its
own flexible structure. There is interrelationship between the parts. The two domains
of personal and social expectations are inextricably linked because personal
expectations are derived from social attitudes about mothering. The new mothers’ way
of being-in-the-world was to adapt personal expectation and to adapt to societal
expectations by creating well-being practices. Being supported was also inherently
important.
Adapting personal expectations

The first pattern of meaning to be discussed is 'adapting personal expectations'. This refers to these new mothers' adapting in order to balance and counter the many losses they experienced. This meaning was comprised of the following subpatterns of meaning; being tied down, being tired, being out of control and just somebody's mother. Practices associated with this personal adaptation included going out, my time, being in control, being confident and knowing.

Becoming a mother involves the metamorphosis of a woman's identity, roles and practices. For the new mothers in this study, this involved adapting personal expectations in order for them to achieve well-being. Dianne spoke of the challenge of this life change, the need to accept these changes and the need to let go of previous expectations in order to adapt:

Dianne: I mean your life has changed, you can’t have what’s been before ... you can modify things to hopefully have what you had before, but now life changes so you think here is the next challenge and it's the biggest challenge you are ever going to have in your life // You just have to make it, accept it , accept the fact that this is how life is going to be for the next few years.

Many of the new mothers' words were about adapting to the many losses they experienced. These included loss of freedom, energy, control, confidence, personal identity as well as social status. In the face of these losses, the new mothers demonstrated resilience, strength and flexibility in their ability to adapt and create practices to balance, or counter the losses they experienced.

Being tied down

Since all the new mothers worked during their pregnancy and were on maternity leave, they were adapting their lives and roles to those of mother and housewife. Dianne expressed this confining nature of mothering as being tied down:
Dianne ... it is just an ‘I’ thing. I mean I can’t get away when I want to get away now. Or I can’t just leave. I just can’t come and go. I am sort of like for the first time in my life, being tied down.

All of these new mothers expressed their inability to achieve previous expectations and goals made pre pregnancy for their own future selves because of the lack of their personal time. Lisa voiced her concern in relation to this:

Lisa: ... there is heaps I want to do, like out in the garden and stuff, but if he would just sleep for a few hours during the day I could do some of those things but I can’t, so that is really hard.

As Dianne explains, motherhood removes some spontaneity from mothers’ lives. These new mothers’ lives were different because motherhood was socially isolating due to the loss of social contacts derived from the cessation of their paid employment. “Being tied down” also meant that these new mothers experienced a loss of personal time due to the work of mothering. Therefore, these new mothers experienced a loss of freedom not only in regards to the confined nature of the space in which they perform mothering but more importantly they experienced being tied down in regards to their personal time. Consequently, their own space and their own time was restricted.

All of these new mothers recommended going out to escape being tied down by the confined space of mothering and the subsequent social isolation experienced. Going out was important for them in maintaining and developing social contacts. Michelle stressed the importance of maintaining previous social contacts derived from her prior employment. However, Jo, who was a migrant to Australia and a recent resident in her community found local sources of social support beneficial for her well-being:

Jo: Yes, I like going outside, it’s good for you and I met another girl who got a ten months old baby. When I walk around people wave at you and I feel much welcome in the Mountains and I meet like new mothers if I am pushing the stroller.
In addition to going out, which meant socialising with other adults, these new mothers advocated having my time to counter being tied down by personal time restrictions. My time meant that these new mothers had time for themselves in which they could choose what they wanted to do. My time meant that they were able to have their own needs met. Some new mothers' definitions of well-being revealed that having my time was crucial for their well-being (Kathi, Julie, Nicola).

These mothers' meanings of being tied down is echoed in research on motherhood (Barclay et al., 1997; Brown et al., 1994; Crouch & Manderson, 1993; Oakley, 1974, 1980). The practice of going out and my time is consistent with current understandings of well-being practices by new mothers.

Similarly to previous research, this study confirms the importance of social support in motherhood (Knapman, 1993; Oakley, 1992; Tarkka & Paunonen, 1996). However, unlike previous findings from research by Brown et al. (1994) which suggests that mothers were unable to control or define the use of their time which resulted in a personality change, the findings from this study about my time suggests that these mothers were able to control and define their use of time which consequently created their well-being. This study's findings in regard to my time, affirms Everingham's (1997) argument about the politics of mothers' time. She argues that there is a rationality involved in the generation or constitution of time which involves mothers working with time, considering both her infant's needs as well as her own.

In this study, these new mothers reinforced the idea of choice expressed by taking my time and having their needs met in order to counteract the loss of freedom experienced. This interpretation also is consistent with Gilligan's (1982) theory of women's moral development. It recognises the importance of mothers' own needs in the morality of care to themselves as well as to their infants. This study found that although the new
mothers experienced conflict by experiencing a loss of freedom they asserted their need for freedom, choice and selfhood in their actions through their practice of my time.

*Being tired*

All the new mothers expressed how demanding motherhood was and that it resulted in them being tired. Dianne described the unpaid labour of motherhood as “not a holiday, you don’t get overtime ... I have never worked this hard in my life”.

Kathi recalled how her state of being tired affected her ability to cope:

Kathi: You are less likely to cope with normal everyday stuff simply because you are so tired ... I just thought I can’t do this ... I need to sleep. // ...so tired as there are so many demands on my body, breastfeeding my baby and having to keep moving, washing and cleaning... .

Kathi said that as a new mother you “can’t rationalise through stuff that you normally could”. In contrast, Dianne was able to rationalise her inability to cope because she was tired:

Dianne: ... if you are not coping ... if Rob was here and had to experience, then maybe you could get some sympathy ... I am lucky enough to be able to rationalise that and say well because you are tired, have had a full day you just can’t [cope].

The new mothers spoke of being tired. This was a result of the physical demands on their body because of breastfeeding and the resultant sleep deprivation experienced as well as because of the work of infant care (settling, cleaning, washing) and housework. This work of mothering was also exacerbated by postnatal recuperation, that is the physical adaptations and healing which occur after birth. Being tired affected these new mothers’ ability to cope. These new mothers also experienced ambivalent feelings in regards to their ability to think clearly because of being tired.
All the new mothers said that they needed to rest by having my time so that they could balance their tiredness, resulting from the continual and repetitive demands of mothering. They identified a variety of practices. Nicola, in her definition of well-being, stressed the importance of adequate sleep. Kathi felt that the quality of sleep was more important than the quantity:

Kathi: Well-being is when I feel rested and that doesn’t necessarily relate to the amount of sleep and maybe it is quality of sleep I got.

The new mothers rested in other ways apart from sleeping. They needed to create a luxurious environment in order to feel rested, relaxed and pampered. Dianne and Nicola emphasised the importance of having a relaxing bath, whereas Kathi, Julie, Jo and Dianne found watching television relaxing. Aromatherapy and massage was also perceived as being relaxing (Dianne).

On the other hand, exercise was perceived as being rejuvenating. Julie, Dianne, Jo and Kathi signalled the importance of walking whereas Dianne and Julie emphasised that they enjoyed exercising; that it was fun. Rest and rejuvenation resulted in the new mothers feeling good and healthy which was significant to their well-being. Lisa, Kathi, Jo, Julie, Kim and Nicola emphasised the importance of this in their definitions of well-being.

This meaning of being tired is reflected and emphasised in previous research on motherhood (Brown et al., 1994; Crouch & Manderson, 1993; Oakley, 1974, 1980). Similarly to research by Brown et al. (1994), this study affirmed that mothers need to rest to counteract feeling tired.

This study extends the current understanding of practices which create new mothers’ well-being by stressing the importance of mothers creating a relaxing environment. Whereas previous research has emphasised the importance of rest, this study extends
and challenges this understanding by pointing out that exercise as well as a repertoire of activities (aromatherapy, massage) was also rejuvenating.

**Being out of control**

The mothers in this study spoke about feeling a loss of personal control because of the chaotic days they experienced. Dianne voiced the problem in this way:

Dianne: It is totally out of your control and get this, even now things are sort of out of your control because we were saying you can’t go off and do all those little things that you wanted to do. You can’t be away by 10 o’clock, it will always be 10.30.

Kim recalled the ambiguities about personal control “aspects of it you do like you can control maybe that the rooms are tidy and all that but your days aren’t in control”.

Their days were not in control because they had to cope with good and bad days:

Nicola: ... Life changes a lot after you’ve had a baby, it doesn’t totally change, you still get your good days and your not so good days um you can’t expect anything more, I guess you know you can’t expect everyday is going to be wonderful, as long as you cope with the bad ones yeah, then you feel I think, you still feel good.

Kathi asserted in her definition of well-being that she did not have well-being because she had a fragile self esteem and felt anxious over things she was unable to plan. She described experiencing contrasting feelings:

Kathi: I think it is the contrasts ... you can feel happy and sad, confident and frightened at the same time, proud of what you have done, what you have produced, this beautiful human being and what I am doing, so it is feeling confident and feeling unconfident at the same time // I am surprised at how fragile my self esteem was and how fragile my emotions were and I suppose that its partly hormonal but that took me by surprise.

The new mothers described the sequelae of having to cope with the bad days as; confusion, depression and stress. They experienced contrasting feelings and fragile desperate feelings of irritation, intimidation, over-sensitivity and defensiveness (Kathi,
Julie, Dianne, Kim, Lisa, Jo). They described feeling frustrated, unable to cope, having to cope with an unsettled baby as well as resorting to unhealthy activities (smoking, drinking alcohol) in order to calm down (Lisa). They recognised when they were out of control and appreciated others taking control when necessary. Partners (Julie, Kim, Kathi) and community nurses were perceived as being more in control and took control when problems arose (Michelle, Kathi, Julie).

Julie felt this loss of control was a result of coping with her dependent and helpless baby. The new mothers voiced the ambiguous nature of personal control. On one hand they were able to control the environment, however, on the other hand they were unable to control their good and bad days as well as the resultant fragile emotions they experienced.

Michelle emphasised that personal control was essential for meeting her infant’s needs as well as her own personal needs:

Michelle: There’s nothing I can’t do cause I have got children so you still meet your own needs. You’ve got to do that because otherwise you become solely a mother ... .

Michelle’s excerpt reinforces her felt responsibility to meet her infant’s as well as her own needs. Kim emphasised that being in control was essential for her definition of well-being. She described how getting out proved her ability to be in control:

Kim: ... getting out, proves that I can do it, yeah that I can turn up on time still to meet somebody, with a baby and a bag and stroller and all that sort of stuff. I suppose that’s the one thing I aim to do, ... makes you feel in control still.

The mothers in this study recommended that being in control of some areas of their lives was achieved by being organised. Lisa, Kim, Dianne and Michelle stressed that by being organised they could achieve in relation to caring for their infant, completing
their housework as well as in regards to themselves by achieving my time. The following excerpt by Lisa illustrates how being organised helped her:

Lisa: ... if I know I am going out I get really organised the night before, I get all his clothes out and all the bag, you know the nappy bag packed and my bag is at the door and so forth, so when I get up all I have to do is bath myself or you know have a shower, give him a bath and then go and I know that everything is ready, but if I had to get up and do all that, I would probably, I would never get out of the door, you have to be organised.

The new mothers expressed feeling ambivalent about being in control by being organised. Some felt that structure, that is organisation and routines was beneficial for their well-being (Lisa, Kim, Dianne, Michelle) whereas some also felt that they needed to relax these pressures and routines (Kim, Nicola). For Dianne, although structure made life easier for her, she spoke about resenting the structure because she had lost her personal freedom.

This meaning of loss of personal control supports previous Australian research on motherhood (Barclay et al., 1997; Crouch & Manderson, 1993). Crouch and Manderson’s Australian study of 93 new mothers transition to parenthood during the 1980’s describes the continuous, ever-present, demanding, unpredictable nature of motherhood. They claim that the loss of control mothers experienced was a result of the unscheduled nature of mothering which called on them to cope with circumstances as they occurred.

This study highlights that personal control is essential for a mother to meet her own and her infant’s needs. This finding is consistent with Gilligan’s (1982) theory of women’s moral development by emphasising that women meet their own needs in the ethic of care to themselves. This study affirms the belief that mothers feel an urge to be in control of what they can so that they can cope, that is survive. Being in control through organisational practices extends current understanding on motherhood. The finding that mothers needed to prove themselves by being in control needs further investigation as it
fails to draw out and reveal to society the chaos (structural and personal) of mothers’ experience. Therefore, being in control is notably perpetuating the ‘mask of motherhood’ (Maushart, 1997) (refer to literature review).

*Just somebody’s mother*

Motherhood has an ambiguous status, as Julie emphasised:

Julie: You feel as though you have lost your identity for a while, you are not really a person, you are just somebody’s mother running around doing the dirty nappies and washing and carrying on // I think I’m getting past like I’m Kate’s mum, I think I’m getting my own identity back and I am probably what would you say I don’t know what I won’t be sort of classed as anything.

Julie’s excerpt highlights her felt loss of personal identity and loss of social status. Social status and self esteem are inextricably linked. Unfortunately, new mothers experience a loss of self esteem and consequently, a loss of identity because of a loss of social status. They experience a loss of social status because they are not a part of the paid workforce. They also experience a loss of self esteem due to their lack of confidence in motherhood.

The mothers in this study described feeling less confident than in their previous competent career roles because they were learning something new, that is how to mother. Kathi realised her reality had been transformed to include isolation, a simpler life and a personal sense of being less capable than her performance before motherhood. She expressed this tension:

Kathi: People are used to seeing you as being capable - pressure on you to continue to be capable ... people are used to seeing you as being able to solve other peoples problems - I was used to being a source of guidance - no-one here can help me with this, I have to do this on my own // You don’t know what the right answers are // ... all you have done is watch TV and that’s horrible when you are used to doing all this stuff.
Because mothers feel less confident, they seek verification of their mothering actions from others:

Kim: ... I must admit I felt less assertive, less confident since having Nathane then I did before. I felt like a little girl at times you know. I’d be looking for like what would you say looking for people to say yes, that’s the right thing to do yeah and I actually got that support from Peter because his two girls from his previous marriage were bottlefed from birth and he sort of quotes there is nothing wrong with them.

Some of the new mothers (Kathi, Julie, Michelle), in their definitions of well-being, stressed the importance of feeling and being confident. Michelle emphasised the importance of being positive, that is having a positive attitude:

Michelle: Yeah I think you’ve got to have a positive attitude otherwise everything does start to go down.

An example of Michelle’s positive attitude is reflected in the following excerpt. She conceded to her present reality of being tired by rationalising that her sleep deprivation would not last forever:

Michelle: But I think sometimes sleepwise its a bit hard. Yeah, I’d like to sleep in, I think I’d like to sleep all night without having to get up ... I keep thinking of the future, this isn’t going to happen forever, he’s not going to be waking forever.

All the new mothers described how their personal appearance reflected their sense of well-being, that is that they felt good, looked good and were seen to be coping. For the new mothers’, “looking good” and “looking well” refers to the notion of personal grooming (hygiene, haircut) to boost their confidence. Lisa described this:

Lisa: ... if you physically look alright, then I suppose you look like you are coping and you are doing it hands down, no problems and everyone says you look really great and that makes you feel really good.

Nicola, Kim, Julie and Jo were concerned about the unfortunate societal expectation to losing weight and getting back into shape. Julie identified her father-in-law as the source of this pressure:
Julie: ... I think the first thing he said to me are you exercising yet? Like Kate was two weeks old and I said, oh no and he said, you don't want to end up flabby and I think that comment put me a little, do you know, I stepped back a fair bit.

For the new mothers in this study, a positive attitude was reflected in their personal appearance. A process of gaining confidence occurs for new mothers as they learn to trust their mothering decisions and actions. For all these new mothers, self esteem and knowing how to mother were inextricably linked, as Nicola so clearly stated:

Nicola: ... I guess if you've got a good self esteem you believe in yourself, you trust yourself, if that makes sense, you know what you are doing is right and then you sort of I guess, that I guess when having a baby one of the things is that being the first time you don't know whether what you're doing is right, so that knowing that this is right and it works and it makes the baby happy and whatever, makes you feel really good.

The findings of this study that new mothers experience loss of personal identity, social status and confidence is clearly reflected in previous research on motherhood (Barclay et al., 1997; Brown & Harris, 1978; Brown et al., 1994; Wearing, 1984). Similarly to research by Brown and Harris (1978) these findings indicate that mothers experience a loss of self esteem because of the loss of social and financial rewards associated with employment. The practice of being confident and having a positive attitude extends present understanding of coping strategies in motherhood.

Unfortunately, the notion of looking good by maintaining appearances in order to be seen to be coping perpetuates the 'mask of motherhood' (Maushart, 1997). It also reflects the cultural inscriptions on women's bodies (Grosz, 1994) which are stereotypically defined by a patriarchal society. Like Oakley's (1979) study, this study emphasises the practice of knowing how to mother for the development of mothers' confidence, self esteem and maternal competence.

To summarise, being a mother involves new mothers adapting existing practices and creating new practices to balance the losses experienced. Going out, my time, being in
control, being confident and knowing were identified as practices for achieving new mothers’ well-being.

**Adapting to societal expectations**

Adapting to societal expectations refers to new mothers’ redefining and resisting the notion of the ‘good mother’ because this discourse results in them feeling ambivalent and guilty. This pattern of meaning was comprised of the following subpatterns of meaning; you should be a good mother and redefining and resisting the notion of the ‘good mother’. The practices associated with adapting to societal expectations included ways of knowing, normalising and my time.

**You should be a good mother**

The new mothers in this study stressed that there are authoritarian messages from a male-dominated society to mothers conveying the message “you should …”, especially “you should be a good mother”. These new mothers redefined and resisted this notion of being the ‘good mother’. They used ways of knowing, normalising and my time to achieve their well-being and redefine for themselves the notion of the ‘good mother’.

The idealistic images of the ‘good mother’ as received from society by these new mothers were voiced by Nicola, Julie, Lisa, Dianne and Kathi:

Nicola: I think it took me probably 7 or 8 weeks to realise about the good mother // the good mother is the one that runs around and does all the things and has all the things organised and I suddenly sort of sat down one day and I thought the good mother is the one that’s happy because the baby and you know Timothy doesn’t really care if I haven’t made the dinner yet or whatever you know and so to me the good mother is the one that has a bit of sanity there you know.

Julie: ... and the whole thing of having a baby is you love them which you sort of read about in books or you see a photo of a woman breastfeeding and they look so much in love you sort of wonder if there is something the matter with you if you don’t have these waves of love with the baby.
Lisa: You should naturally know what your baby is crying for.

Kathi: ... it is supposed to be this deliriously happy time in your life.

Dianne: You are expected to be the perfect mother as soon as the baby pops out // People expect you to be all self sacrificing and not have any time for yourself.

Kathi: ... taboo to tell society that you are not coping

Some of these new mothers felt that the notion of a ‘good mother’ as received from society was dependent on having a ‘good baby’. Mothers are expected to sacrifice their time to care for their ‘good baby’ as well as perform their other duties as Dianne commented:

Dianne: [The] good baby is one who sleeps and isn’t so demanding on your time and I’m lucky that I am able to scoot around and do the washing do the nappies have a play with him, as I said before, sometimes I am probably feeling a little bit guilty that maybe I don’t give him as much time because you hear about what other mothers do, you think gosh they must spend a lot of time and you think maybe just maybe you don’t put enough time ...

These new mothers’ personal expectations of being a ‘good mother’ were derived from general societal expectations and attitudes. These new mothers stated that the ideals of the being a ‘good mother’ refers to doing all the things that mothers are supposed to do, that is infant care as well as housework. Some of the new mothers in this study spoke about the expectation to love their infant from the moment of birth and moreover naturally know how to love and care for them. Kathi voiced that she felt an expectation to feel deliriously happy when in reality she could not define her own well-being.

The new mothers in this study stressed that they experienced tension between these expectations and their experiences of being mothers. They described feeling ambivalent and feeling guilty as a result of this discourse; this societal expectation of being a ‘good mother’. Feeling ambivalent was a result of the tension they felt between the societal
and personal expectations they felt and their own realities. Feeling guilty was also a result of them being unable to achieve the expectation.

These new mothers felt an expectation to do all the things ‘good mothers’ do; that is infant care and housework. These new mothers reported that “getting things done” in relation to infant care and housework meant that they were achieving, that is that they were accomplishing tasks befitting a ‘good mother’. This feeling of achievement was essential for some new mothers’ definition of well-being (Michelle, Nicola, Kathi).

These new mothers felt ambivalent about “getting things done” because they endured days in which the rhythm was repetitive, monotonous and long and little was achieved in the housework area:

Kathi: ... it would be endless days of washing and breastfeeding and what am I? When is this going to end? When is there going to be a break in the routine?

They also stressed that they felt ambivalent about the “chore” of housework:

Dianne: I am at home so I feel I should [do the housework] one thing I really love is cooking but yeah like doing housework is a chore and unnecessary evil, usually Rob does it anyway:

Some of the new mothers in this study felt that they had to do the housework in order to feel that they were achieving, that is, that they had something to show for their work. The following excerpt illustrates how Lisa fails to recognise the sign of a contented baby as something to show for her work:

Lisa: ... getting through the day is a big achievement // I don’t have anything to show for it ... but if I just feed him and comfort him all day it is like I have nothing to show for it.

The new mothers felt ambivalent about “getting things done” because these demands resulted in them being tired. As well as feeling ambivalent about “getting things done”,
the new mothers felt ambivalent about the societal expectation of naturally knowing how to mother, which includes knowing how to breastfeed. Some of the new mothers felt at ease breastfeeding, however Kim expressed her reality, it didn’t come naturally for her:

Kim: ... and I can remember one night when it was the last straw and I’d try and feed him and I was crying my eyes out and he was crying his eyes out and I was screaming for Peter and he never woke up ... I said [in the morning], I’d called you last night when I was feeding and you wouldn’t come ... you should have heard me I was screaming enough and he said, “why didn’t you come and get me?”, and I had no answer.

The new mothers also recalled ambivalent feelings about being “deliriously happy”.

Some did feel happy (Jo, Nicola, Michelle), however the majority expressed a variety of feelings in regards to their experience of being a mother. As I have pointed out previously, the new mothers experienced contrasting feelings.

They spoke about feeling ambivalent in regards to the notion of being self-sacrificing.

Some of the new mothers commented on feeling selfish if they had my time, for example Kathi stated “I feel selfish if I just sit down and put my feet up”. In contrast, Michelle felt that she was willing to sacrifice her time as she felt satisfied with her life:

Michelle: I’m pleased that I’ve had him now we’ve been married 7 years. I’m pleased that I’ve had him now cause I can sacrifice my time, if I had him a couple of years ago oh I’m missing out on doing this and doing that, I didn’t feel like that anymore.

The new mothers emphasised the public facade regarding mothers being expected to cope. Kathi related how mothers pretend to be coping because it is a taboo to tell society that you are not coping. Because mothers are expected to cope they do not access support easily:

Kathi: On the third day after ... taboo to tell society that you are not coping // There are times when it is awful // Mothers are supposed to be capable // [The] easiest thing to do is just pull the covers over your head and pretend everything is OK when it is not ... it takes enormous strength to ask for help.
These new mothers disclosed feeling ambivalent about coping. For some mothers, coping was essential for their definition of well-being (Lisa, Dianne, Kathi). On one hand they interpreted their personal appearance as a sign that they were coping:

Lisa: ... if you physically look all right then I suppose you look like you are coping and you are doing it hands down, no problems and everyone says you look really great and that makes you feel really good.

On the other hand they appreciated others recognising their inability to cope:

Kim: God you look a wreck ... I thought, thank God someone noticed!

The new mothers felt ambivalent as a result of the tension they experienced between the societal expectation of being a ‘good mother’ and the consequences for their well-being. For example, as I have pointed out, they felt ambivalent about “the good mother ... does all the things” because this expectation is physically demanding and results in them being tired.

This discourse of being a ‘good mother’ who is expected to do all the things that mothers are supposed to do, love their infant from the moment of birth, naturally knows how to mother and feel deliriously happy whilst self sacrificing her needs is incompatible with many mothers’ realities. There is a tension or conflict between these social expectations and their realities. The focus on the physical societal expectations fails to recognise the creative qualities of mothering such as ‘co-constitution’, that is the creative relationship between the mother and her baby as well as the development of maternal competence. This tension that the new mothers experienced between the societal expectations and their realities not only resulted in them feeling ambivalent but also feeling guilty if they were unable to achieve the societal expectations of being the ‘good mother’.
The new mothers in this study identified a variety of sources of external authority covering how they should act. For example, Lisa felt that her mothering was being judged by others and that she needed to defend herself by justifying her mothering decisions and actions. Lisa identified the source of authority as the standards endorsed from a variety of social sources:

Lisa: ... people are always on at you about giving you their opinion on what you should be doing // Why don’t you try that // Doing all these set things ... everyone seems to think I should go to the clinic // Are you having him immunised? // I am sick of trying to justify to them //... respect my decision my opinion it is up to me it is my baby ... I will work it out for myself.

Kim also identified another source of authority as community nurses especially in relation to their promotion of breastfeeding according to the World Health Organisation’s policy. Kim felt that others labelled her as being postnatally depressed when in reality she simply did not enjoy breastfeeding:

Kim: Everyone kept saying you’re getting postnatal blues its like a big thing maybe you’ve got postnatal depression um maybe we should look at that aspect and I kept saying no it’s just breastfeeding I’m just not happy breastfeeding yeah oh no it can’t be that you’re too depressed for that and I’m thinking I know myself enough to know as soon as I’ve finished, I stopped breastfeeding I’m very happy to feed anytime of the day or night now.

In contrast to medical authorities such as the World Health Organisation, Kathi identified another source of authority as other mothers, especially older ones:

Kathi: ... when people say what you should do is and it is usually offered as helpful advice but it is often other mothers and older mothers.

The discourse on being a ‘good mother’ dictates how mothers should act. Like the judge in a legal court whopunishes those who do not abide by the law, these new mothers punished themselves with guilt in accordance with their views of their own ability to meet the societal expectations of a ‘good mother’. For example, because some mothers feel an expectation to have something physical and concrete to show for their work in order to be a ‘good mother’, if they do not achieve in relation to
housework, they feel guilty. Julie spoke of feeling guilty because she did not feel
waves of love with her baby. Dianne, Kim and Nicola expressed feelings of guilt, that
they had failed and were inadequate mothers because breastfeeding was unattainable for
them. Kathi spoke about feeling selfish if she had my time.

This discourse of the ‘good mother’ is incompatible with many mothers’ realities. It is
detrimental to their well-being because it results in them feeling guilty because of the
felt inconsistencies between the knowledge circulated in their society and their
experience of being mothers.

This discourse has a long history. I presented in Chapter 3 the domestic labour debate
which indicated that capitalist and patriarchal power are in play with the institution of
motherhood (Firestone, 1971; Mitchell, 1971; Oakley, 1980; Rich, 1976; Wearing,
1984). My discussion showed the development of the feminist analysis of the ideology
of motherhood from an economic, to a biological, then a social analysis of gender. My
discussion of post-structuralist feminism pointed to the necessity of including an
analysis of the female body and gender in understanding the power relations acting on
women. To understand these power relations I discussed Foucault’s notions of power
and knowledge (Foucault, 1977).

This dominant discourse of the ‘good mother’ circulates social values on mothering
which support existing power relations in a male dominated society. It is a discourse
which has been derived from medical (including psychoanalysts) and scientific
knowledge. The knowledge of this discourse is circulated throughout society by a
variety of sources in which the new mothers in this study indicated involved
predominantly men but also women. This discourse is a form of social control which is
utilised to maintain a context of gender relations which favours men by exploiting
mothers’ time and labour.
The crux of Gilligan's (1982) theory of moral development is that the condemnation of exploitation is the major principle of moral actions by women. The new mothers in this study demonstrated this condemnation of the exploitation of their time and labour by redefining and resisting being the 'good mother'.

Redefining and resisting the notion of the 'good mother'

_The good mother ... does all the things?_

Nicola described that for her it took time and experience as a mother to realise about the 'good mother'. She redefined the 'good mother':

Nicola: ... the good mother is the one that has a bit of sanity there you know.

The good mother that has a bit of sanity resists being the 'good mother' who does all the things she is supposed to do. Although most of the new mothers in this study assumed the responsibility for housework, they resisted these demands by relaxing their personal expectations in regards to housework responsibilities to favour of infant care and themselves. The following excerpts by Nicola and Kim illustrates how they rejected being the 'good mother' in relation to "does all the things" in order to achieve well-being:

Kim: I don't put pressure on myself anymore [about] the house being untidy.

Nicola: I took the advice that all the books and all the nurses tell you is don't worry about it as long as you've got something in the fridge that you can eat, have salad and cold ham every night and it doesn't matter, I took to heart especially when I was having problems with the feeding but even afterwards it wasn't the most important thing, I relaxed about that.
Waves of love with the baby?
The majority of the new mothers redefined experiencing waves of love with their baby to include the necessity of interaction from their baby for the development of a relationship with them. They emphasised that their relationship with their baby enhanced their maternal confidence and competence which in turn was essential for their definition of well-being.

It was important for them to be recognised as the mothers of their baby by the babies themselves (Michelle, Jo, Julie, Lisa, Kathi, Nicola):

Julie: ... feeling that Kate is responding to me is as much coping that sounds probably strange but getting some response from Kate, like smiles I feel that she enjoys being with her mum, that we are relaxed with each other, she doesn't terrify me she doesn't scare me ... good thing for my ego ... you need to feel and the only person who can give it to you is the baby, that is the only person who you can get these signals off ...

Nicola: ... when baby's happy I feel good. When he smiles and laughs I feel great. When he's laughing at me I think its great and I don't actually feel like doing anything except sitting in the corner and laughing with him you know.

The good mother develops a relationship with their baby, which in turn develops their maternal competence and self esteem. Similarly to research by Crouch and Manderson (1993), the mothers in this study suggest that a relationship with their baby develops over time and is reciprocal in nature.

Naturally knows how to mother?
These new mothers defined various ways of knowing. These included “mother knows best”, “sussing out”, “trial and error”, “babymoon”, signs of maternal achievement, comparing, interpreting in a nonjudgemental environment and sources of advice.
“Mother knows best” refers to intuitive knowing, the gut instinctive level of knowing how to mother. Kathi and Julie felt that they had this form of intuitive knowledge in regards to motherhood:

Kathi: Mother knows best and you think intuitively and your instincts will tell you what to do and I think that is true ... I think they do but it takes you a long time to realise that.

The majority of the new mothers said that an experiential learning process occurred which resulted in the acknowledgment of their mothering expertise. “Sussing out” by “trial and error” refers to how new mothers learn in interaction with their baby in order to meet their babies needs (Lisa, Michelle).

The ways in which they were mothered and their concerns about their own upbringing affects their ways of being a mother:

Kathi: I am worried that I won’t cope because I don’t have a good mothering role model // I was going to show the world that what happened to me wasn’t going to happen to my baby.

Dianne, Kathi, Julie and Lisa described that they desired time on their own with their baby during the first two weeks of life to learn mothercraft in order to fulfil their baby’s needs as well as to bond with their infant. Kathi expressed this as a desire for a “babymoon”:

Kathi: Babymoon for five to six days where you just kind of lie around and you get used to changing nappies and you learn how to breastfeed // [There is a ] social pressure to invite people ... I was really angry, because I thought just leave us alone.

Motherhood involves mothers making decisions which take into consideration not only their infant’s needs but also their own. The following excerpt by Nicola describes her decision not to breastfeed because she didn’t enjoy it:
Nicola: Once I made the decision, I really made the decision in my own mind went outside and had a real think about it and had a little cry cause I felt disappointed that its going to come to an end but I felt a major, major, major sense of relief like I really don't have to do that and I think it was getting to the stage where I was really getting stressed about it which was stopping the milk flowing and it was stopping me enjoying all the things about being a mother, I suddenly realised that there is more to being a mother than feeding the baby.

This illustrates how mothering is an act of problem solving. Nicola recognised her problem with breastfeeding and consequently rejected breastfeeding in order to be relieved of her problem. The new mothers interpreted other situations and made appropriate decisions. For example, they interpreted the 'good mother' expectations as problematic and so rejected some of the associated social values and practices detrimental for their well-being.

Michelle described achieving in regards to her baby as a sense of "everything ... falling into place":

Michelle: So I think everything felt better once everything was going right ... everything you know is falling into place.

The new mothers defined the signs that they were achieving in regards to their baby. These were; enjoyment of their baby (Dianne, Nicola, Michelle, Jo, Julie), the baby's weight gain (Michelle, Nicola, Julie), development (Nicola and Michelle) and a happy, contented, healthy baby (Nicola, Dianne). Integral to this meaning was the development of a relationship with their baby which resulted in them being recognised as their mother.

The new mothers described how a nonjudgemental environment was necessary for maternal decision making, including problem solving. The majority found the 'new mothers' group' such a non judgemental environment because other new mothers were new at mothering, and therefore at an equal level. This nonjudgemental environment was conducive for their learning as well as developed "kinship" with other new
mothers. Sharing with other new mothers their experiences of mothering helped them with their mothering. By comparing their own experiences and interpreting other mothers’ advice they were able to make appropriate maternal decisions appropriate to their own situations.

Further advice was sought from a variety of sources. These included other mothers and female members of their family, community nurses and popular literature about mothering and parenting. The new mothers stressed that they needed supportive relationships with people who enhanced and respected their own decisions.

These new mothers experienced difficulties with learning about mothering as there was inconsistent information and advice which they needed to interpret before they could make a satisfactory decision:

Kathi: No one knows Peter as well as me so it is conflicting stuff all the time I’m not quite sure whether to listen to what people are saying or whether to decide for yourself.

These new mothers’ ways of knowing are consistent with Belenky et al. (1986) ‘women’s ways of knowing’. Some of the new mothers were subjective knowers, that is they possessed the intuitive, gut form of knowing how to mother. Similarly to Belenky et al., these findings indicate that subjective knowing is experiential in nature as these new mothers learned by a process of trial and error. However, unlike the Belenky et al. study, these findings indicate that the experiential process of learning by trial and error is dependent on advice from ‘received knowledge’ sources.

It is interesting that the new mothers desired a “babymoon”, that is a period of social seclusion in order to learn mothercraft and be by themselves with their infant. This finding supports anthropological literature which recommends social seclusion as a postpartum structure for the prevention of postnatal depression (Stern & Knuckman, 1983).
The new mothers were also objective knowers. They ‘received knowledge’ about mothering. They received ‘procedural knowledge’ in the form of advice, predominantly from other mothers including their own and especially other new mothers. They also ‘received knowledge’ from community nurses and popular literature. The majority depended on the interpersonal ‘connected knowing’ as a form of ‘procedural knowledge’ in order to learn how to mother. The new mothers compared and interpreted their own experiences of mothering with other new mothers who advised them.

The new mothers also integrated subjective and objective forms of knowing. They constructed knowledge. As I have shown, they demonstrated their ability to critique, redefine and resist the ideology of motherhood through their well-being practices.

These findings are consistent with previous sociological research (Oakley, 1979; Crouch & Manderson, 1993). Like Oakley’s (1979) findings this study found that the ways in which they were mothered and their concerns about their own upbringing affects their ways of being a mother. Like the findings from Everingham’s (1994) study which indicated that mothering is interpretive, this study emphasised the interpersonal dependence on other mothers who were ‘in the same boat’ (p. 79). The mothers needed to discuss their maternal practices and judgements with other new mothers. However, unlike Everingham’s study, this study found the new mothers did not want their judgements confirmed; the process of comparing and sharing experiences helped advise their decisions and normalise their experiences which will be discussed further in the following section. This finding extends current understandings about the benefits of ‘new mothers’ groups’.
Deliriously happy?

The majority of the new mothers in this study asserted that they did not feel deliriously happy but instead experienced ambivalent feelings. Because the new mothers experienced ambivalent feelings as well as being tired and being out of control and lacking confidence, they all compared themselves to other mothers to put their problems into perspective. Lisa and Dianne gave an account of this:

Lisa: It's upsetting when you see your younger sister coping and she has two // ... he is just sort of a demanding baby and she doesn't have one.

Dianne: [I] look at others who are worse off and think I'm lucky.

Other new mothers especially from the 'new mothers' group' were the main source for normalisation of these ambivalent feelings. By being with other new ("equal") mothers and sharing (Jo, Michelle, Dianne) and comparing experiences in a nonjudgemental environment, experiences were put into perspective (Kathi). A sense of "kinship" (Lisa), a bond (Julie), developed whereby other mothers' experiences helped to advise and normalise experiences.

In addition to support from other new mothers, normalisation occurred with support from their mothers (Nicola, Dianne, Lisa), mother-in-law (Jo) and sister (Kim). These sources of positive support offered help, encouragement and verification of their experiences (Nicola).

As well as seeking external sources of normalisation, the new mothers normalised themselves by having my time and by getting out of the house and being with nature. Through these practices they were able to put their feelings and experiences into perspective. Julie described how she maintained her perspective on things:

Julie: ... the ocean was a wonderful thing and you go to the beach and you look at the ocean and whatever worries you have, it is so big and you look so small and it sort of puts everything back into perspective or nature, because I think that helps as well because probably living here in the Blue Mountains you just go out
and look at all these trees around you and you think, that puts things more into perspective, like my mother gave me a hint once. Take the time to put your baby into a possum pouch and go out for a walk because sometimes things can seem really bad in four walls, but it’s almost like closing in on you sort of thing, but if you can go out for a walk and get some fresh air and as well as the physical thing.

Also, Kathi commented on the need for antenatal education to include discussion of the variety of normal feelings experienced being a new mother:

Kathi: Just for partners to understand that you will get anxious, that you will be very emotional, that there will be times when they will just have to sit down with you and say you are doing great and let’s talk about how you feel because I think partners tend to be on the watch for the big signs but they need to understand there is normal stuff that goes with having a baby and they can help with that, it isn’t crisis point stuff, that is just day to day.

Kathi also stressed that mothers need to be prepared by knowing that there will be good and bad days:

Kathi: ... it is good days and bad days and no one really tells you that, no-one says, look there will be good days and there will be bad days and it takes you a while to be able to reason through that. Now I can sit down and say I am having a bad day, you know, tomorrow will be better, tomorrow will be OK. Today I am tired, today Peter is not feeling well, he is running a fever, but tomorrow he will be OK and no-one warns you about that, you expect it either all good or all bad.

This meaning of motherhood not being a deliriously happy time is consistent with previous research findings on motherhood (Barclay & Lloyd, 1996; Crouch & Manderson, 1993). The finding that the new mothers needed to normalise their feelings and experiences extends understandings from previous research on ‘new mothers’ groups’ which has already indicated other benefits such as education, advice and the development of interpersonal relationships (Lawson & Callaghan, 1991).

Like the findings from Mauthner (1995), this study emphasises the importance of mothers talking about their feelings. In this study, the new mothers found that interacting with women who were also mothers was helpful to their own decision making. This could be in part related to the nature of friendships between women
which has been phenomenologically described as involving the attributes of care, sharing, commitment, freedom, respect, trust and equality (Becker, 1987).

**Self sacrificing?**

The new mothers in this study asserted that they had to meet their own needs in order to achieve well-being. Julie emphasised the importance of my time for achieving personal goals. The mothers described my time as having time for self by choosing an action which would provide relief in order for them to feel rested, relaxed, pampered as well as rejuvenated. Having my time meant that they were achieving in relation to themselves. This meaning is reflected in literature by Everingham (1997) who asserts that the politics of time for women involves them rationally creating time for themselves. My time is consistent with Gilligan’s (1982) theory of moral development which highlights that women making moral judgements consider their own needs.

**You should cope?**

Nicola and Kathi described coping with good and bad day, Julie related coping as just getting by and Nicola saw coping as the step before well-being. The new mothers defined coping as the step before well-being:

Nicola: ... yeah in a way its something you’ve got to do to have well-being but its like a step before well-being yeah to me coping is just getting through the day and nothing really disastrous has happened you know you’re still all together.

Jo however spoke about survival in a different and a more concrete sense:

Jo: ... you can earn too much money, you can save too much money, that is when you get hit by it, it is the money I think, we used to get two salary and now we need to buy all the things and thinking this is all we can afford, but we are surviving anyway // oh because we eat three meals in a day, and we buy any clothes you want, but we still need to buy things but there is no problem with that.
These new mothers defined coping as being the step before well-being; as just getting by and surviving the daily existence of being a mother. That is, they distinguished coping from well-being. This shows that there is more than just coping and to surviving motherhood, that in fact these new mothers demonstrated the strength and flexibility to go beyond coping, in order to achieve well-being. These new mothers created practices to resist the detrimental effects societal expectations have on their well-being. This finding is consistent with Gilligan’s (1982) theory of moral development in that it shows the development of mothers moral reasoning from survival to an ethic of caring for oneself.

The new mothers in this study redefined and resisted the notion of the ‘good mother’. By redefining the perceived societal notion of the ‘good mother’ they replaced this discourse, that is the set of statements about the ‘good mother’, with their own statements and knowledge about motherhood. They created a new discourse which was grounded in their own experiences and which demonstrated their resistance to the power relations operating on them. These new definitions about the ‘good mother’ extend Wearing’s (1984) utopian ideas about motherhood and demonstrate how dominant discourses can be displaced and transformed (Foucault, 1980).

Within this framework, Winnicott’s (1965) conception of the ‘good-enough mother’ can be viewed from another perspective. Winnicott described the ‘good-enough mother’ as one who through instinct and empathy meets her infant/child’s needs in order to reduce the infant’s negative emotional experiences. The findings from this study suggest Winnicott’s ‘good-enough mother’ would be one who, in receiving empathic understanding and support from significant others, is better placed to meet the emotional needs of her infant.
As well as redefining the notion of the ‘good mother’, these new mothers also resisted the societal ideology of motherhood in their practices. Ways of knowing, normalising and my time were practices new mothers created in order to achieve their well-being.

**Being supported**

The third pattern of meaning was ‘being supported’. **This** refers to supporting new mothers in order for them to be able to achieve their well-being. **This** pattern of meaning was comprised of the following subpatterns of meaning: partnership; kinship, others sources of support, types of support. Supportive practices included “being there” (presence), helping (empathic understanding) and being non-judgemental. As I have pointed out previously, this pattern of meaning is interrelated to the first and second patterns of meaning.

**Being supported** meant for these new mothers, others “being there” and sharing their experiences with them. This presence developed these others’ empathic understandings of these new mothers’ experience which consequently facilitated helping the new mothers with their daily activities. Respite was needed. For new mothers to feel supported, relationships needed to be empathic, mutual, non-judgemental, encouraging, respectful and engendering trust. A sense of “partnership” which symbolised sharing responsibilities with their partners was necessary. A sense of “kinship” with other new mothers also helped to normalise experiences.

**Partnership**

All of the new mothers said that their partners were the main source of support for them. Julie stressed that the “partnership” with her husband was the number one priority for her well-being. All these new mothers perceived support from their partners
as help, as though they assumed the main responsibility in what they considered a
“partnership”:

Dianne: It’s a shared responsibility.

Nicola: Mark would walk in the door at 7.30 and I’d say this baby has been
crying for an hour and he’d say give him to me and he’s got these wonderful
beautiful relaxed warm arms, Timothy would hop in and quite often he’d settle
down or if he didn’t I’d have time to have a drink, maybe get some dinner ready
and then Mark would give him back to me and he’d eat and you know we’d sort
of pass the parcel for a little while but having the partnership I think helped an
awful lot.

The majority of the new mothers described that their partner’s presence, their “being
there”, sharing and understanding their experiences was supportive for them. The
partner’s presence was perceived as a mechanism by which they could share their lived
experience, consequently their partners could develop sympathy or empathy and this in
turn increased their understanding and realisation of the difficulties the new mothers
were facing. Understanding this reality was necessary in order for the others to help in
the daily activities of infant care, provide a source of relief as well as encourage and
support the new mother:

Michelle: He’s very good actually - Stuart took a couple of weeks off work // ... to have someone else here who was going through it with me at the same time ... and I think having Stuart here and Stuart seeing me trying, at the same time it made him realise it wasn’t that easy.

However, some of the new mothers resented the fact that they experienced the prime
responsibility for coping or not coping with their infant:

Lisa: ... he has been here of a night and he will have him for five or ten minutes
and he is stressing out over him crying non stop or whatever and I say you should
cop that all day.

Partners were supportive by offering encouragement (Nicola) and being affectionate
(Jo, Julie). I have previously discussed how partners were perceived as being more in
control and that in contrast the new mothers described being out of control. The new
mothers were appreciative of their partners taking control when they were not coping. Partners also assisted their decision making. The development of a father/baby bond was also perceived as emotionally rewarding by the new mothers.

The majority of the new mothers said that their partners provided support by helping them with tasks in relation to infant care and housework. Help from partners was appreciated as it enabled the new mothers to rest and have respite from the care of their baby. Kathi, for instance, said that she needed to develop a trusting relationship with her partner. As the following extract shows she was unable to completely relax and trust her partner to care for their baby:

Kathi: Partner, he is a huge support, I could never imagine doing this without a supportive partner because he does more than half the housework, he does all the night time nappies, he baths Peter, he is very involved ... "I will take Peter for an hour, you go and rest" ... I have sort of just one ear out listening to hear what is happening.

Kinship

All the new mothers identified that, as well as their partners, other new mothers were their main sources of support. A sense of "kinship" developed which was supportive for them. Lisa has summed up this meaning:

Lisa: We are first time mothers // Nobody is judging you and nobody is saying you are doing good or you are doing bad // Kinship, it was sort of kinship // ... going through the same experiences together // ... not offensive // ... help each other out // We can say anything to each other // ... no one trying to give each other a hard time.

By being with other new mothers who are therefore equal in mothering experiences and by sharing and comparing experiences in such a nonjudgemental environment, these new mothers were able to normalise their feelings and experiences. The following excerpt from Michelle's transcript illustrates this meaning:
Michelle: And I think just talking to other people ... they said the same thing, they had problems, it wasn’t just me.

Other sources of support

As well as support from partners and other new mothers, support was also obtained by these new mothers from their own mothers, other mothers, other members of their family and from community nurses. Their own mothers provided emotional, informational and tangible forms of social support:

Nicola: ... but just to have the emotional support I think, somebody else, she just verified what I was doing and she was perfect as far as a support person because she didn’t interfere, she didn’t suggest or give lots and lots of advice that I didn’t want or whatever, if I wanted any advice I had to ask for it yeah and the rest of the time she just watched me and it just meant that I felt everything I did was OK because somebody else was watching it yeah and mum you know it wasn’t me doing it wrong basically it was OK, breastfeeding wasn’t working.

Their own mother’s presence was appreciated. Their emotional support verified the new mothers actions and feelings. However, the new mothers did not appreciate unasked for advice. Their mothers also provided tangible forms of support in that they helped with infant care and housework.

Kathi stressed that it takes enormous strength to ask for help because mothers are expected to cope. Community nurses offered emotional and informational forms of social support. Kathi was appreciative of these kinds of support and had these things to say about support from community nurses:

Kathi: I don’t think I would have called out for help myself // I wasn’t smart enough to ask for guidance because I thought, no I am going to cope with this, I am doing OK, I am capable // You need more tricks, you need more things to be able to do, you know more things in your repertoire to get your baby to sleep // Community nurses have to be quite assertive with you and say, I think you could use this // Need to be able to assess and be perceptive of signs of your baby not sleeping etc // [Community nurses need to ask] What was your experience of being mothered as a child?, on a one to one open communication/information level.
Types of support

These findings are consistent with previous research on social support. Similarly to previous research (Gjerdingen et al., 1990) this study found that partners provide emotional support. Unlike previous research, these findings emphasise that empathic understanding can lead to a partner’s tangible support. Emotional support was also obtained from other new mothers, their own mothers and community nurses who were empathic, non judgemental, respectful and verified their experience. These qualities helped these new mothers normalise their experiences. This finding extends current understandings of emotional support for mothers and the benefits of being with other new mothers (Knapman, 1991; Lawson & Callaghan, 1991). These finding also extend current understandings of community nurses offering social support to new mothers by also being emotionally supportive.

The findings from this study are congruent with those of Everingham (1994) in that a mother’s own mother provides emotional and tangible support. This study, like Everingham’s, found that the new mothers did not appreciate unsolicited advice, however, these new mothers identified the main source of unsolicited advice as being their own mother.

The findings also indicate that informational support was obtained from other new mothers, their own mothers and community nurses. I have previously commented on this in the section ways of knowing.

Being supported was a pattern of meaning of new mothers well-being. These new mothers needed to be supported whilst they were adapting to the losses they experience as new mothers and whilst they were resisting the societal ideology of being the ‘good mother’. Being supported was essential for new mothers’ in creating their well-being.
So, to summarise and to answer the third question of this chapter: What are the practices necessary for new mothers’ to create their well-being?

**SUMMARY OF CHAPTER: THE PRACTICES NECESSARY FOR NEW MOTHERS TO CREATE THEIR WELL-BEING**

There were three patterns of meaning identified by this study: adapting personal expectations; adapting to societal expectations; and being supported. Adapting personal expectations refers to new mothers adapting to the losses they experienced. These losses included loss of freedom, energy, control, confidence, personal identity and social status. These new mothers created well-being practices to balance or counter these losses. Adapting to societal expectations refers to the new mothers redefining and resisting (through their practices) the notion of being the ‘good mother’ because they felt ambivalent and guilty as a result of this discourse. The new mothers also stressed the importance of being supported so that they were able to create their own well-being. Being supported involved others “being there”, sharing their experiences, helping them, and being empathic, nonjudgemental and respectful. The notion of a “partnership” with their partner and the idea of a “kinship” with other new mothers was significant for their well-being.

The well-being practices identified by the new mothers in this study, that is the active ways they created their own and the baby’s well-being included; going out, my time, being in control, being confident, maintaining perspective and ways of knowing.

**Going out**

Going out refers to the adaptive practice by new mothers of physically removing themselves from the confines of the house in order to balance and counteract the loss of freedom they experienced. It represented an escape, being involved socially and being with nature. It helped them to prove to themselves they could cope and they
appreciated public recognition of their inability to cope at times. Going out was also a normalising practice.

My time
My time refers to these new mothers having time for themselves in which they could choose what they wanted to do in order to balance and counteract the loss of freedom and loss of energy they experienced. My time for these new mothers meant feeling rested, relaxed, pampered as well as rejuvenated. Having my time also meant that they were meeting their own needs.

Being in control
Being in control refers to these new mothers being in control of what they can in their lives in order to balance and counter the loss of control they experienced in some areas of their lives. Being in control meant being organised in order to meet their infant’s needs as well as their own needs it was important to their own sense of well-being.

Being confident
Being confident refers to these new mothers having a positive attitude towards the development of maternal confidence, self image and self esteem in order to balance and counter the loss of confidence and self esteem they experienced. Being confident meant being positive, “looking good”, “feeling good” and maintaining a public appearance of coping.

Maintaining perspective: Normalising
Normalising refers to these new mothers personally and socially putting their feelings and experiences into perspective. This consequently aided their coping. Normalising involved getting out of the house, being with nature and comparing and sharing experiences and feelings with other new mothers, thus developing “kinship”.
Ways of knowing

New mothers’ ways of knowing includes subjective, objective and constructed forms of knowing. Ways of knowing includes mothers possessing an innate way of knowing which is intuitive as well as experiential in nature and interdependent on received knowledge advice.

I have summarised the active practices identified by these new mothers in this study. These practices show that these new mothers were active in creating their own well-being. These new mothers identified that they needed to be supported by the important people in their lives so they could create and achieve their own well-being.

In relation to current phenomenological understandings of health, new ideas have emerged from the findings of this study. The notions of escaping, proving they can cope, appreciating public recognition of their inability to cope and normalising their situation extends current understandings of phenomenological descriptions of health.

A new idea which has been revealed concerns the idea of new mothers being pampered. Also, the importance of being with nature and the importance of being with others who share similar experiences in order to normalise feelings and experiences. This second idea extends current understandings of the benefits of ‘new mothers’ groups’. Finally, this study’s findings signal the importance of subjective, objective and constructed forms of knowing for new mothers’ well-being.
CHAPTER 7: CONCLUSIONS

INTRODUCTION

This chapter answers the remaining question of the thesis: what can we [as nurses] do for new mothers? I will discuss implications of this study for nursing practice, education and research.

WHAT CAN WE [AS NURSES] DO FOR NEW MOTHERS?

The purpose of this study was stated in the introduction. It was this: The information, knowledge and understanding obtained from this study will inform nursing practice. This study provides some understanding of new mothers’ well-being. The new mothers have provided some definitions of well-being. The common patterns of meaning in their definitions were articulated along with the practices necessary for them to create their own well-being.

Three patterns of meaning were articulated. First, adapting personal expectations, second, adapting to societal expectations and third, being supported. These patterns of meaning were related to each other.

New mothers create their own well-being through their practices. The practices they identified included; going out, my time, being in control, being confident, maintaining perspective: normalising and ways of knowing. This understanding derived from these patterns of meaning of new mothers’ well-being will inform nursing practice.

The new mothers in this study identified that they needed to be prepared for new motherhood by knowing that they would experience a variety of normal feelings and that they would experience good and bad days. They recommended that antenatal
education should include discussion of these experiences. So, what can we [as nurses and midwives] do for new mothers?

1) We need to explore adapting to becoming a mother, which involves adapting personal expectations and adapting to societal expectations in educational programs with expectant mothers and new mothers. We need to discuss with women, before the birth of their child, losses including loss of freedom, energy, control, confidence, personal identity and social status. Through discussion of these normal experiences antenatally, mothers will be informed and prepared for new motherhood.

2) We need to discuss the ideology of the ‘good mother’ in educational forums with expectant mothers and new mothers. Through the development of critical analysis of the ideology of motherhood and knowing how to resist this ideology in their practices, the well-being of new mothers will be enhanced. Critical analysis of the representations of mothers in the media is one way to discuss the ideology of motherhood and the implications of this discourse on mothers’ well-being. We need to re-image motherhood so that images depicted are real and positive.

3) The revelation of this study is that new mothers’ themselves create their own well-being. New mothers can also be prepared by knowing what practices can create their well-being. The knowledge that the new mothers in this study have provided, and which we [as nurses] can inform other mothers about, will give them strategies to transcend coping in order to achieve their own well-being.

4) The above discussion may be more appropriate at ‘new mothers’ group’ forums as personally I have found that antenatally, expectant mothers seem to focus on preparing for birth. My discussion of the benefits of “kinship” with other mothers illuminates how other new and therefore equal mothers who have similar experiences can normalise their experiences and advise them in a nonjudgmental manner.
5) The new mothers in this study have indicated that being supported is essential for their well-being. Knowledge of social support, types of support and sources of support will prepare them for knowing who is available at the interpersonal and community level to provide support if needed and what will be gained from particular types of support.

6) The new mothers have articulated that they require empathic understanding of their experiences. They need respite, they need tangible help, they need relationships which are empathic, mutual, nonjudgemental, encouraging, respectful and engender trust. So what can we [as nurses] do for new mothers? We can demonstrate these qualities in our nursing practice.

7) Community nurses need to listen to new mothers, be perceptive and be aware of the problems they experience. Community nurses need to be proactive in asking about their experience of mothering including their own experience of being mothered as a child. Community nurses need to assess the problems new mothers' experience and offer advice on how they can cope.

8) We need to incorporate an understanding of a social view of health into the dissemination of information about new mothers' well-being. By incorporating the philosophies of primary health care, that is of social justice, equity and self reliance and health promotion strategies of; building a healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services towards prevention of health problems, social justice can be achieved.
IMPLICATIONS FOR NURSING EDUCATION

There were a number of issues raised in the literature review. The first concerns current conceptualisations of health which have not adequately considered the social context of people. The second concerns the question of ‘empowerment’. Can nurses empower their clients?

Nursing education needs to explore further the social view of health and incorporate the philosophies of primary health care and health promotion strategies into conceptualisations of health. The knowledge of new mothers’ well-being gained from this thesis provides new conceptualisations of health for the development of nursing and midwifery models and nursing theories.

This study has questioned health promotion’s claim that health care professionals can empower people’s health. The nursing literature indicates that nurses are confused about the meaning of ‘empowerment’. We need to explore further the notion of empowerment along with power in nursing studies. This study has indicated the benefits of incorporating feminism and Foucault’s ideas on power, knowledge and truth in order to understand women’s lived experience of well-being.

Hermeneutics as a creative process needs to be given credence in nursing education. My metaphor ‘hermeneutics as dance’ highlights the benefits of metaphorical thinking, that is of analytical thought which is desirable for all nurses whether in the clinical area, education or research arenas.
IMPLICATIONS FOR NURSING RESEARCH

This hermeneutic study focussed on how new mothers define their well-being, what common meanings were in their definitions of well-being and what practices create their well-being. The framework of this study can be a foundation for further studies, multicultural and socially. It would be useful to explore other cultures meanings of new mothers well-being, especially less privileged countries than Australia and disadvantaged groups of women in Australia, that is Aboriginal women, Non English Speaking Background women, lower socioeconomic groups, single mothers and differently abled mothers.

Hermeneutics transcends description to include interpretation of phenomena in historical, cultural and social contexts and also incorporates the researcher's understanding into the research process. I have incorporated a post-structuralist feminist perspective and used Foucault's ideas on power, knowledge and truth in this hermeneutic study however further research could adopt an alternative interpretive framework.

I created my metaphor ‘hermeneutics as dance’ to highlight the creativity of hermeneutics. Through creative thought the researcher can illuminate and discover lived experiences. Imagery, creativity and discovery are inextricably linked in order to gain understanding of people’s experiences not only in a literal sense but also in a visual and kinaesthetic sense. The richness of this kind of imagery can be used to discover the vividness of any lived experience. ‘Hermeneutics as dance’ is an innovative, creative way of understanding people’s lived experience.
EPILOGUE

Imagery and creativity have been an integral part of this thesis. From the beginning I attempted to image the patterns of meaning of the new mothers’ well-being. For my presentation at the International Nursing Conference, Research for Practice: Making a difference at Newcastle in July, 1995 (refer to Appendix D), I collaborated with two dancers Fiona James and Sara Nyssen from the Blue Mountains. Slides were made of tableau vivant and dance movements to depict the new mothers’ patterns of meaning. These still images were exhibited through a slide projector at the conference. We choreographed a dance about new mothers supporting each other to the song and music track called Tiddas presented at the beginning of chapter 1. This song about the meaning of sisters is sung by the Aboriginal women’s group of the same name, as part of their first album Sing about life. This choreography has been presented at various venues including the Research for Practice: Making a difference conference and Katoomba Dance Theatre’s production of Living in Women’s Flesh, September, 1996 in the Blue Mountains.

Imagery has been expressed in other media including performance poetry. The poem, titled Metamorphosis: Things new mothers need presented at the beginning of the findings chapter was composed by a friend, who is a poet/painter, Frances Jowett, and myself. This poem was performed in alternate voice at the Katoomba Dance Theatre production Living in Women’s Flesh in 1996 and at poetry performances at the Blue Mountains Folk Festival, 1997 and Parakeet Poets monthly meeting, Katoomba, 1997.

This kind of imaging and creativity has all been a part of my hermeneutic understanding of the new mothers’ well-being.
Appendix A: INFORMATION / CONSENT FORM

What is the nature of women’s well-being in the first three months after the birth of a baby?

Researcher: Rose Cole
Phone: AH: (047) 592503

The purpose of this research is to explore the nature of women’s well-being experienced during the first three months after the birth of a baby.

This study will involve tape recording of a conversation between myself and individual women exploring the theme of “Talk to me about your experiences of well-being”. There will be no time restriction for the conversation. The time and place of the conversation will be chosen by the participants. Information will be reviewed at the end of the conversation so you can identify material which you do not wish to be included in the study. The tapes will be transcribed verbatim. I will then interpret the information to identify themes which emerge from the conversations. This information will be of benefit in preparing and educating women before and after the birth of their baby.

Participation is voluntary and you may leave at any time. Reflection on the meaning of well-being may be stressful as involves descriptions of feelings, moods and emotions. Stress may be felt immediately or at some time after the conversation. If you do feel stressed do not hesitate to let me know as I will counsel you or refer you to a professional counsellor at Lawson Community Health Centre ph: (047) 591707. I’m sure the majority of you will find reflection of your well-being a positive experience. Participation or nonparticipation will in no way affect your care from the community nurse.

Names and specific situations which can identify you will be changed to ensure confidentiality and privacy. I will be the only person to have access to the information obtained, that is on tape, disk and in written form. I will keep all the information in a locked cabinet in my study at home for a period of five years. I will send all participants a copy of a summary of the findings of this study.

CONSENT

I give my consent to participate in a conversation for the above study. I understand that:
1. My consent to participate is voluntary and I may leave when I like with no questions asked.
2. I have read the above information and I feel adequately informed. I will keep a copy of this form.
3. If I decide not to participate, my decision will be respected.

(please sign here) Thanks for participating in this study.
Appendix B: THE NEW MOTHERS: BACKGROUND INFORMATION

Lisa
Lisa was 25 years of age; her partner Matthew, a carpenter, was 27 years old. Lisa worked in a bank and left when she was six months pregnant. They moved to their new house in the Blue Mountains one week prior to the birth. The birth was a planned homebirth, however Lisa was transferred to the regional hospital for failure to progress during labour. Lisa “sobbed” as a result of this transfer. Hospital meant drips, monitors and an epidural anaesthetic. Brendan’s birthweight was 8lb 1oz and he was 51cms long. Whilst in hospital Lisa felt she was overtly discriminated against because she had decided to birth outside the system. This was perceived in the postnatal ward because she was not seen by a midwife and her baby was not checked by a paediatrician. She felt “disappointed”. Brendan was nine weeks old when Lisa and I had our conversation.

Kathi
Kathi was 35 years of age, her partner Bill was 37 years old. Kathi was employed as a head of management training for a firm, Bill was a surveyor. Kathi spoke of her pregnancy as a “good pregnancy” in that she hadn’t been sick, however she was frightened of birth. The birth occurred at a private hospital at the regional centre. Peter weighed at birth 9lb. Kathi recalled the birth being a positive experience. She felt “proud” of the natural breech birth, with no stitches! She felt “strong and well” after the birth. She had few expectations. She stressed to me that there was an emphasis on her physical state in hospital. In the postnatal ward she felt that she didn’t talk to other mothers although there was a visitors room. At the time of the conversation between Kathi and myself, Peter was 20 weeks and 4 days old.
Dianne

Dianne was 32 years of age, her partner Robert was 45 years old. Dianne worked as a TAFE teacher until 34 weeks pregnant. They had moved from a coastal suburb of Sydney at Christmas after being married. The pregnancy she viewed as “fate, just happened”. The birth occurred by vacuum extraction at a birthing unit at a large Sydney hospital. Dianne commented to me that her baby “had a temperament”. After the birth, Dianne emphasised that she felt she was treated as a leper due to the isolation procedures on account of her having chickenpox. Dianne also told me that she experienced trouble breastfeeding her baby. Dianne was seen at home by the Domiciliary Midwife and then by the Community Nurse. At the time of the conversation with Dianne, Alexander was 15 weeks old.

Jo

Jo was 30 years of age, her husband Richard was also 30. Jo worked in an industrial laboratory in the western suburbs of Sydney, Richard works for a social service organisation in another western suburb of Sydney. They moved to the Blue Mountains six months prior to the birth and at this time she also left the lab. Jo gave me an account of her life prior to migrating to Australia from Manilla. Jo’s parents died when she was 13 years of age and she spoke of her life as being poor. Jo migrated to Australia in 1989 and was adopted by an aunt. She is a Catholic and expressed “a strong faith in God”. Jo experienced morning sickness during pregnancy and was also diagnosed as having Gestational Diabetes where treatment involved insulin administration. Her labour was “painful”. Sophia was a Normal Vaginal Delivery at a large Western suburbs hospital. After the birth she felt “lonely, missed family, painful, bleeding, waking up depressed”. At the time of my conversation with Jo, Sophia was five and a half months old.
Julie

Julie lived with Grant who was 40 years of age. Julie worked at a large Sydney university in Administration Science, Grant worked as a marine engineer at a Sydney location. They had been married for three years. Julie described having a baby as "the next stage". Julie viewed her pregnancy as a "good pregnancy, was well!", she didn't experience morning sickness and swam. She described the birth as "pretty good". However, she needed to "voice her opinion", that is assert her opinions in labour. Julie remembered having the gas and having "good concentration", however was "out of it" once given pethidine. The labour was induced and Kate was born at the local hospital in the Blue Mountains. Julie described a spiritual experience at birth, she saw her grandmother who was half Chinese and half Koori giving her a tapestry. This was a vivid memory for her. At the time of the conversation with Julie, Kate was 17 weeks and 2 days old.

Michelle

Michelle was 29 years old and is married to Stuart of the same age. Michelle worked as a clerk at an organisation in a large western suburb of Sydney. They had been living in their house for five years. She described herself as being well during pregnancy as she didn't experience morning sickness. When she was five months pregnant, the January bush fires destroyed her parents' home and subsequently they were living with them. Michelle said her pregnancy was "a positive experience and I pulled together with my husband". The birth was "long", was induced, involved an epidural for pain relief and resulted in a normal birth of Jordan. "I felt good at birth". After the birth she experienced the three day blues (teary), Jordan was jaundiced and "he wouldn't suck". She was seen by the Community Nurse as well as the Lactation Consultant. At the time of my conversation with Michelle, Jordan was 25 weeks and 3 days old.
Kim

Kim was 25 years of age, her partner Peter was 40 years old. They had been together for four years. Kim worked as a supervisor at a credit control department at a western suburb of Sydney. She experienced pregnancy discrimination at work. This was in the form of “put downs” (referring to pregnant women as being emotional and incapable) by male staff and power dressing women managers who hired men when women were on maternity leave. Kim attended the midwife clinic at a local hospital and said “it helped to know their first names”. Her labour was painful and long. The midwives “were so good” because they listened. She wanted to do it “natural”. Nathane was born by Caesarean Section and he was 9lb 14oz. Breastfeeding problems resulted in an admission to Tresillian. Kim felt pressure to breastfeed and perceived a lack of empathy from the Community Nurses who labelled her as being postnatally depressed when she had problems with breastfeeding. At the time of my conversation with Kim, Nathane was 16 weeks and 4 days of age.

Nicola

Nicola was 27 years of age, her partner Mark the same age. Nicola worked as a yellow paper trainer (clerk), Mark worked in pharmaceutical exports. Nicola and Mark had been together for 10 years. Nicola attended the midwives clinic and described them as being “receptive, had more time than the doctors and there was a rapport as the midwives were rotated from antenatal, delivery and postnatal”. Hospitalisation during pregnancy made her realise there were people “worse than me”. Timothy was a normal birth. After the birth she felt euphoric. In the postnatal ward Nicola expressed that the midwives didn’t have much time to spend with her. Nicola expected breastfeeding to be natural and felt unsupported by the nursing staff who emphasised the physical and didn’t ask “How are you feeling?”. Nicola was seen by the Community Nurse and Family Care Nurse who were “wonderful”. At the time of my conversation with Nicola, Timothy was 20 weeks and 3 days of age.
Appendix C: ETHICAL CONSIDERATIONS

The ethical framework for this study was based on the Australian Health Ethics Committee draft discussion paper which incorporated the National Health and Medical Research Council (NH & MRC) guidelines Assessment of qualitative research: Information for institutional ethics committees (1993). The following is a summary of these ethical considerations and how I dealt with them.

(1). Informed written consent being obtained from the new mothers prior to the study. This involved written consent by the new mothers after an explanation of the purpose of the study, procedure and ethical considerations.

(2). Maintenance of the principle of non-coercion (House, 1990). Voluntary participation occurred with the opportunity for the new mothers to leave from the study if desired.

(3). Confidentiality and anonymity being maintained. All women were asked at the conversation if they wanted any name change, one woman requested name changes of family members only. All women requested that they be referred to by their first name and this was respected throughout the research process.

(4). Access to the results of the study being offered to all the new mothers. This was done.

(5). Ethical issues arising from the methodology were dealt with by a referral mechanism for counselling to the health service if stress was experienced by the new mothers.

(6). NH & MRC guidelines for storage of information obtained from the study was adhered to. This information is being stored on disks and hard copy in a locked filing cabinet in my house for a period of five years.
Appendix D: CONFERENCE PAPER

METAMORPHOSIS: HERMENEUTIC ANALYSIS AS A DANCE

EXPLORING AND DISCOVERING WOMEN'S WELL-BEING AFTER THE
BIRTH OF THEIR FIRST BABY

Metamorphosis in this context refers to the change that occurs when women become
mother’s for the first time. Women’s needs also change.

As a Community Nurse, my experiences caring for women in the early mothering
period has led me to reflect and be concerned about well-being for women. Well-being,
which is central to nursing practice can be understood only through personal
descriptions (Parse, 1987). The goal of nursing is to respond to personal needs by
developing strategies with women to promote and maintain their well-being.

What is well-being? What is the meaning of well-being for women who have had their
first baby? What are the essential structures of well-being? These questions have
inspired me to search for the nature and meaning of well-being from the woman’s
perspective. Here is one participants definition and description of well-being:

Well-being is feeling good and being happy and it means; a happy healthy baby,
having time for yourself, adequate sleep, feeling of achievement, good self esteem
and support.

The literature exploring aspects of women’s well-being after the birth of a baby has
been primarily quantitative where researchers have attempted to objectify and quantify
women’s experiences. There is a need to study the lived experience of women from
their own perspectives.

Phenomenology aims at the understanding of the nature or meanings people ascribe to
their experiences. There is significant nursing Husserlian phenomenological studies in
relation to health (Beck, 1991; Parse, Coyne & Smith, 1985; Rose, 1990) however these
do not explore women’s lived experience after the birth of their first baby. There is a need for quality insight into the question of well-being for women.

Aims

The goal of this study is to understand the lived experience of women’s well-being after the birth of their first baby. The aims are to explore and discover women’s well-being:

To define it
To describe it
To identify well-being practices
To inform and prepare women antenatally for well-being postnatally
To contribute to nursing practice and research
To contribute to feminist research
To empower women.

Methodology

A phenomenological approach achieves the aims of this study. Phenomenology involves describing lived experience, the taken for granted everyday experience of the life-world, to disclose common shared meanings (Cohen, 1987).

In the Husserlian phenomenological approach, researchers bracket presuppositions, reflect on described experiences and describe the essential structures of the experience being studied. Hermeneutic phenomenology transcends description to include interpretation. Hermeneutics comes from the Greek word “hermencia” which consists of three directions of meanings: to express/expression, to interpret/interpretation as well as to translate/translation (Reeder, 1988).

Heidegger shifted the philosophical debate from epistemology to ontology, he was interested in the meaning of existence (Leonard, 1989). Being-in-the-world encapsulates the meaning of a unity of people in the world incorporating holism and
context, that is cultural, social and historical influences. Heidegger rejected bracketing and advocated the valid incorporation of presuppositions into meaning (Ray, 1994). Gadamer, a pupil of Heidegger introduced the term effective historical consciousness to symbolise an awareness of prejudices ruling one's own understanding. A fusing of horizons occurs when one's horizon, that is one's point of view is understood to comprehend another's. The act of fusion of the two horizons is through an act of understanding.

In this study, hermeneutic phenomenology involves description of the lived experience of well-being for women who have had their first baby as well as hermeneutics which is the act of interpretation to discover the nature of the lived experience. The goal is understanding the lived experience.

Hermeneutic phenomenology involves the researcher within the research by contacting the researcher and participants during the research process (Walters, 1994). Bergum (1989) describes this as an interactive involvement. This concept is developed into the metaphor of dance for hermeneutics.

**Hermeneutics as dance**

My Being-in-the-world involves being a nurse, a dancer and a feminist. As the researcher, my history affects the lens with which I view the research process and its interpretation. From my initial conversations with women, I interpreted the process as a dance. A dance of hermeneutics. Table 1 summarises the similarities between dance and hermeneutics.
Table 1: Similarities between Dance and Hermeneutics

<table>
<thead>
<tr>
<th>DANCE</th>
<th>HERMENEUTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim to describe, interpret, communicate and understand lived experience</td>
<td>Aim to describe, interpret, communicate and understand lived experience</td>
</tr>
<tr>
<td>Communication occurs through movement</td>
<td>Communication occurs through language</td>
</tr>
<tr>
<td>Dancer as instrument-interaction</td>
<td>Dancer as instrument-interaction</td>
</tr>
<tr>
<td>Process involves:</td>
<td>Process involves:</td>
</tr>
<tr>
<td>*Preparation: purpose, background understanding</td>
<td>*Preparation: purpose, background understanding</td>
</tr>
<tr>
<td>*Exploration: concepts/ideas</td>
<td>*Exploration: concepts/ideas</td>
</tr>
<tr>
<td>**Illumination: symbols=patterns of meaning communicated through body language (movement).</td>
<td>**Illumination: themes=symbols=patterns of meaning communicated through language.</td>
</tr>
<tr>
<td>*Formation: choreograph into composition</td>
<td>*Formation: thematic analysis</td>
</tr>
<tr>
<td>The dance demonstrating an integrated whole, uniqueness of meaning (Blom &amp; Chaplin, 1988)</td>
<td>A written document demonstrating an integrated whole, uniqueness of meaning (van Manon, 1990)</td>
</tr>
<tr>
<td>Cylindrical pattern</td>
<td>Hermeneutic circle</td>
</tr>
<tr>
<td>Projection: something comes alive resulting in understanding</td>
<td>Projection: something comes alive resulting in understanding</td>
</tr>
</tbody>
</table>

Dance is compatible as a metaphor for hermeneutics due to similarities in aims, interaction and process. Dance and hermeneutics aim at an understanding of lived experience. In dance, there is interaction between the dancer and the dance. In hermeneutics there is interaction between the researcher and the researched as well as the researcher and the text.

The process of dance and hermeneutics includes: preparation, exploration, illumination, formation and projection. The process of dance will be described for hermeneutics.
Preparation refers to interpreters stating the purpose of the research as well as using their background understanding to comprehend a lived experience.

Illumination involves imaging patterns of meaning. Lived experience is articulated by participants through conversation and turned into text through the process of transcription. The interpreter enters into dialogue with the text by a process of hermeneutic phenomenological reflection. Interpretation involves the hermeneutic circle where the whole of the text is understood from its parts and the parts from the whole (Schleiermacher, 1977 cited in Reeder, 1988). Through reflection interpreter's seek commonalities in meanings, situations, practices and bodily experiences (Benner, 1985). These images are symbolised as patterns of meaning or themes.

Thematic analysis results in the formation of a written document which is integrated and expresses a unique understanding. It is through projection, a reaching out and contacting the reader in some way that understanding is created.

Hermeneutics as a dance is a creative way of exploring discovering and understanding women's well-being after the birth of their first baby. To search for this meaning, I chose the context where my community nursing experiences fostered a concern for women.

**Context**

I conducted this study in the Blue Mountains. It is known for; its national heritage status, Australia's highest bushfire risk and its climate. There is enormous geographical diversity with highly urbanised, as well as isolated rural communities. Isolation and transport issues concern residents as well as the reliance on regional services, especially for birth.
Participants
There were eight participants in this study. One participant was accessed through an independent Certified Midwife and the remaining through a new mother’s group at a local Community Health Centre. Women were experiencing their first baby and all had partners.

Research Process:

I present
METAMORPHOSIS

Prelude
I contact and connect with women’s experiences of well-being through conversations. This occurs with the women and their baby’s in an exchange of food, drink and talk.

Act I- imaging the journey begins

Scene I-spotlighting: This scene involves spotlighting transcribed text to illuminate patterns of meanings: themes. I search for images.

Scene II-dancing through the maze: This scene involves a choreographic process of hermeneutic phenomenological reflection and thematic analysis.

Act II- metamorphosis: The patterns are expressed in an integrated form. Sense of; realisation, knowing, achievement, maintaining appearances, time for self, being supported and a sense of transcending coping.

Act III-revelations: The audience interprets the expression and there is a unique understanding.
Patterns
The thematic analysis revealed the patterns, sense of; realisation, achievement, knowing, maintaining appearances, being supported and having time for self. A sense of transcending coping was a prerequisite for women’s well-being. Well-being is the integration (fusion) of the preceding patterns. The meanings of the patterns will be described as follows.

Sense of realisation- “falling into place”, “letting go”, “acceptance”
Realisation emerged as the central pattern. Realisation meant for the women the challenge of; letting go of the past (prior goals, career), acceptance of the life change (being tied down, enjoying the baby relationship), as well as having realistic goals.

Sense of achievement- “getting things done”, “feeling that its working”, “my time”
This pattern refers to the ability of women to care for their baby (enjoy relationship, settling) as well as complete their housework tasks. Being organised was a prerequisite for achievement. A sense of time for self was also needed for women to feel a sense of achievement.

Sense of knowing- “sussing out”, “trial and error”, “mother knows best”
This pattern refers to women personally knowing themselves as well as acknowledging themselves as a mothering expert. A process of experiential learning occurred. A positive attitude, a sense of being in control as well as being selfish was integral to a sense of knowing.

Sense of maintaining appearances- “Looking good”, “looking well”
This pattern refers to the notion of personal grooming (hygiene, haircut) to boost self image as well as to be seen to be coping by others. Looking good meant for the women having a positive attitude and feeling confident. Weight loss was integral to this meaning.
Sense of being supported- “being here”, “partnership”, “kinship”
This pattern refers to women having help with daily activities as well as others sharing and experiencing with the women. Respite was needed by women. For women to feel supported, relationships need to be; empathic, mutual, reciprocal, non judgemental, respectful and engender trust. A partnership which symbolised sharing responsibilities was also necessary. A sense of kinship with other mothers helped to normalise experiences.

Sense of time for self- “my time”
This pattern refers to women choosing an action which would pamper and rejuvenate them. Coping was seen as; restoring energy, having relief and the ability to feel rested and relaxed. Rejuvenation occurred by; getting out of the house, creating a luxurious environment (bath), sleeping, exercising, reading, watching tellie, having a cuppa or being social.

Sense of transcending coping- “the step prior to well-being”, “surviving”, “you feel you should cope”, “you should ...”
A sense of transcending coping was identified as a prerequisite for women’s well-being. Women need to cope with New Mother Abuse, which results in women feeling guilty because they are unable to meet society’s unrealistic, authoritarian expectations of new mothers’. These expectations do not reflect their lived experience. Women transcend coping by rejecting these expectations and images by accepting life at this time. Believing and trusting themselves is essential as women take control of their lives in a process of self realisation.

Implications for nursing practice
I will discuss implications for nursing in relation to the; antenatal, labour, postnatal and early mothering periods. Initially, there is a need for nursing education.
NURSING EDUCATION

Nurses need education regarding the significance of well-being in the early mothering period. Only then can they prepare to develop strategies to meet those needs in association with women.

CLINICAL PRACTICE

Antenatal

There needs to be:

1. A change of focus from labour in antenatal classes to the postnatal and early mothering/parenting period. Positive, realistic experiences also need to be incorporated.

2. Exploration of socialisation and subsequent expectations, both personal and societal in the antenatal period for both women and partners. Critical analysis of media images is a strategy to explore and discuss society's views of women.

3. Midwives' Clinics as midwives develop rapport with women. Continuity of care is maintained by the rotation of midwives through the; antenatal, labour and postnatal areas.

Labour

During labour midwives need to respect women by listening to them, seeking opinions and acting as advocates.

Postnatal

There needs to be:

1. An increase in midwife staffing in postnatal wards or the development of strategies to increase time given to women. An example of this is group work with mothers.

2. A reduction in the focus on the physical by asking women "how are you feeling?".

3. Debriefing of labour and birth for women.
(4). Common meeting areas for women to be with other mothers so they can share experiences and learn.

(5). An increase in Lactation Consultants to support women experiencing breastfeeding difficulties.

(6). Regular inservice for nurses to maintain professionalism.

(7). An increased number of Clinical Nurse Specialists to ensure accurate advice is given to women.

(7). Awareness of community nursing services by midwives to inform women of appropriate resources in the community.

Early motherhood

There needs to be:

(1). Domiciliary Midwife Programs. Integral to this role is knowledge of community resources to support women.

(2). Community Nurses who are; non-judgemental, supportive and give advice on request from women.

(3). Debriefing of labour, birth and the postnatal experience.

(4). Community Nurses who are up to date in knowledge to ensure accurate advice.

(5). Adjunct community nursing services, especially Lactation Consultants and Family Care Nurses.

(6). Awareness by Community Nurses of resources for referral, that is for physical, social and economic needs.

(7). Promotion of New Mothers’ groups for their normalising effect for women.

(8). Community nursing knowledge of the Domiciliary Midwife Program, Tresillian support in the form of day clinic and residential care, local mothers’ groups, Nursing Mothers’ Association, home help and family support.

(9). Advocacy by nurses for the extension of home help services beyond the Domiciliary Midwife Program.
(10). Liaison with General Practitioner's to increase their awareness of community services.

NURSING RESEARCH

The framework for this study can be a foundation for further studies; multic culturally and socially. It would be interesting to explore other cultures meanings of well-being for women who have had their first baby, especially less privileged countries than Australia. Disadvantaged groups of women in Australia, that is, Koori, Non-English Speaking Background, lower socio-economic groups (single mothers), socially isolated and differently abled women could be studied to identify needs and strategies to aptly support women. Statistically with more women returning to the workforce after the birth of their first baby it would be worthwhile to study working women who are recent mothers to elicit their well-being needs and the strategies they adopt to meet them. The possibilities for nursing are endless.

In conclusion, this study is the depiction of the experience of metamorphosis of women to motherhood and how this process reflects on their well-being. The patterns of meaning revealed a sense of; realisation, achievement, knowing, maintaining appearances, being supported and having time for self. A sense of transcending coping was identified as a prerequisite for well-being. Dance is a creative language for communicating this meaning.

Acknowledgement

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References


REFERENCES


Cole, R. (1995). Metamorphosis: Hermeneutic analysis as a dance exploring and discovering women’s well-being after the birth of their first baby. *Research for Practice: Making a difference*. Conference proceedings, International Nursing Conference, the University of Newcastle, the Faculty of Nursing, NSW, Australia, 6-8 July, 1995 (pp. 103-110).


