Chapter 1  CHILD DEVELOPMENT

From the point of sperm meeting ova to full adult human is a stream of constant, transformational change - a metamorphosis of magnificent proportions. There are many views about what contributes to, and influences this change. The history of how children have been seen and the theorizing about child development is fascinating (see Hope, 1992; LeDoux 1996). The fortunes of children change according to the values dominant in any family, culture or period of history about what is 'good' parenting and what are 'good' children. Following is a potted tour of the approaches that informed my clinical work and the development of this thesis in which I sought to understand how to prevent children's emotional and behavioural problems. It is important to take you on this journey because the threads gathered from disparate sources inexorably lead to and support the power of the prenatal relationship.

The quality of a child's early experience of emotional availability, security, attachment, nurturing, discipline, has a powerful impact on development and is the basis of a massive literature.\(^2\)

Clearly.....CHILDHOOD IS POTENT.

Thinking about child development has been, and continues to be, influenced by the pathological, and driven by the quest to answer why is this child or adult suffering, or inflicting suffering? What is the cause of problems? This current study, motivated by a clinical desire to prevent the development of childhood problems also started with research into pathology which demonstrates the powerful role of experience in shaping a life in childhood, adolescence and adulthood.

Imagine

A 2 year old child at a supermarket checkout, screaming and flailing in agony at mother’s refusal of a lolly that sits temptingly in hand's reach. The mother, harshly hitting and verbally abusing her tantruming offspring; powerless, embarrassed, furiously angry at the supermarket for having lollies in children's reach - at her partner for working such long hours to support the family financially and so never there to support her emotionally - at herself for her exhausted impatience - at society for its family unfriendly policies and structures.

A 13year old boy, sullen, non-communicative, learning difficulties, problems at home and school where he’s been suspended 4 times for abusive outbursts at teachers. He mumbles in a brief moment of talk that ‘they wanted a girl not me’. He sits stabbing at his arm and grunts at the notion that life feels too hard to live. He brightens a little at any positive attention - but not for long - he just can’t trust that someone cares. His parents, frustrated, consumed with hopelessness about his impossible behaviour, confirm to him his unwantedness. A vicious cycle in which all feel helpless victims.

Intervention, like research, is not neutral. What one believes about the 'cause' or nature of these children's behaviour, will influence what one thinks can be done and thence the goals and design of intervention. For example, if genetic or biological, surgery or medication are the logical interventions; if intrinsic to the person because of their experiences and unresolved reactions, then personal therapy may help; if learned, then re-learning is necessary; if produced by society's injustice, then social factors and social change become the focus; if mothering is to blame, then mothers need to be changed.

Herman, (1992) and Daly (1990) provide an example through their descriptions of the change in Freud's approach. Initially he believed many of the women he saw were suffering the consequences of being sexually abused. The social and personal implications of this were so problematic that he reformulated his theories on the assumption that these women were fantasising and projecting their sexual longings onto their fathers. One can only speculate on what massive differences there would now be in psychology AND society if he had had the courage to risk society's outrage and the offence of his friends (some of them the fathers of his clients). Freud's work has had a major impact on views of the child in theory and practice. Analytic psychiatry gave childhood a central focus and recognized the potency of childhood experience. However, his theories of child development were formulated primarily through the eyes of adult patients struggling retrospectively with problems that seemed rooted in their early childhood.

In my practice as a child and family therapist I meet the full spectrum of attitudes and beliefs, from children are born good and need nourishment, to children are born bad and need punishment - the gardening versus animal training models. (I lean toward gardening).

Parents frequently indicate a need to show "who's boss", fear of newborns being in control or being spoilt, concern about picking their child up when s/he cries in case s/he becomes addicted to it and manipulative. Hope (1992) reports that the origins of the control approach to parenting go back to the Puritans who believed in the innocence of childhood but feared that leniency and too much affection would make children irreverent and contemptuous. Self-control and submission of will were instilled by physical means, including levels of violence now deemed abusive.

"the young child which lieth in the cradle is both wayward and full of affections; and though his body be but small, yet he hath reat (wrong-doing ) in his heart, and is all together inclined to evil ...If this sparkle be suffered to increase, it will rage and burn down the whole house" (17th Century writing of John Dodd cited in Hope, 1992, p24).

Despite contrary evidence, puritanical notions linger and form the basis of much Western childhood advice.

Mary Ainsworth and her colleagues .... found that infants who in the first three months were held tenderly and carefully, picked up and cuddled merely to show affection and held for relatively long periods, tended to enjoy the physical contact and were happy to be put down. On the other hand, they found that infants who were picked up frequently and abruptly and held tentatively for relatively brief periods of time, tended to respond negatively to being held. They tended to fuss and squirm to be put down but then immediately, as though in protest, began to
cry and reach out to be picked up again. At 12 months these neither enjoyed being cuddled nor wanted to be put down. They were the clingy, dependent ones who were more reluctant to separate from their mothers and explore their surroundings (Hope, 1992, p 24:25).

While the understanding of child development in the Western world has also been influenced by the nature - nurture debate and cognitive behaviourism, my work fits broadly under the wings of attachment theory pioneered by John Bowlby (1971; 1979a; 1988) and elaborated by Mary Ainsworth (1989; Karen, 1990, 1994). Their theorizing, research and teaching has inspired others (see Karen, 1994) to research and apply clinically the basic idea that an infant’s relationship with its primary care giver has distinct, observable patterns which become the template for future affectional relationships. It is also influenced by sociological/social work perspectives which move beyond the personal psychological focus and help put prenatal relating in a broad context.

1. ATTACHMENT THEORY

In 1956, John Bowlby began theorizing about the response of young children to the temporary loss of their mother and the process by which maternal deprivation contributed to a variety of psychiatric disturbances.

26 The classic nature/nurture debate has dominated theories of psychology and human development. New voices are gaining ground. Garbarino (1990) & Johnson et al (1999) speak of the ecological approach and the interaction of many factors - genetic, psychological, relational, sociological, economic. Do prenatal experiences contribute more than genetics to temperament and development? This is a frontier question still despite Perry’s (2000) assertion that neurological and physical developments are dependent on the interaction of genetics and development. Support for the power of prenatal experience has dramatically increased and challenges many of the studies attributing childhood characteristics to genetics.

27 Skinner theorized that behaviour is developed and maintained through conditioned stimulus-response interactions, which reinforce even dysfunctional behaviours. Cognitive behaviourists then included in the equation the mental processes that occur between the stimulus and the response. Social learning theory and cognitive behaviourism have gained prime currency in current approaches to parenting, psychological and family problems. Both approaches consider that much of a child’s behaviour is learned from the way parents respond to reinforce it. Patterson’s extensive work (1982, Patterson et al, 1992) into conduct disorders found (p45) that “mothers are actively involved in the coercion training that takes place in families with problem children.” Cognitive behaviourists, (Patterson, 1982; Patterson et al, 1992; Barkley; 1990; Dadds et al, 2000, Kosky et al 2000; Rickel & Allen, 1987) have generated much of the research into child behaviour problems and have influenced a plethora of parenting books and programmes (eg Barkley, 1990; Forehand & Long, 1996; Sanders, 1992; Sanders et al, 2000; McFarland & Saunders, 1993; Green, 1987). While being a useful tool in the management of difficult children and family relationships, my experience led me to see its limitations and dangers. (I found no support, in fact active resistance, to my thesis from this camp.) I am concerned that the ’sticker and stamp’ approach to child rearing creates materialism and people who are at the mercy of external reaction rather than internally guided action. Greenspan (1997) speaks eloquently about this in relation to his work with autistic children in which, by working with contact and relationship, many were able to go beyond performing wooden, appropriate behaviours and engage in rich emotional interactions.
It was gradually borne in upon me that the field I had set out to plough so light heartedly was no less than the one that Freud had started filling sixty years earlier, and that it contained all those same rocky excrescences and thorny entanglements that he had encountered ... love and hate, anxiety and defence, attachment and loss. What had deceived me was that my furrows had been started from a corner diametrically opposite to the one at which Freud had entered and through which analysts have always followed (1971, p.11).

His new direction proved a challenge to the Psychoanalytic Society that did not welcome him and his radical approach (Karen, 1994; Parkes et al, 1991). He broke with psychoanalytic tradition by directly observing children, and empirically and prospectively testing his theories.

Bowlby felt very strongly that psychoanalysis was putting far too much emphasis on the child’s fantasy world and far too little on actual events...in emphasising the influence of early family environment on the development of neurosis, he (Bowlby) claims (p.2) that psychoanalysts like the nursery man should study intensively, rigorously, and at first hand 1. The nature of the organism, 2. The properties of the soil and 3 the interactions of the two (Bretherton, 1991, p.10).

Bowlby welcomed multidisciplinary influences28 and collaborated with social workers, ethnologists, economists. This strengthened and enriched the base of attachment theory (Parkes et al, 1991).

James Robertson made a film in 1952 tracking the emotional changes in a child hospitalized and separated from parents. The effects were powerfully obvious (high levels of distress, withdrawal, clinging, self-soothing, regression, symptoms of depression) and helped change the handling of children in hospital in the 1950’s.29 It also influenced Bowlby (1971) who over-viewed the observational studies of separating children during 1940 - 1960 and found that all revealed a predictable, sequence of three - phase behaviour - PROTEST, DESPAIR AND DETACHMENT. His accounts (1971) of children are vivid and heart rending. Initially the child cries, resists, throws self about, shows distress, rejects others or, conversely, clings desperately, searches, seems to expect mother to return. This gives way to a quiet stage of hopelessness, little or no activity, monotonous or intermittent crying, withdrawal. Then s/he may begin to smile, accept care, stop rejecting or clinging, take an interest again.

Because the child shows more interest in his (sic) surrounding, the phase of detachment which sooner or later succeeds protest and despair is often welcomed as a sign of recovery (Bowlby, 1971, P.50).

However, a quality of remoteness colours relationships, especially with the mother on her return. The Romanian orphans are modern and extreme examples of this process.

Witnessing the pain of children led Bowlby and colleagues to search for the nature of the child’s bond to its mother just as it has led me to seek the beginning of this bond in pregnancy. Mary Ainsworth (nee Salter), joined Bowlby after independent investigations

28 He acknowledges a social worker, James Robertson in the first lines of Attachment and Loss, 1971.
29 Karen, 1994, P72 -79 documents the struggle.
into the effects of early security and insecurity. Her observational and experimental methods facilitated research that tested and extended Bowlby’s theories.30

She articulated the basic three patterns of attachment - secure (B), ambivalent (A) and avoidant (C). Ainsworth’s foundations appear to be strong and provide the ‘secure’ base for extensive exploration into the ways in which children form relationships and operate relationally throughout their life. Main and Solomon (1986) extended these by describing the disorganized or disoriented (D) attachment, and Patricia Crittenden (1990, 1993, 1994) showed how the different attachment styles manifest in human psychopathology. The Adult Attachment Interview, developed by Mary Main and colleagues (Karen, 1994), contributed to the understanding of how attachment status develops in adulthood, and is transmitted to the next generation by the way the parent’s attachment influences their parenting style.

Longitudinal studies31 and cross-cultural investigations32 have also been undertaken. Quietly but persistently the nature of an infant’s attachment to mother, father (or caregiver), has unfolded revealing the consequences of that attachment across the life span and generations.

Robertson’s work brought changes for children in hospitals in the 1950’s but, despite more evidence about the impact of emotions and support on dis-ease and healing (Ornish 1998), children are still often left alone in hospitals and child care centres. Some staff still discourage parental visits to avoid ‘upsetting’ the child on separation assuming that a child who has ‘settled’ (quiet and compliant) after the distress of separation, is OK. Robertson’s film demonstrated that this kind of quietness can be devastatingly close to depression and despair – the child, though quiet is often not OK. The Strange Situation procedure is used to demonstrate how some children, coping in situations of anxious attachment, can appear unaffected and quiet (van den Boom, 1994). Grossman and Grossman (cited in Karen, 1994 p302) monitored physiological changes in children with different attachment styles. By tracking the changes in cortisol levels in saliva and heart rates they found that, despite the apparent calmness of the avoidantly attached children, the physiological responses were consistent with high arousal and distress.

Attachment theory has moved in and out of popularity but is currently (2000) undergoing a revival influencing some Australian practitioners. It was a wonderful experience to go to my first infant mental health conference in Sydney, 1994 and find others interested in, indeed passionate about, the impact of events in pregnancy, birth and infancy on a child’s development. I thought I was jumping into a swimming pool with this research, and found I was swimming in the ocean! Daunting but stimulating. The World

Association of Infant Mental Health. The Marce Society and Zero to Three are actively promoting the social and political importance of relationship in the perinatal period.

2. SOCIAL, ENVIRONMENTAL CONTEXT

There are limits to an individual, personal psychological understanding of children.

*Imagine*

A child stands stock still on stork like legs; belly 9 months-pregnant-round; eyes dark, deep, passive pools of perception reflecting back - what? ...the horror and poverty of war-torn Rwanda; the impassivity of pain and powerlessness, seeking a sign of compassionate action bringing hope for relief? A quizzical accusation? A challenge to see my part in the suffering of the silent despair of the world’s poverty? A poverty and despair which I can choose not to see or respond to; a despair that haunts many in my own community but, being relative to the average opulent standard, is not so blatant and thus more easily assumed to be “their” fault.

In the extensive literature on risk factors for child and family dysfunction, poverty and social disadvantage feature significantly, though viewed more as the context for personal dysfunction rather than the focus for intervention. Poverty affects the infant’s development and creates vulnerability implicating the mother-infant relationship and the development of the child.

..where a child is situated socially and economically in society has a profound influence on the nature of that child’s experience. Yet in spite of this recognition, we still do not understand adequately how broad situational factors, such as the character of a family’s neighbourhood or a family’s dependence on the state for its subsistence, influence specific processes in very young children’s lives. Infancy researchers especially have tended to view contextual factors as additional sources of explanation rather than as central in interpreting what is observed in an infant and his or her family (Halpern, 1993, p73).

A fussy, disorganized, low birth weight infant is likely to overtax the limited physical and emotional resources of an already over-stressed mother (Halpern, 1993, p74).

A vicious cycle is in the making. Poverty, despite a capacity by individuals to cope, confronts a family with a whole range of situations such as inadequate housing and health care; physically neglected, unsafe or unhealthy environments; social and sometimes geographical isolation; inadequate transport; stigma (having to prove worthiness to receive help and then being labelled negatively for needing it); emotionally and physically overtaxed care-givers, who, while struggling to cope, have their capacity to nurture undermined; inadequate food and necessities; frequent crises and greater exposure to situations of drug and alcohol abuse, violence (domestic and other), sexual, physical, emotional abuse and neglect, eviction, unemployment, crime, victimisation; inability to access needed services.

Probably hardest of all is a sense of hopelessness with little respite from the relentlessness of poverty (Halpern, 1993). This hopelessness can contribute to pain-numbing activities such as substance abuse, violent relationships, depression, which in turn can damage relationships and the development of both adults and children. Still birth, low birth weight, physical, mental and developmental problems can result from maternal

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33 Patricia Mrazek, 1993, p163 gives a useful summary

Garbarino (1990) is unequivocal that chronic and acute episodic impoverishment threatens children’s welfare. He gives examples of where infants with developmental delay at 8 months are more likely to remain delayed IF they grow up in impoverished environments, and decreasingly likely to remain so with increasing social status and wealth. Even recalculated twin studies indicate that twins brought up in different social strata are far less likely to be similar than those brought up in similar strata. Striking similarities in twins overshadow the range of differences (averaging 50%).

Even less is said about the fact that the similarities may have been promoted by similar or parallel environmental experiences (Karen, 1994, p308).

Prenatal experiences may account better for similarities in twins but little has been done to my knowledge in this area other than Piontelli’s work (1992).

Maternal mental illness and socioeconomic status produce a variety of social, emotional and cognitive deficits in children 0–4 years.

both groups of at-risk children were less cooperative, more timid, more fearful, more depressed, and engaged in more bizarre behaviour (Sameroff et al, 1982, p 54).

Perinatal mortality, congenital malformation and low birth weight are all greater in lower social class (Oakley, 1993, p114).

Disentangling the social and medical factors and their effects is complex. Studies exploring single risk factors are of dubious use. Specific events and circumstances work together in varying combinations to influence the degree of risk to a child or family. Campbell’s review (1995) concludes that the weight of evidence supports the additive effect of risk factors whereas Yoshikawa’s review (1994) leads her to favour the notion of interactive effects. My experience is that the more risk factors, the greater the chance of dysfunction, and that, while the actual dynamic of factors interacting is still being understood, a multiplier and potentizing effect is more likely than a simple additive effect.

The link between socioeconomic status and perinatal risk applies in all countries and does not relate simply to lack of access to health services. During both world wars, when doctors and health services were less available, perinatal health improved. Oakley (1993) speculates on the role of better food distribution and employment, or perhaps reduced

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34 Cicchetti, 1987; Tomlison, 1996, a & b; Children-The neglect of neglect, 2000; Rodgers, 1994.
35 Garbarino, 1990; Sameroff et al, 1982; Sackett, 1982
36 They have few references in common.
intervention in, and medicalization of normal births. Adele Horin (2000) reports the results of a study of 170,000 low risk women between the ages of 20 and 35 years by the NSW Centre for Perinatal Health Services Research. Only 18% of women birthed without intervention in private hospitals, compared to 35% in public hospitals, despite the knowledge that increased intervention increases complications for the mother and infant. The doctors' working hours played a major part in inductions. In 1997/98, Australia's caesarean rate was 20% compared to the Netherlands rate of 6%. Could home births be a factor? Australia has 0.2% compared to 30% home births in the Netherlands (Whelan, 1999).

Oakley's work (1993) indicates that the mother's health as a child is more important than nutrition in the pregnancy and that

perinatal and infant mortality are associated with ... such factors as the size and distribution of the Gross National Product of a country and the proportion of this devoted to military expenditure... (and not the) ...ratio of doctors in the population or per capita expenditure on health care (Oakley, 1993, p121).

Such information illustrates the long-term consequences of childhood experience and the importance, for prevention, of ensuring a child's health and well-being. Social and environmental factors are critical for the health and survival of infants, but often discounted or overshadowed by the medical and pathologizing approach to pregnancy and birth. This reflects society's attitudes to women's status and roles which in turn help shape women's attitudes and perspective of themselves. I see in clinical practice the difficulty of inducting children into society from a position of relative powerlessness38.


There has always been an appreciation that the society in which individuals live and work has a powerful influence on the health and well-being of individuals and populations. It has been difficult until recently for this subject to be an area of extensive research. As a result, our knowledge has been constrained as to how the environment in which individuals live and work determines their health ... In the last twenty years, there has been a substantial increase in our understanding of this subject particularly in the possible biological pathways by which the social environment contributes to the development of disease problems. Ten years ago investigations showed that in some population groups the biggest risk factor for coronary heart disease is not cholesterol or smoking, but the nature of an individual's work, the control they have over their job and their social support (Mustard, 1998b p1).

From detailed historical analysis, Fogel (cited in Mustard 1998b) concluded that the seeds of chronic adult health problems lie in the quality of nutrition and environmental conditions of early childhood.

An important conclusion of Fogel's was that 50% of the economic growth of the United Kingdom following the Industrial Revolution was due to better quality of the population. He also found ... that when economies got into difficulty, mean height could decrease and that this was associated with a decline in the health status of the

population. ... The conditions of early childhood set much of the risk for chronic disease in adult life and the better quality of the population produced by improved conditions for children is an important factor in economic growth (Mustard 1996b p 2).

Despite long standing evidence that social conditions directly affect health and well being, political and social policy continues in Australia to promote a two tier medical model and a widening inequity in health status between rich and poor. Health expenditure does not necessarily address the greater health problems of those lower down the social scale - the gap is widening. The Black Report (cited in Mustard, 1998 b), examined why the National Health Service in England had resulted in an increase in health inequalities, not a decrease as intended. It concluded that it was necessary to ensure mothers and children benefited from equitable social conditions if health inequities were to be reduced. Medical interventions have a minimal effect on a population's health and well-being.

Traditional social work approaches to social change and political restructuring are based on the clear acknowledgment that social conditions - such as housing, public health, jobs, education, material and practical support, access (or lack of it) to resources and services, marginalisation - shape and affect individuals for better or worse and must be addressed. Despite (or perhaps due to?) a long tradition of advocacy and social action, social work has itself become marginalised in a managerial, economic rationalist society and needs to reassess (Pease and Fook, 1999; Ife, 1996). Thus I emphasise social stress and support factors in this thesis.

a. SOCIAL POLICY

Social policy creates a political and community context, which impinges on the daily life of families and infants. This is particularly so for pregnant and birthing women in a society constructed by patriarchy and dominated by a medical model that treats birth as if it were an illness. I am painfully aware (through my work in a Family Support Service) of the current political climate in which economic rationalism holds sway and is rapidly dismantling the support structures that have been in place. My service has had a 49% increase in referrals in 2 years. Australia in the early part of last century led the world with its advanced social welfare policies. Now it follows America whose social indicators are the worst in the developed world.

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Social, environmental and human costs, despite increasing awareness, are ignored in
the financial bottom line. Miringoff highlights the incredibly fine, almost obsessive detail
with which economic indicators are measured and reported on a daily basis.

Thus, news of a 2.5 gain over the last quarter implies vigilance and rationality, and a quarter-of-a-percentage-
point increase in the interest rates has about it a sense of surgical precision (1995, p463)

In contrast, social indicators are infrequent, time-lagged, vague, inconsistent and
portrayed as crises ... the epidemic of teen suicides, the war on drugs ... Hence social problems seem far more
out of control and social policy far more vulnerable to ideology and the politics of the moment than do economic
problems and policies (Miringoff, 1995, P463).

From his work bringing together an index of social indicators, the picture is not an
encouraging one.

Six of the (16) indicators - children in poverty, child abuse, health insurance coverage, average weekly earnings,
out-of-pocket health costs for those over 65, and the gap between rich and poor - dropped to their lowest
recorded levels in 1993. It marked the first time in 24 years that so many social indicators were at so poor a level

This refers to USA at a time when the economic strength of the States is held as
worthy of emulation. Australia is a faithful follower, albeit a little 'behind'. In the United
Kingdom, Oakley (1993) expresses concern at the implications for the health of
disadvantaged children and women as support dries up in a climate of shrinking
infrastructure.

Personal health and well being are not separate from the health and well being of
society. Mustard (1998a, b, c,2000) presents compelling data about the social and
economic factors that interface with child and human development. Those who only take a
personal psychological, pathologizing approach to child development run the risk of
adjusting people to their destructive circumstances, rather than seeing the symptoms of
distress as sane responses in an insane world, but policies promoting early intervention give
hopeful signals.

b. EARLY INTERVENTION

In 1997 AusEinet was funded by the Commonwealth Government to gather
information and promote prevention and early intervention for the mental health of young
people (Kosky et al 2000 p.iv; O’Hanlon et al 2000). Families First is a $54 million NSW
state government initiative to implement an early intervention programme for families with
children 0 - 8 year olds, using a variety of strategies including community development. The
new Child Protection Act 2000 in NSW is also promoting early intervention but with few

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42 Eva Cox, Boyer Lectures, 1995, Fraser Mustard, LifeMatters, 2000, Dexter Dunphy, Ockim’s
Razor, 2001 have spoken rationally, clearly and passionately about these issues on the ABC.
43 Frank & Mustard, 1995; Mustard 1995; 1998a,b,c, 1999, 2000; Oakley et al, 1990; Totman 1979;
MacDonald 1993; Halpern 1993.
44 Australian Network for the Mental Health of Young People
extra resources. There is increasingly an emphasis on the interplay between the social and psychological - an approach familiar and welcome to Social Workers.

Early interventionists\textsuperscript{45} suggest the longer intervention is left the more entrenched and less amenable to change the child's difficult behaviour becomes. The costs to society of entrenched, intractable social and emotional dysfunction is extremely high - often over generations\textsuperscript{46}. In Australia the realisation is dawning in the political landscape that leaving childhood dysfunction unaddressed has costly consequences for government budgets - especially those of the health and justice systems. (AusIEnet (1997) estimated 7 times more costly than early intervention).

The United States has developed a variety of programmes for the cognitive, emotional enrichment of children (Weikart et al, 1984.) - Sesame Street is the most renowned product. There are many interventions such as maternal nutrition, prenatal education, (Parr, 1996) postnatal support, sensitive and appropriate caregiving.\textsuperscript{47} Most tend to focus on mothers.

While I agree that the social environment is mediated for the infant and young child by their care-giving environment, the wider social context in which children and families operate must not be ignored. It is essential to address the very real effects on people of the abuse of power enshrined in social structures (Pease and Fook, 1999). This manifests in such indicators as the gap between rich and poor,\textsuperscript{48} health inequities,\textsuperscript{49} oppressive organisational structures,\textsuperscript{50} sexism, racism, classism, ageism, heterosexism and the like. Appropriate interventions depend on an accurate assessment of the social, political, cultural context of people's personal pain. But personal psychology, mental health and poor parenting skills are often reflections of social conditions. While noting parents may have environmental problems, behaviour management programmes aim to improve adult skills to modify the child's behaviour rather than tackle the hard issues of social injustice which can stimulate aggression.\textsuperscript{51}


\textsuperscript{48} Basuk, 1995; New Internationalist, 2000; Mirrington, 1995; Mustard, 1998b

\textsuperscript{49} Totman, 1979; Halpern, 1993; Ashton & Seymour, 1985

\textsuperscript{50} Dunphy & Griffiths, 1998; Stace & Dunphy, 2001; Torbert, 1991; Campbell, 1990; Patterson, 1982; Patterson et al, 1992; Forehand & Long, 1996; Weikart et al 1984

\textsuperscript{51} Patterson, 1982; Patterson et al, 1992; Barkley, 1990; Forehand & Long, 1996
While some recommend intervention with preschool children,\(^{52}\) many writers\(^{53}\) consider the infant’s earliest relationship with the primary caregiver to be the most potent site for early intervention. My experience in therapy and early intervention with preschoolers supports the view that many patterns and problems have become strongly established by age three or four. Early intervention needs to be \textit{very} early - this thesis proposes we begin in pregnancy.\(^{54}\)

So far I have overviewed the family and social factors that contribute to troubled children, and the links between attentional/behavioural problems and traumatic stress. Attachment theory demonstrates that affectional bonds are critical. Social environments and policies create the context that strengthens, constrains or traumatizes relationships. Many social and family factors stress children and impair parents’ ability to parent well enough, producing trauma-like emotional and behavioural responses. Political interest in early intervention indicates recognition of these issues. However, why do some children survive, even thrive, in circumstances overwhelming to most?

3. RESILIENCE

Resilience emerges from the quality of early relationship, (attachment theory) plus the quality of the social environment (including policy and programmes such as early intervention) in which these early relationships are developed.

Risk and resilience (what Anthony and Cohler, 1987 call vulnerability and invulnerability) are complex notions to study. Single factors can not be isolated (Sameroff et al, 1982; Garbarino, 1990). Bell (1992 cited in Coie et al, 1993) found children’s risk fluctuated at different stages of development and that factors had differential importance, eg. deviant peers and antisocial behaviour were potent in adolescence but not childhood. Being ignored and left alone as a newborn has quite a different impact than to be ignored and left alone as an adolescent.

Bleuler suggests that such stressful childhood experiences may not inevitably and inexorably lead to an abnormal adult outcome if a child can develop a sense of purpose and a satisfying life task appropriate to his (sic) nature (cited in Anthony and Cohler, 1987, p160).

A child’s well-being is potentially affected by a long list of factors found within the child,\(^{55}\) within the child’s environment,\(^{56}\) and within the family’s social/community environment.\(^{57}\)

\(^{52}\) Campbell, 1990; Patterson, 1982; Patterson et al, 1992; Forehand & Long, 1996; Weikart et al 1984; Hazel, 2000


\(^{54}\) Olds et al 1994; Zeanah, 1993; Diagnostic Classification, Zero to Three, 1994; O’Donough, 1993

\(^{55}\) Halpern, 1993; Moriarty, 1987; Anthony, 1987; Call et al, 1984.
What are needed are models that encompass the complexity of developmental processes so that one may properly understand the interplay of risk factors and protective factors in young children (Sameroff et al, 1982, p52).

Emmy Werner (1990) gives an excellent overview of childhood resilience, distilling essential factors from a meta-analysis. Factors include an ability to attract positive attention, an experience of at least one positive relationship, an ability to find meaning in life’s negative experiences – as she quaintly put it, being able to make lemonade out of the lemon. This capacity to make meaning of the experience contributes significantly to the capacity to cope with and survive extreme and distressing adversity (Cohler, 1987; Werner, 1996; Young-Eisendrath, 1996). These qualities also increase the likelihood that the child will become a parent capable of supporting their child’s resilience despite adversity (Main, 1990; Tomlison, 1996a & b; Steele et al, 1991). Sameroff and Emde (1989) suggest that a mother’s perception of her child increases resilience (positive image) or risk (negative image) for that child which is consistent with my clinical experience.

Age (perhaps maturity?), experiences of nurturing, current social supports and degree of hardship, capacity to protect their child from the stresses of the situation are other parent factors that ameliorate or accentuate experiences of poverty (Halpern, 1993, p 74). Nurturing, warm parenting in the first year of life by at least one parent, and a lack of persistent criticism are protective, in adverse circumstances, against antisocial behaviour (see reviews by Yoshikawa, 1994 and Tomlison, 1996a & b).

(The resilient infants differed significantly from their age-mates who later developed serious learning and/or behaviour problems in the amount of attention given to them by their primary caretaker during the first year of life (Werner and Smith 1982 cited in Yoshikawa, 1994, p34).

Bingo! This supports my view that attention deficit disorder is about the child’s deficit of received attention and that lack of good-enough attention in those early critical years is potentially traumatic for an infant. Attachment theory supports the importance of early nurturing for resilience (Bowlby, 1979b).

Polly Young-Eisendrath’s words provide an expressive summary.

We don’t know enough about what enhances resilience to be sure about what is helpful and what is not ...We certainly know that human development is strongly buffered by stable caregivers. Warm friendly interactions, responsible child care and internal resources (such as intelligence and easy temperament) play important roles in providing the strengths and securities that carry over in the face of adversity. We also know that low self-esteem, lack of self-determination, and hopelessness bode poorly for resilience ...the ideal childhood for a resilient, purposeful adult life may not be the happiest, the most secure, the most privileged. It may not include two ideal parents, the best educational opportunities, the best possible preparation for a highly competitive world, but it must include some kindness, even if only a passing kindness. It must include enough food, housing, and clothing to keep together mind and body. It must include some witnessing of love, whether love given or love received. It must include plenty of opportunity for self-determination, some fundamental self-respect and enough

return for one's efforts in helping others to be able to give more. There must be opportunities to use the dance of one's gifts... What appears to count most for resilience is the opportunity to encounter pain within a context of meaning and to find that one's compassion (one's suffering—with) has power. From those who are resilient from childhood adversity, we learn that help is often valuable to the giver as much as the receiver. We learn that giving help in childhood, even to a parent who is ambivalently loved, can be the first step toward a purpose in life. We also learn that an ubiquitous sense of being different, feeling like an outsider or deviant in a family that is hostile or abusive or even uncompassionate, may be the seed of hope. To become resilient and to use pain for transformation, we must expand on this hope with a larger context of meaning, usually a spiritual context, that permits us to translate deficits and losses into potentials for new development (1996, p96 – 98).

The literature on resilience provides hope for children who have experienced trauma or crushing circumstances (Kagan, 2000) and encouraged me in my quest. At this point I have demonstrated the numerous factors traumatic for children; that attentional and behavioural problems are responses like PTSD; that relationship aids resilience. But what prevents childhood difficulties? For this I turned to 'normal' development literature.

4. NORMAL DEVELOPMENT

Cultural, sub-cultural, value issues challenge notions of normality. I accessed predominantly Eurocentric literature describing normal and abnormal pathways for children in Western societies. Thus this thesis is embedded in this cultural perspective.

Piaget (1952 cited in Greenspan, 1997 and D. Mrazek, 1993) developed a detailed analysis of the cognitive map infants gradually create of the world by watching his own children. His work has been extremely influential both on the theoretical understanding of children's cognitive development and the popular guidance given to parents, but ...

... what was not appreciated by Piaget was that the children's postulated perspectives incorporated the additional almost infinite numbers of perceptions afforded by affective experiences. To neglect this element is therefore to fail to appreciate the rich array of experiences that contribute to forming abstract concepts (Greenspan, 1997, p36).

Schore elaborates:

... the infant's emerging socio-affective functions are fundamentally influenced by the dyadic transactions the child has with the primary caregiver. In these fast acting, "hidden" communications, the mother senses and modulates the nonverbal and affective expressions of her infant's psychobiological states. In other words, experiences that fine-tune brain circuitry in critical periods of infancy are embedded in socio-emotional interchanges between an adult brain and a developing brain... the infant's affective interactions with the early human social environment directly and indelibly influence the postnatal maturation of brain structures that will regulate all future socio-emotional functioning (1997, p xxix –xxx).

As a mother, I had not read Schore's weighty tome but still, like many other mothers, quietly disbeliefed when I was told that my babies could not see, that the communicative smile was just facial twitches due to wind; that they were too young to be affected by separations and trauma. It was exciting and incredibly confirming to discover descriptions of the emotional and relational capacities of infants and how they attempt to get what they need from their caregivers. Stern's "Diary of a Baby" (1990) brought tears to my eyes as I saw the world through infant eyes. Similarly, I felt alternatively joyful and distressed
when watching videos of synchronous and dys-synchronous interactions between mothers and infants.58

There are exciting developments. Awareness of the role of early experience in neurological development has intensified political commitment to the early years, and facilitated the coming together of theories about cognitive/behavioural phenomena, affective-relational aspects of human development and the subjective experience of the infant59. Together they form a picture (still mysterious in parts) of the potency of early experience for human loving. What is the magic of love and kindness (Ornish, 1998, Adelaide, 1996; Jampolsky, 1979), in preventing childhood difficulties?

a. LOVE AND RELATING

The quality of love, trust and security provided for me as an infant – even prenatally – will heavily influence my later growth and development as a human being (D. O Murchu, 2000, p146).

Niles Newton, critique-ing Cranley says

There has been a hesitancy to do research on love, possibly because love is not a clearly enough defined word in the English language…. Major progress in the study of early family love resulted from the invention and use of the term "attachment" and the related terms, "bonding" and "engrossment," to indicate more precise types of family love (Cranley, 1981a, p 75).

Love is the beginning (at least Life is sometimes conceived in love), and then there is the beginning of love - a quality of early experience facilitating the journey toward the capacity to love and relate. Love is not an easy concept to capture, despite the efforts of many. Trungpa (1973) speaks of being totally open to what is, which reflects the receptive attitude needed by infants (and prenates) from caregivers (Adelaide, 1996 shares some wonderful stories).

Infants are active partners in the relationship from birth, reaching out for what they want and evoking responses (Murphy 1987; Brazelton & Cramer, 1989a, b; Chess and Thomas, 1987). Chamberlain describes the interlocking and mutual chemistry that operates between mother and infant. For example sucking triggers oxytocin to expel the placenta, prevent haemorrhage and promote bonding.

Other powerful forces are at work in this critical period just after birth. If the babies have not been drugged and are left undisturbed and warm on the mother’s abdomen for about an hour after birth, babies will calm themselves, periodically look up at mother, begin to show signs of hunger, and will climb upward, find the breast, and begin sucking with no assistance. Other provisions of Mother Nature are the exchange of friendly nasal flora, the natural ingestion of Vitamin K in the colostrum, the unique elements of mother’s milk that coat the lining of the baby’s intestines with an abundance of helpful antibodies which the mother has accumulated during her lifetime… and the psychological consolation of being safely in the mother’s embrace which is reminiscent of the heart and body sounds which were the music of life inside the womb (1998, p206).

58 Video clips shown by Lynne Murray, 1995, Judith Dean and Mary-Sue Moore in Sydney 1998, 1999 and Trout’s telecourse.

Michael Odent describes the role of oxytocin - the 'altruistic love hormone': 'hormones of pleasure and attachment' - secreted during orgasm and childbirth by the foetus, newborn and mother.

During the birth process, the baby releases its own endorphins: In the hour following birth, both a mother and her baby are impregnated with opiates. Since opiates create a state of dependency, when a mother and her baby are close to each other before they have eliminated their opiates, they are creating a mutual dependency or attachment relationship. When sexual partners are close to each other and impregnated with opiates, another kind of dependency is created: this dependency is chemically similar to the attachment relationship of a mother and her baby (2001, p4).

Within the first twenty-four hours of life, Brazelton (1984) is able to demonstrate to parents the newborn's capacities and individual style of response. Chamberlain (1998) notes that, under hypnosis many adults describe knowing and loving their parents from, and perhaps before, birth.

The infant and young child need to be held in mind - in someone's 'I' - for their own sense of self, security, relating, to develop (Pawl, 1995). This is the act of love. Lovers can't get the loved one out of their mind (Schachter, 1959).

As for the lover, his (sic) soul dwells in the body of another (Marcus Calo).60

An exact picture of the pregnancy, when the body makes space for the 'not-I' to have a place to grow and develop. Similarly, the 'not-I' needs a spiritual or emotional space in which to grow and develop affectively - to be in love, to become connected and enabled to love (or, if you prefer, to form 'object relations').

Stern (1985) describes a Sense of Self as the organizing principle in human development. Though developing throughout life, sensitive periods in early childhood are important for building the layers of Selfhood. The infant/child's growing capacities and stages of selfhood are parallel processes and are consistent with Bowlby's (1971) notion of internal working models. We relate to the world through the clarity or distortions created by the early experiences that shape our understanding of how we, and others are. Attachment theory promotes awareness of the importance of early, loving, responsive, caregiving for a child's healthy capacity to love and relate, and is gaining support despite Kagan's (2000) scepticism.

But, the developing sense of self is especially vulnerable to relationship stressors.

The most serious and lasting damage incurred by developmental traumata is that sustained by the emerging and fragile sense of self and involving the establishment of rigid criteria by which the self is defined (Brandschaft, 1994, p70).

Dismissive or negative attitudes, internalized from parents, distort the sense of self, and can manifest in a whole range of symptoms listed in the DSM IV (1994). A person thus develops, as a

central organising principle ... a persistent and agonizing doubt concerning the truth about the essence of their humanness. These individuals are continually asking if they are good or bad, destructive or innocent, hateful or lovable. In this torment is the echo of the central and still unresolved dilemma of childhood: Whose version and whose perspective is to be believed? (p71.) ... Developmental traumata derive their lasting significance from the establishment of invariant and relentless principles of organization that remain beyond the accommodative influence of reflective self-awareness or of subsequent experience (Brandschaft, 1994, p180).

b. CAREGIVERS

When caregivers cut across the child’s developmental processes, the child is deprived of that developmental progression by which he (sic) could come increasingly to rely on his (sic) own spontaneous, authentic and non-compliant experience as central in his (sic) perception, motivation and interpretation. This failure has momentous consequences. It renders the individual permanently the hostage of the responses of another for the determination and definition of who he (sic) is (Brandschaft, 1994, p72).

(Is behaviourism perpetuating this trend by emphasising external rewards?)

by mediating and modulating environmental input, the primary caregiver supplies the "experience" required for the experience-dependent maturation of a structural system responsible for the regulation of the individual's socio-emotional function. By providing well modulated socio-affective stimulation, the mother facilitates the growth of connections between cortical limbic and subcortical limbic structures that neurobiologically mediate self-regulatory functions. ... Early object relational experiences thus directly influence the emergence of a frontolimbic system in the right hemisphere that can adaptively auto-regulate both positive and negative affect in response to changes in the socio-emotional environment. The core of the self lies in patterns of affect regulation that integrate a sense of self across state transitions, thereby allowing for a continuity of inner experience. Dyadic failures of affect regulation result in the developmental psychopathology that underlies various forms of later forming psychiatric disorders (Schorie, 1997, p 33).

Translation: Warm, sensitive, responsive, consistent care creates neurological and physiological structures that enable the child-to-be-adult to function behaviourally, emotionally, socially and intellectually in warm sensitive responsive ways. Love is critical (Ornish, 1998). It is possible to sense a parent-infant pair that can 'dance' together intimately - and equally possible to sense a pair that can't. Chess and Thomas (1987) captured this in the notion of 'goodness of fit'. Stern (1985) calls the sensitive matching (not imitating) of interaction, 'attunement'. Attachment theory is all about the nature and quality of parent-child relationships and the consequences for development (see above).

Technological developments have enabled the gathering of internal data - firings in the nervous system, flows in the endocrine system, pulsings in the cardio-vascular system - and fine interactional data - movement of infant eyes; flashes of facial expressions; the signalling of the sensitivity, timing and mutuality of interaction moving across the intimate space between parent and infant. This material gives the physical sub-text to the emotional/relational story in which both parent and infant are active participants. The millions of minute, momentary interactions between parent and child co-create and potentise the very cells, hormones and processes of the body - the neurological and

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61 Field & Fogel, 1982; Murray & Cooper, 1997; Erickson, 2000; Perry et al, 1995; Schore, 1997.
physical structures that underpin a child’s sense of self, capacity to manage psychobiological states, to relate, empathize, love.

The mother acts as a hidden regulator of the infant’s biological control systems. In affective interactions, the mother induces hormonal alterations in the child’s developing brain by regulating the infant’s production of various hypothalamic releasing factors... It is now known that the level of maternal interaction influences both the infant’s serum levels of growth hormone and the sensitivity of specific tissues to this hormone (Schanberg and Kuhn, 1980). And that severe maternal emotional deprivation leads to hypopituitarism and growth retardation... other data also suggest that regulators within the mother-infant interaction directly influence the evolving structure-function relations of neonatal brain mitochondria (Schore, 1997, p511-512).

Thus, the very cellular substance of the psyche and soma are co-created. Video analyses have enabled microscopic observation of the way a caregiver’s responses affect the infant and visa versa. When a mother even feigns a blank unresponsive face, the infant either becomes more active as if trying to recapture the connection or its body goes limp as if hopeless and in despair.

Only recently have cognitive psychologists become aware of the significance and frequency of nonconscious processes of thought in the regulation of human behaviour and begun to pay them necessary respect (Kihlstrom, 1987). Neurophysiologically, intuitive behaviours are faster and less strenuous than rationally controlled behaviours. Intervals between stimulus and response are usually within 200 – 400 ms; thus they are longer than in simple innate reflexes (40-60ms) but shorter than latent periods in rational decisions... if the brain cortex is stimulated directly, a minimum of 500-600ms stimulation is necessary for conscious perception (Vander, Sherman & Luolano, 1990 cited in Papousek & Papousek, p 38, 1997).

No wonder it is so hard to change human behaviour and patterns of relating!!

There is power in what a parent thinks and feels about a foetus and infant (Benoit & Parker, 1994; Belsky et al, 1991). Rowan expressed this when her child was nearly two.

IT IS THE IMAGINAL THAT TAKES UP 90% OF MY ENERGY... having to think all the time about what has to happen, where they are, what they need. I can’t not think about the children even when I’m away – the men can do it (Rowan, research participant, 2000).

Biased or not, it influences the way she perceives and responds to the infant.

maternal negative affect (eg anxiety and depression) is a prime determinant for maternal ratings of child temperament (Sameroff, Seifer & Elias, 1982 cited in Biringen et al, 1991, p35).


.. a correlation between mothers’ ratings of how difficult their infants were during the first six months of life and problem behaviours at 3 and 4 years of age (1991, p35).

There is some evidence that even pre-natal perceptions correlate with how the child turns out. The influence of the mother’s perception (like observer bias) makes it hard to

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62 Mitochondria provide the energy behind the firing of each cell of the body.
63 Field & Fogel, 1982; Field, 1995; Murray & Cooper, 1997; Call, 1984.
65 A participant in this study.
determine what is inherent (genetic/biological) and what is environmental - which is chicken and which is egg?  

Loeber and Dishion's meta analysis (cited in Yoshikawa, 1994, p34) found parenting variables to be more powerful than child behaviour, socioeconomic status and family instability in predicting delinquency. Yoshikawa, (1994) cites a range of supportive studies and also indicates that key, predictive parenting variables include hostile and rejecting parenting, lack of supervision, lack of involvement with children, plus the reinforcement of aversive behaviours and use of coercive management. Literature in the fields of psychotherapy, attachment, trauma and abuse, risk and resilience cover, from different perspectives, the important contribution a parent's unresolved experiences have for a child's development - what Selma Fraiberg quaintly called the 'ghosts in the nursery' (1974). However, if parental and family tensions do not come through in punitive parenting, effects on the children are reduced.  

Parental attitudes and relating, though formed in past experiences, are affected by current circumstances, including the quality of the spousal relationship, social support, economic and neighbourhood circumstances, whether the pregnancy or gender of the infant is wanted or not. I stress again that these aspects of personal psychology MUST be held in the social political contexts discussed above, otherwise it is easy to perpetuate mother blaming and personal pathologising. Oakley (1993) highlights this when she contrasts what health promotion posters did and could say: Above two pairs of infant feet (one full term and one premature) are comments like "Guess whose mother smoked/drunk/missed antenatal care?". She suggests more meaningful comments would be "Guess whose mother tried to get by on welfare/had to live on the streets/was beaten by her husband?"

A final theme from current research is that families function as part of a larger community of social relationship, economic roles, values and institutions ... and need effective community institutions to support their functioning ... parents don’t raise children; communities raise children. However, many of the family supports operating in communities remain invisible until social conditions erode these supports and we recognise them by their absence (Lyons-Ruth & Zeanah, 1993, p15).

**c. INFANT CAPACITIES**

Infancy research explores the developmental world of an infant. Human infants, amongst the most immature at birth, cannot survive without a caregiver who 'cares' for them but are designed to evoke responsiveness. Their 'cute' proportions (exploited by Disney cartoonists), clinging, cuddling, smiling, gazing, vocalizing are ways of attracting the attention, and hopefully the care they need to regulate their world (Bowlby, 1971). What happens if a parent comes promptly when 'called'; reacts sensitively and synchronously to

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the baby's state of arousal; is able to 'be with' that state with warmth, calmness and an ability to maintain their own homeostatic state? What happens if a parent comes only when the infant's arousal is at fever pitch; reacts abruptly, un-synchronously, is highly aroused and unable to tolerate distress? Unfortunately, parents of Western infants are encouraged to tolerate infant distress signals and not respond thus leaving human babies alone more than any other mammalian species (Bowlby, 1971).

The first task of a newborn is to begin to feel at home in their body in a new world - to cope with the impact of outer events on their inner world; to feel trust, safety and care. They need to regulate their organism's functioning - deep sleep through to alert wakefulness and the 4 states between; hunger to satiation; calm to distress; arousal to quietude. Some have the capacity to screen out unwanted stimuli and move smoothly through changing states of being, others don't. How they move from state to state can indicate temperament and the results of pre and postnatal experience.

A baby who moves slowly from one to another, and who can hold onto an alert or a sleep state, is already demonstrating a marvellous capacity to manage his (sic) world. If he (sic) moves rapidly, shifting between states unable to stay in any one, he (sic) will need a patient parent’s quiet help to learn to develop his (sic) own controls. It will take time – a year or more (Brazelton, 1992, p27).

Brazelton's Neonatal Behaviour Assessment Scale (Brazelton, 1984) helps assess the capacity of an individual newborn and their ability to manage and integrate these changing states. It also indicates what an infant needs to assist them to regulate their emotional and physical states (Brazelton, 1969). Light, sound, temperature, gravity, air, touch, though operating in the womb, are experienced differently post birth. Regulation shows in skin colour, muscle tone, jerkiness of movements, the sharpness or smoothness of change, degree of startle, reflexes, the ability to gaze and follow with the eyes. With repeated exposure to aspects of the test (light, rattle, moving ball etc) the initial startle reaction usually settles with familiarity (habituation).

If stimulation is too much or not synchronous, they will attempt to change the state of discomfort, try to turn or look away, become passive, limp, lethargic, go to sleep or discharge the accumulated arousal with intense movement or crying.70

Hyperactivity is one way a baby discharges the overwhelming overload of too many incoming stimuli (Brazelton, 1992, p26).

This has obvious implications for the infant’s experiences in relationship as they cope with the effects of their changing states on their outer world - caregivers primarily. Do I get what I need when I call or do I have to scream? Does my pain go on and on or does it stop? Is there fear or love? Is this a safe, loving, responsive world in which I can relax knowing my needs will be met? Is this a world in which I'd better stay alert and become

70 Murphy, 1987; Seifer & Dickstein, 1993; Stern, 1985; Brazelton, 1992; Cohn & Tronick, 1982; Field, 1984, 1995; Field & Fogel, 1982; Field et al, 1985.
demanding because it is painful, jarring, unsafe, unpredictable, scary? Can I make a difference or am I powerless? The sense of Self begins to form.

d. NEUROLOGY AND EMOTIONAL DEVELOPMENT

An infant must manage to stay afloat in the constantly changing tides of arousal and satiation - the urgent pain of hunger to milk drunk euphoria; alert, fluid engagement with the world, to the heavy slumbering of deep sleep and all the subtle stations on the way. The capacity to regulate one's biological and psychological state lives in the nervous system - the sympathetic that governs arousal and the parasympathetic that governs relaxation. Some babies shift gears easily to the parasympathetic and sink into satiation and the rejuvenation of deep sleep. Babies who cannot are tossed from state to state, out of control, flailing, wailing, on hyper-alert at the slightest stimulation. Temperament? Perhaps, but possibly a result of prenatal experiences during which the quality of the foetal world can be rhythmic, bathed in love, or chaotic, bathed in fear.71 The brain and nervous system develop through experience.

During human development, brain structures and behavioural structures keep closely in step...Throughout the many years of childhood the sophistication of the behavioural systems that can be developed is strictly limited by the state of development of the brain. Without the necessary neural equipment, behavioural equipment cannot be elaborated (Bowby, 1971, p 197).

Neuroscience is a relatively new player that has given dynamic and fresh insight into the physical foundation and mechanisms of emotional development.

Allan Schore's masterful work (1997) details the best knowledge we have to date about the links between the autonomic nervous system and emotional regulation - the indivisible manifestations of soma and psyche and the effects on this of the earliest post birth interactions. These interaction are variously called 'object relations', 'attachment', 'affective development' or, more simply, 'love'.

...(A)ffect regulation and dysregulation can offer penetrating insights into a number of affect-driven phenomena - from the motive force that underlies human attachment to the proximal causes of psychiatric disturbances and psychosomatic disorders, and indeed to the origin of the self (Schore, 1997, p xxi).

...the early social environment, mediated by the primary caregiver directly influences the evolution of structures in the brain that are responsible for the future socio-emotional development of the child (ibid, 1997, p62)

Perry's summary says it all

For humans, the greatest rate of change is during development and, of all of the body's systems, the most dynamic, complex and rapidly changing is the brain. This remarkable organ is comprised of 100 billion neurones, each forming up to hundreds of synaptic connections with other neurones. Chains of neurones form complex functional networks that, ultimately, allow us to walk, talk and think — to create, laugh, love — to envy, hate, and even kill. The properties of the human brain allow us humanity.

Democratic government, complex economies, astounding technologies and social justice are not inevitable genetic manifestations of the human brain; rather they are the distilled products of thousands of generations of experience. The brain has the amazing capacity to store, categorize, process, modify and pass elements from experience to the next generation. It is in this sociocultural distillate — the collective memory of family, community and culture — that an individual child grows. And it is the developing brain's malleability that allows the experiences of many generations to be absorbed in a single lifetime. Yet, this capacity to absorb the sociocultural distillate of the family and community decreases during the life span. The relative impact of experience on the individual, and thereby, on society, is greatest in early childhood.

In childhood, time and experience are magnified, amplified and empowered by the opportunity to express our genetic potential — or not. The young child's undeveloped brain organizes in a "use-dependent" way, mirroring the pattern, timing, nature, frequency, and quality of experience. By age three, the brain is 90 percent adult size and the emotional, behavioural, cognitive and social foundation for the rest of life is in place. During early childhood, the organizing neural networks that are developing require touch, sight, sound, smell and movement in order to develop normally. Absent experiences of sufficient duration or quality, some of the genetic potential of the individual will be lost. An infant born in a hunter-gatherer clan 20,000 years ago had the genetic potential to read and write, to play piano, use a joy-stick and understand the double-helix of DNA. Instead, he (sic) learned to distinguish between two- and five-day-old antelope tracks, to throw a stick with incredible precision, to read the visual-spatial cues of terrain (Perry, accessed 4.8.00 no page number).

In these early phases the mother's nervous system and responses calibrate the immature organism through, what Schore (1997) calls 'bioenergetic transmission' or mutual regulation of infant and mother's psychobiological states. This occurs through touch and the synchronous mutual gaze and vocalization that flash back and forth between caregiver and infant – as between lovers. The separations and reunions used in Ainsworth 's Strange Situation, (Steele et al 1991) map the relationship template laid down and reinforced from birth.

The psychobiologically attuned mother reads the child's face to appraise his (sic) current internal state. This allows her to adjust her output in order to optimally create a 'synchrony or mesh among sequential infant maternal stimuli and behavior' (Petrovich & Gewirtz, 1985 cited in Schore, 1997, p 103).

It is gut wrenching to see an infant or young child who has already learned to silence and control themselves because their cry for help will be met at best with no response, at worst with anger, violence and more pain. I believe we will in time regret the social insistence that young babies sleep long hours and alone (necessary sometimes for the survival of stressed and unsupported parents) and recognize the difference between contentment and helpless surrender (Bowlby, 1971).

A difficult, fussy baby is a strain on any family. If it is born into a stressed, chaotic or dysfunctional system, it is less likely to be protected from over stimulation or to get the help it needs to negotiate internal and external states. Such a baby risks abuse and neglect. In turn, that baby may become a child, adolescent or adult that perpetuates abuse
and neglect. Evidence is accumulating for the link between sensitive caregiving and the development of the neurological foundation for empathy and love. The inability to sense emotion in others and to generate it themselves, leaves psychopaths immune to remorse and punishment. Some think this is due to brain damage; others that lack of maternal bonding may be responsible: close interaction between infants and mothers is necessary to stimulate and maintain normal function in the amygdala (Cater, 1998, p93).

Overall, there is agreement that from birth relationships experienced are critical in the infant’s development. The dance of subtle, frequent interactions – contact, gazing, touch – between infant and caregiver facilitate neural connections, movement, musculature, co-ordination, the subtle but powerful sensory pathways involved in the infant’s sense of Self, capacity for self regulation, relationship and love (Zero to Three; Perry et al, 1995; Perry, 1997, 2000a, b).

There is no certainty that good beginnings lead to good ends nor that difficult beginnings lead to difficult ends. Later experiences can damage, distort, perhaps destroy healthy foundations just as rocky foundations can be shored up and possibly healed by later experiences (Ennish, 1998; Kagan et al, 1989; Kagan, 2000; see resilience above). However, as presented above, the risk of continuity is great so it is important to facilitate the capacity of parents to relate empathically.

Chamberlain, (1998) sees that Tiffany Field’s work confirms Renee Spitz’s view that touch and contact is essential for infant survival and well being. Field introduced a 10 day programme of touch for premature babies.

The infants in the experimental touch group averaged 47% weight gain per day on the same number of feedings and calories – metabolic magic. These infants were also awake more, were more active physically, showed better tolerance for distracting noises, were better able to calm and console themselves, and left the hospital six days earlier. When tested eight months later, ‘graduates’ of the touching program were longer, heavier, had larger heads and showed fewer signs of neurological problems than their counterparts in the same nursery who received standard care. With these results, it is no wonder that massage and physical activity, rather than isolation, are now recommended for all babies (Chamberlain, 1998 p 50).

Heidi Als’ work (1982, 1998) also demonstrates the power of love, physical contact and emotional connection with parents who hold premature babies in a kangaroo pouch against their chest so the infant hears their heart beat and feels warmth, breath and love. Again,

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74 Ledoux, 1996; Greenspan, 1997; Schore, 1997; Stern, 1985; Perry, 2000a, b; Chamberlain, 1998.
the health and development of these babies outstrip that of the babies treated in the 'normal' way.

But why are some infants fussy and difficult from birth? Temperament (Chess & Thomas, 1987; Kagan et al, 1989; Kagan, 2000)? Possibly, but the material presented above indicates a great convergence of thinking about the role of experience in human development. Psychoanalytic, behaviourist, attachment, risk and resiliency literature have paid primary attention to life from birth. Weaving persistently in and out, over and under, is the possibility that life before birth can account for some characteristics attributed to genetic structures and temperament. From this point, I want to take a path less travelled - across the threshold of birth into prenatal life where the same forces that play out in postnatal life are even more powerful prenatally.
Chapter 2  PRENATAL LIFE

... the history of a man (sic) for the nine months preceding his (sic) birth would, probably, be far more interesting, and contain events of greater moment, than all the three score and ten years that follow it (Samuel Taylor Coleridge cited in Montague, 1962, p4).

This chapter overview's current knowledge of prenatal development and provides the foundation for the hypothesis that prenatal relating contributes to postnatal development and thus, is worth investigating.

Almost immediately after conception brain cells begin to gather at the tip of the embryo. The neural tube begins to develop by two or three weeks forming the basis of spinal cord and brain. The neurones differentiate into various components such as the brain stem, cerebellum, cortex, and signals fly back and forth creating connections. The 40 or so systems that develop are the basis for the infant's sensory, language, motor, learning, relational, conscious life (Perry, 2000a, b; Chamberlain, 1998).

Electrical brain activity, though scant, has been recorded at seven weeks at the time of first movement, and becomes more organised by ten weeks. At 18 - 19 weeks' brain and spinal cord connections are evident and probably functional (Lipson, 1994). Neurones develop at a rapid rate (250,000 per minute) till 20 weeks when the multiplication and migration of nerve cells is complete. Chamberlain (1998) reports that the presence of dendrites and dendrite spines between twenty and twenty eight weeks indicates higher brain functioning. The cerebral cortex is mature enough by about this time for awareness and consciousness to be possible (Dominick Purpura cited in Verny and Kelly, 1981 p28).

Over the last trimester connections between neurones continue their dramatic development in number, strength and complexity as the brain and nervous system continue to specialize, organize, and refine, though by six months the somatic basis for mental life is there.

Bruce Perry (cited in Milgrom et al, 2000), notes the parallel between the development of the brain and the developmental stage of the infant. The primary development of the brain stem occurs during the prenatal period, the midbrain during 0 - 6 months of age, the limbic system around 1 year of age, the subcortical system between 2-5 years and frontal cortex after 7 years of age. Experiences encountered by the child at these different ages affect the part of the brain that is developing and thus manifest differently in the life of the child.

The brain stem and mid brain, responsible for the basic regulatory functions (heart beat, breathing, temperature), for the organism's capacity to respond to stimuli and regulate physiological responses, begin to form early in pregnancy. Lipson marvelling at how 100 billion nerve cells make the ‘right’ connections says

The brain must be stimulated. The brain must experience input for the right connections to be made. This experiential effect must then have its origins before birth, which has indeed been proven to be the case. ...The necessity for neural activity to complete the development of the brain has many advantages. One of the most
interesting is that it is genetically conservative. ... We know that the human has only 100,000 genes. It is much more economical for ... experience to be a major factor in the formation of brain connections (1994, p64).

During this rapid development the foetus is vulnerable to the environment provided by the mother’s bodily functioning and what enters directly through the walls of the womb from her environment. This supports the hypothesis that babies with stress in pregnancy come to birth with regulation problems. First let’s consider the foetus.

1. CAPACITIES OF THE PREBORN

Lennart Nilsson’s stunning photos of a growing foetus (Kitzinger & Nilsson, 1990) illustrate the prenat’s amazing development. The heart is activated in the fifth week and complex reflex actions are evident and used over the next month to respond to the outside world. Poke a woman’s stomach and the foetus will withdraw. By eight weeks the reticular formation can generate movements beyond simple reflexes (Lipson, 1994) and by ten or twelve weeks cycles of movement and rest increase in intensity.

The longest ‘exerciser’ did seven and a half minutes straight; the longest ‘restler’ rested only five and a half minutes. Dutch scientists say that because these gyralons are graceful, voluntary, and spontaneous, they are an early example of initiative and self-expression on the part of the preborn (Chamberlain, 1998, p 9).

The face is active (at eight weeks the foetus will arch away from a fine hair touching its cheek) and expressive at fourteen weeks

Puckering of the lips, scowling, and muscle tension around the eyes have been associated with audible crying as early as the sixth month of pregnancy. Appropriate facial and vocal expression imply that some kind of ‘central intelligence agency’ is already linking body and brain (Chamberlain 1998, p6).

By nine to ten weeks the body responds to touch, (Lipson, 1994) and by 20 weeks to change of temperature and flavour of the amniotic fluid (Verny and Kelly 1981).

Add saccharin to his (sic) normally bland diet of amniotic fluid and his (sic) swallowing rate doubles. Add a foul-tasting ... oil ... and those rates not only drop sharply, but he (sic) also grimaces (Verny and Kelly 1981, p 25).

Chamberlain (1998) suggests that the response to saccharin varies - some don’t like it.

S/he grows close to the sounds of the heartbeat, to digestive juices rumbling. Cry prints of newborns reflect maternal speech patterns (cited in Stainton, 1990, p96). Many women report that the foetus responds differentially to the father’s voice or different kinds of music. Michele Clements and Yehudi Menuhin support this and

... discovered that the foetus doesn’t like rock music....The Liley team found that from the twenty fifth week on, a foetus will literally jump in rhythm to the beat of an orchestra drum... (Verny and Kelly, 1981, p 26.)

Sensitivity to light begins in the sixteenth week as demonstrated by startle reaction and turning away when strong light is shone on the mother’s stomach (Brazelton and Cramer, 1989a, b). Thumb sucking (from 14 weeks) and erections (from 26 weeks) have been observed in prenates (Chamberlain, 1998).

The fetus is not only responsive, but assertive, both moving to increase his or her own comfort, and inducing changes in maternal physiology.... He or she not only determines the length of the pregnancy and guarantees its
endocrine success, but single handedly solves the problem of immunological incompatibility (Chamberlain cited in Raphael-Leff, 1993, p95).

It is the hormonal functioning of the foetus that counters the mother's immune response to reject a foreign body, and to trigger birth (Lipson, 1994).

The steady and changing rhythm of heart beat, digestion, lungs, voice, changing chemistry are all unintentional communications to the unborn.

One of the earliest hints of attentive fetal listening can be seen in intrauterine photos of a prenatel, eyes sealed but looking profoundly absorbed, delicately holding the umbilical cord ...(that) links the solitary womb with the surrounding world. ... Better than a television cable, the umbilical cord pulses with the traffic of life passing back and forth between you and your unborn. Ever-present, it is a handy plaything but alive, changing, and flooded with information. This lively conduit may be a biofeedback unit from which the baby gains information about the flow of nutrients and the slowing or speeding of circulation, a type of maternal-fetal monitor that carries reassuring or worrisome news (Chamberlain, 1998 p 67/8).

During this critical, formative time the foetus's developing brain and organs are washed in the mother's hormonal, physiological state of calm or arousal. Foetuses move and behave distinctively perhaps due to the mother's state or indicating that personalities or temperaments already exist in the womb (Chamberlain, 1998: Piontelli, 1992).

Chamberlain reviewed neonatal findings and concluded

That by the second trimester of pregnancy, all human senses are operative. This indicates that the fetus is responsive to tactile, auditory, visual, kinaesthetic, vestibular (balance), gustatory (taste), thermic (heat and cold), and painful stimuli (cited in Raphael-Leff, 1993, p95).

Obstetric practices, based on the long held belief that babies and prenates lack memory, feeling, consciousness are now being challenged.76 Chamberlain’s (1998) stories of people who remember birth and the pain of being left alone, rough handling, rejecting comments, are distressing. He is concerned at the ability of health professionals to ignore the distress signals of newborns and infants.

Infants have always talked with their bodies, turning red with rage, tensing with fear, clenching fists emphatically, but too often ... (n)ewborns have been talking to a wall. While we have been earning low grades in receiving their messages, the latest scientific research indicates they have been doing superbly well receiving ours. Infants scrutinize adult faces and moods and react accordingly. Looking and listening with amazing precision, they wait for us to join them in intimate dialogue. Newborn communication is quick, sometimes instant. This ability is so precocious, it may be inborn rather than learned (1998, p25).

... or, possibly learned prenatally. The capacity to move, to initiate, to discriminate between stimuli and respond are facets of postnatal relating (Brazelton, 1984; Bowlby, 1971). Bowlby (1971) notes that behavioural systems become more refined, specific, organised, complex, sophisticated and differentiated with maturity post birth. Clearly the same capacities and processes are evident pre-birth albeit immaturely which supports the likelihood of a continuum of pre and postnatal development (Prechtl, 1984). Some women in my study

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attributed agency and intent to their prenatals. Others hypothesize that the foetus is an active player initiating not just responding. There is evidence of independent response to stimuli received directly from the world beyond the womb. A foetus can habituate (learn to ignore) stimuli such as the sound of a toothbrush rubbed on the mother’s stomach (Leader and Bennett, 1994; Leader, 1998). Pert (cited in Chamberlain 1998) suggests that the capacity for emotion and memory results from neuropeptide receptors linking the brain stem link to the limbic system. This supports my thesis that prenatal experiences of stress and trauma make the foetus vulnerable to dysregulation.

Young children are born with complex memory, indicated by complex neurological development and the capacity of adults under hypnosis, altered states of consciousness, rebirthing to remember their birth (Chamberlain, 1987, 1998).

I have been repeatedly confronted with the hidden wounds left by hostile words, outbursts of emotion, or worrisome questions raised at birth. ... As long as babies were considered senseless and mindless, memory was logically impossible and the evidence for it was set aside. (Chamberlain, 1998, pxiii)

Some young children spontaneously talk about people present and events occurring at their birth. A friend attended a birth with her 3 year old who said

When I was being born I had a terrible headache and my feet were tied together and I had to push really hard to get out.

The third stage of her birth was 3 hours, but the mother did not know if the cord was around her feet. Another child squatted down on the floor. “When I was born I did this” and she suddenly leapt into the air. The mother reported that she was held back by the cervix and then suddenly flew out.

The possibility of prenatal experience arose in a class I was teaching at TAFE. Several students shyly told or wrote personal stories. One woman, from birth, screamed every time her father came in the room - he had been violent during the pregnancy. Direct experience or reaction to the mother’s tension? Another woman told of a family member who, as a very young child, described features of a room she had not been in except in utero - and there were no photos in the family album. Anecdotes, yes, but Chamberlain (1998) reports his study of 10 child parent pairs to assess consistency of birth memories obtained under hypnosis. The children had no conscious memories and the mothers had not discussed the birth with the children who ranged from nine to twenty three years at the time of the study. Dovetailing details numbered 137 as against 9 contradictory details.

According to Australian neurosurgeon Richard Bergland, the brain is itself a giant gland because it produces hormones, contains receptors for hormones produced elsewhere in the body, is bathed in hormones and has hormones running up and down the fibres of individual nerves. ... The significance of this for the unborn is that it changes all the chronologies about when the ‘brain’ starts working (Chamberlain 1998, p11).

Prenatal and birth experiences contribute to the developing organism and how the baby is at birth. This supports my early clinical observations that many children referred for therapy with behavioural and attentional disorders were fussy and difficult babies from birth and the mothers reported stress and trauma in pregnancy.

2. HISTORICAL VIEWS OF PRENATAL LIFE

Across cultures and throughout history, pregnant women have behavioural contraints, and sometimes a requirement to be protected from stressful and upsetting events.\textsuperscript{78}

Our ancestors were well aware that mother's experiences impressed themselves on her unborn child. That's why the Chinese established the first prenatal clinics a thousand years ago. It is also why even the most primitive cultures have had strictures warning pregnant women away from frightening events such as fires. Centuries of observation had shown them the powerful effect of maternal anxiety and fear. The first man to grasp the idea in all its dimensions, however, was...the great Italian artist, inventor and genius Leonardo da Vinci. ... "the same soul governs the two bodies...the things desired by the mother are often found impressed on the child which the mother carries at the time of the desire...one will, one supreme desire, one fear that a mother has or mental pain has more power over the child than over the mother, since frequently the child loses its life thereby" (Verny and Kelly, 1981).

Kylie,\textsuperscript{79} seventeen and homeless, supports da Vinci - 'it feels what I feel' she says.

For the most part, twentieth-century medicine and psychology have paid little attention to the likelihood that a mother's experience during pregnancy could affect the behavioural and physiological development of the newborn; even though, as Ferreira (1969) recounts, this belief can be seen in such traditional writings as the Bible and the Vedas (Catana & Catano, 1987 p45).

Research in the '50's, '60's and '70's explored the impact of prenatal experience,\textsuperscript{80} but was displaced, though not totally silenced, by the focus on genetics. The effort to disentangle factors affecting human outcomes has continued in the 1980's and 1990's and the importance of prenatal experiences peppers the literature on child development, human dysfunction and distress.

It is plausible to argue that events occurring between conception and 3 yrs of age are the first steps in a developmental sequence leading to childhood conduct disorder and eventually to juvenile delinquency and adult crime (Farrington, 1994, cited in Fonagy, 1996 p8).

By the end of last century the importance of prenatal and perinatal experience featured frequently in the public media.\textsuperscript{81}

There is now a substantial scientific basis for the fact that our fundamental behaviour, reactions and attitudes – indeed our very spirit – can be changed by experience, particularly in regard to the brain and the senses before birth. The question to ask is not whether it occurs, but how much can be attributed to prenatal experience (Lipson, 1994 P16).

\textsuperscript{79} A research participant.
Sontag (1941 cited in Lipson, 1994) was a pioneer in this area, and documented the significant increase in movements of the foetus after intense emotional maternal distress. Rogers, Pasamanick and Lilienfeld (1955, cited Montague, 1962) found that prenatal complications had occurred more frequently in behaviourally disturbed children than in a control group (the behaviours described were similar to those of attention deficit disorder).

In 1962 Ashley Montague reviewed studies that explored maternal health and prenatal effects with a view to preventing infant malformation and dysfunction. Nutrition during pregnancy, before conception and in the mother’s own prenatal and early life were important (supported by Oakley, 1992, 1993 and Mustard 2000).

While acknowledging the data on the whole to be simplistic and limited, he concludes as we have seen, the best security for the birth of a healthy functioning baby is a healthy functioning mother during pregnancy. ... Things to be avoided are infections of every kind, noxious gases including anaesthetics, analgesics, the majority of drugs, disturbing noises, upsetting emotions, undue fatigue, overweight, smoking and preventable or controllable dysfunctions of various sorts (1962, P500 & 501).

Montague appears to be courageously challenging the Western belief of his time that life begins at birth and that the foetus is insulated in the womb from outside forces. It was widely held that only venereal disease affected perinatal health.

The fact is that the old wives were a great deal nearer the truth than were many learned professors who, more than a generation ago, presented their students with what at the time seemed to be the incontrovertible facts which rendered such tales utterly unworthy of serious consideration (Montague, 1962, P7).

Subsequent work has validated his direction.

What struck me most about the work was just how subtle the attitudes and beliefs of the time are in guiding the interpretations of data. For example, in talking about maternal fatigue, Montague concludes from one study of women athletes with reduced pregnancy complications that it should be reasonably clear that work and exercise, are in most cases far better for the mother and fetus than inadequate work and exercise (ibid, 1962, P223).

His other studies tended to show that rest improved outcomes for mother and baby. Montague persistently indicated that paid work was not good for the baby, especially in the latter months of pregnancy, despite mixed results and one study showing women employed in the first four months actually had better perinatal outcomes than both the home-only and the work after-four-months groups. His introductory paragraph indicates the cause of my discomfort.

Should a mother work during pregnancy? The answer to that question is that it largely depends on the work. If the work is fatiguing, then the pregnant mother should not work. But what is ‘fatiguing’? How does one determine when the margin of safety has been passed? I know of no adequate answer to that question. The ordinary household duties of the average woman cannot be said to be entirely exhilarating and free from fatigue, but in general, it is reasonably clear that the average home-maker, other things being equal, does not appear to be
unfavourably affected during pregnancy when she continues without much alteration in her domestic chores. Millions of women have done so without any apparent effects upon their offspring. This is, of course, not saying very much, for we do not, in fact, know whether more rest from her customary labours would not have benefited her and her offspring (ibid, 1962, p217).

I noted earlier that he challenged the accepted medical wisdom that experiences in pregnancy have no effect on the foetus, but here he uses that lack of knowledge as support for women’s domesticity.

A rather emotive reaction of mine was: "well let him stay home and be a home-maker with three children for years and see what he thinks then!" I remember in the 1950’s my grandmother (a farmers wife) boiling sheets in the copper in the yard and struggling to lift them out with a copper stick and seeking any available help to wring them by hand; and my mother in the 1960’s, similarly boiling sheets in a copper in Balmain, struggling to lift the steaming mass in and out of the old Pope agitator washing machine, but now wringing them with the help of the little wringer on top - still very heavy work. Both were absolutely exhausted and cranky at the end of washing days - and neither was pregnant!

With the privilege of hindsight and feminist analysis, I believe we can now penetrate the complexity of this field in a way that was not possible from a previous objectifying, patriarchal paradigm. Thus, I question the adequacy of many of the findings that were generated by standing totally outside the experience of people, assessing their possession or non-possession of visible characteristics and then making judgements from an undeclared perspective about the causal connections and their generalized meanings (Fook, 1999; Pease & Fook, 1999).

My research accesses the subjective experience of pregnancy, birth and parenting to throw fresh light on previous findings. A dialogue is necessary between the information generated in a climate unaware of gendered knowledge, and knowledge forged with this awareness. An example: in his consideration of the effects of maternal emotions on pregnancy, Montague says:

It is today a well-established fact that a large number of women dislike being pregnant, and exhibit a variety of emotional disorders during pregnancy. This emotional instability constitutes a genuine stress factor, which serves to create malfunctioning of metabolism and physiology (1962, p170).

I find myself questioning the reference to 'disorders' and 'emotional instability'. In the context of a patriarchal, reason-dominated society, what may be very appropriate and functional emotionality and reaction in pregnancy could become problematic or abnormal because doctors define it as such and label it as pathological. Depression, anxiety and a sense of inadequacy may arise as a reaction when women's feelings are not supported, understood or responded to as normal and adaptive. (Brown et al 1994, found that only 4% of women identified in a population study as postnatally depressed attributed recovery to medical intervention: 96% attributed improvement to partner or family support, the baby settling or return to work.)
Montague (1962) reports studies that relate morning sickness to the unconscious rejection of the pregnancy, to unwanted sex, the woman being nonorgasmic, or extreme dependence on her own mother. The studies don't seem to consider that suffering nausea and vomiting, can be enough to cause one not to feel like sex and to seek support from Mum. (Condon 1997 supports this two-way interaction of social support and depression).

Oakley (1993) connects the prescription of an approved femininity, which is the background of women's experience of pregnancy, to the construction by the medical system of many common problems.

Pregnancy nausea is taken as evidence of lack of femininity in some studies and of its presence in others ... Are real women sick and prone to labour pain or are they not? (1993, p26).

She reports one investigator who, on finding that

more 'masculine' women reported fewer pregnancy problems ... conclud(ed) that such women, because they wish to appear healthy, simply deny their symptoms (1993, p27).

Could it be that women who are powerful, in charge of their lives, and assertive manage to keep at bay the very consequences of patriarchy that make most women suffer, especially in the most exclusively female part of life - child birth? Oakley (1993) considers that the particular psychology used as the template for a woman having a baby is

that particular psychodynamic structure which expresses the socially secondary meaning of womanhood in a patriarchal society (1993, p28).

- a femininity that is selfless, passive, giving, non-assertive.

While Montague reports studies that seem blatantly patriarchal in their interpretation, he is clearly struggling himself to emerge from the dominant paradigm and advocate for the power of the prenatal period. He sees this field as a "vast territory which has lain in virtual darkness until very recently." (1962, p ix) With its neglect by medical science,

...we have slighted, neglected a period in the history of the individual which is perhaps more important for his (sic) subsequent development than any other in his (sic) life (1962, p3).

Though difficult to prove at that time, he clearly believed that prenatal experiences affect the foetus physically and behaviourally.

Joffe (1969) extended Montague's work and reviewed what he considered were methodologically sound studies looking at the link between prenatal factors and child behaviour. This, also, is an interesting but very dated work. Disentangling the relative importance of hereditary/constitutional and environmental factors was his major preoccupation. Approximately three quarters of the book reported animal studies which, though fascinating and supportive of prenatal influence on outcomes for offspring, were exceedingly cruel. Joffe concedes almost no conclusions because of the complexity of the methodological issues required for proof and lack of experimental design even though:
There is a large body of evidence, varying considerably in conclusiveness, on the influence of a large variety of prenatal variables on the growth and health of human offspring (Joffe, 1969 p230).

Almost all the studies had data indicating trends supportive of the notions that prenatal and birth complications adversely affected the outcome for children. Some postnatal factors were 'neuropsychiatric disorders' including intelligence; cerebral palsy; epilepsy; behaviour problems; speech disorders; tics; reading disorders; hearing, accidents in school age children; strabismus, autism; juvenile delinquency (which interestingly was the only one not following the trend.) These findings are consistent with the recent developments in neurological research. Joffe concludes that only detailed prospective, longitudinal studies with an experimental design will "prove" anything. On the other hand, the human studies provide sufficient evidence to enable preventive prenatal action to be initiated with regard to a variety of pregnancy and childhood disorders without waiting for the methodological issues to be unravelled precisely - though the action may be more effective when they are (Joffe, 1969, p308).

This prophetic statement is now, thirty years later, well supported and gaining political currency.


Wolkind reviews studies that explored the impact on foetus and child of stress in pregnancy, and concludes

There is clearly far too little evidence in man (sic) to answer with any confidence whether a mother's emotions during pregnancy will have lasting effects on her child. Equally clearly, however, there can be little doubt that the question is not absurd and is well worth asking. ...Despite the problems of design and interpretation it is difficult not to be struck by the very similar descriptions of the babies of stressed mothers given in each of the studies (1981, p 191).

In Toronto, 1983, the first International Congress on Pre- and Perinatal Psychology brought together many interested in birth psychology who felt marginalised in their professions. Thomas Venn took a leading role and has continued to speak, write and provide opportunities for others to contribute to the development of understanding about the perinatal period, despite mainstream resistance.

...we envisioned a conference marked by freedom of expression and with emphasis on papers that would be relevant, original and divergent,... Many of the things that truly matter to us as human beings, such as love, hate, beauty, honesty, creativity and faith, cannot be quantified and elude traditional scientific inquiry (Venn, 1997, p 14).

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Awareness about the importance of prenatal experience has been a continuous thread to the present. Evidence is accumulating for the link between prenatal experiences and a child’s health and development. Mustard says:

Even more interesting is the increasing body of knowledge that the risks for many of the chronic diseases in adult life are set in utero and during the first 4 to 5 years of early life (1998b p1).

Thus, it becomes vital to pay close attention to prenatal care and what contributes to a pregnant woman’s (and man’s) well-being. Certainly psychotherapeutically and in many cultures around the world, importance is given to the mother’s prenatal experience out of the belief that it does affect her infant’s development.

3. FACTORS INFLUENCING THE PREGNATAL ENVIRONMENT

a. PREGNANCY PLANNED AND WANTED. Pregnancy occurs in a particular time, place and situation in the life of the individual and of the community. Is conception welcomed, accepted reluctantly, actively not wanted? Is it the right time, with the right partner, in the right family, economic, social circumstances? If the pregnancy is somehow “wrong” there are potential adverse effects on a mother’s capacity to parent, and the child’s behaviour. My clinical experience and the results of this study support this. I worked once with a very difficult 13 year old boy who cried one day that his mother did not want him and, worse, he was a boy. Though the parents denied this and tried to reassure him that he was wanted, a family friend confirmed that he was correct. Many women have shared how difficult it was to cope with a pregnancy, and the subsequent child of a pregnancy, that was not wanted. In my experience, marital or extra-marital rape is a heavy burden for a child especially if the child is a boy. Chamberlain (2001) describes the links between pre and perinatal violence and later perpetration of violent behaviour.

b. THE MOTHER’S PHYSICAL HEALTH: Nutrition, ingestion of drugs (legal, illegal, and prescription), exposure to toxins like lead, X-rays, are routinely considered in prenatal care. Flu in the second trimester increases the risk of schizophrenia and affective disorders (Watson et al, 1999). Some women’s health literature link psychological and social-political views of motherhood to promote women’s wellbeing in transition to parenthood.

c. EMOTIONS AND FEARS: Kitzinger (1989, 1994) outlines some emotions and fears that women may face on becoming pregnant: Fear of pain, of how the baby is, loss of control, dignity and autonomy, of having to manage alone, loneliness, loss of attractiveness, fear of the huge changes she will face in her life, fear of failing to live up to hers and society’s expectations, of managing the birth itself. Expectations about the pregnancy and birth, if

85 Raphael-Leff, 1993; Roddick, 1991; Von Raffler-Engel, 1993
86 P. Mrazek (1993); Beckwith (1990); Raphael-Leff (1993); Condon (1997); Chamberlain, (1998)
disappointed, can interrupt the mother’s response to the infant and is a possible risk factor for postnatal depression. It can be a very anxious and worrying time. If this is not understood a woman can receive a psychiatric diagnosis.

The mother’s subtle feelings can affect the foetus as demonstrated by a study that considered the effects of music on foetal activity. The important factor was not the music but whether the mother liked the music or not (Oakley, 1993, p74). If something so apparently trivial as the mother’s reaction to music can affect the foetus, how much greater is the likely impact of very powerful mind/mood altering experiences or substances? What also of the subtle power of images or expectations of motherhood?

i. Maternal depression in pregnancy affects the infant. The capacity of the parent to hold the baby in mind and interact is frequently impaired in depression, grief or trauma and when viewed on video is powerfully apparent. The baby’s whole body is engaged with either trying to actively re-engage the mother or collapsing in despair when she withdraws her attention. Davies and Cummings, while advocating the need to go beyond a biological model, speculate that

early appearing, difficult temperaments could reflect prenatal or perinatal correlates of maternal depression, such as elevated intrauterine hormones (eg. catecholamines), alcoholism, drug abuse, inadequate weight gain and birth complications (1994, p74).

ii. The father’s acceptance or non-acceptance of the pregnancy also has its effect and paternal depression or anxiety is very evident. Joanna’s story (see chapter 4) illustrates this. The difficulties fathers have in adjusting to ‘being pregnant’ are beginning to be identified and acknowledged in the literature (Parr, 1996; Mattey, personal communication; Barclay, 1996; Lamb, 1986).

Some men become really depressed during pregnancy or experience violent mood swings similar to those that a pregnant woman may go through. A few even walk out of the relationship because the stress is too great for them to handle (Kitzinger, 1989, p139.)

iii. Domestic violence frequently occurs or increases in pregnancy (my clinical experience) perhaps because of the depression and adjustment problems described above. Though the effects of paternal depression have not been fully explored (Davies and Cummings, 1994) it may reduce the amount of support for the mother which affects perinatal outcomes. It may also increase marital tension and conflict, another factor correlating with child problems. Support is a critical factor in the process of resolution (Ornish, 1998; Pawl, 1995; Main & Hesse 1990). Thus, I have attempted to understand

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91 Video presentations by Lynne Murray, 1995; Judith Dean, 1999; Mary-Sue Moore, 1999; Martha Erickson, 2000; Pawl, 1995.
specifically what it is that women find stressful in pregnancy and what supports them to cope. All the women in this study indicated that partner’s support and emotional availability were extremely important. Those without support ended up in the high stress group (see chapter 5).

iv. Substance use is a worrying factor given the widespread use of both legal and illegal drugs in Australia. Substances affecting the mother generally affect the foetus and usually its developing central nervous system. This makes the infant biologically vulnerable (Zuckerman and Brown, 1993 review the findings). But substance use is complex and often coexists with lifestyles that can be harmful making it hard to be definitive as to specific effects. Different drugs have differential consequences according to the dose, timing of ingestion, duration and frequency of exposure. Central nervous system changes, reduced foetal growth, low birth weight, birth complications, foetal alcohol syndrome, problems planning, initiating and following through of tasks, learning difficulties, hyperactivity, behavioural disorganization, irritability, developmental delay are some of the possible consequences in the progeny (Zuckerman & Brown, 1993; Johnson et al 1999).

d. Medical model of pregnancy: Oakley’s studies (1992, 1993; Oakley et al, 1990) of women’s experiences of prenatal care show how the medical model of pregnancy and birth can increase women’s fears and can add dangers iatrogenically to the health of herself and her baby. Intervention is increasing as women are screened and labelled. Lumby (1999) notes that well educated middle class, privately insured women are most likely to have a ‘highly interventionist labour’ - 51% higher caesarean rate for privately insured women. There is a debate raging currently about the high rate of caesarean sections (higher in private hospitals) and whether this is a good or bad thing (Sydney Morning Herald 16th March, 2001). A fearful woman is at greater risk of a difficult birth (Dick-Read, 1981).

Merely the assessment of a client as potentially at risk is sufficient to render that client at risk through the expectations and beliefs of the practitioners (Peterson & Mehl, 1984, p134).

Eight of the eleven women in this study voiced dissatisfaction with medical care and two specifically wanted a less medical approach. Numerous studies have indicated better outcomes for non-medical births: that public health improvements, not obstetrics, has reduced infant mortality (Kathleen Fahy cited in Lumby, 1999). Parr also advocates an integrated psychologically supportive, problem solving model in the transition to parenthood rather than a medical model in which

Women’s expression of distress are perceived as ‘problematic’ and women are considered to have ‘improved’ when they express less dissatisfaction with their new roles (1996, p62).

Most support programmes Parr assessed in England and the United States paid attention to birth outcomes and postnatal depression, ignoring such critical, complex issues as relationships with partner or family and informal support networks. These were most important to the women in the current study.
e. Social Images and Attitudes: For many women the images and messages of society about pregnancy and motherhood become part of their ambivalence and difficulty. Some women do not enjoy the experience of pregnancy, birth and motherhood but struggle with the belief that they *should*. Others identify as mothers and want to be at home and struggle with the belief that they *shouldn’t*. Either way this can affect their capacity to respond and interact with the infant. Even being able to own negative feelings or ambivalence in pregnancy or post birth is perceived as unacceptable (Parker, 1995; Raphael-Leff, 1993; Schaffer, 1977). Certainly, the media images would have one believe that pregnancy and motherhood are blissful, smiling experiences. No wonder that when the reality hits, many women feel inadequate failures and get depressed. This is captured wonderfully in the title of a 1994 NSW Consultative Committee report on postnatal depression: "If motherhood is bliss why do I feel so awful?" Rozsika Parker (1995) writes specifically on the experiences of maternal ambivalence and Smith (1995) on the consequences of social attitudes on mother-son relationships. Some of these issues, especially in relation to work, were raised spontaneously by participants in my study.

f. Social Policy: Oakley (1993) challenges the notion that improved medical care is sufficient to improve perinatal outcomes. Her work indicates that it is the overall status of public health (availability of income security, housing, water, quality food etc) and the health and nutritional status of the mother in her childhood that seems to improve perinatal outcomes most. This is consistent with the findings of those exploring the social causes of postnatal disease. Poverty and social factors are potent risk factors.

g. Intervention in pregnancy assumes that events in pregnancy influence the future of the foetus (Olkin, 1987; Danby, 1987; Kestenberg, 1987) and have found that children’s emotional, learning and social capacities can improve with prenatal intervention.

By interviewing and offering continuity of midwifery care through pregnancy, Oakley (1992 & 1993) found that social support proved to be of paramount importance for women.

...The main lesson to be learnt for the antenatal services is what the consumer movement has been telling us all along, that pregnancy is above all a social relationship. It is this relationship, rather than its fragmentation into parts owned by different experts or fought over by the courts, or jeopardised by poverty and material deprivation, which remains the main challenge for the development of appropriate care in the 1990’s; how to respect the integrity and autonomy of each woman and baby in their own, unique social context, while at the same time using the best endeavours and most appropriate resources of the health-care system to provide safe, sensitive and effective care (Oakley, 1993, p154).

The women in this study overwhelmingly mentioned support as what they needed or valued. Ernest Freud (1987) notes the importance of support from the mother’s own experience of adequate mothering as an infant through to the support available to her at

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the birth. A number of projects offering family support interventions prenatally reduced the risk of delinquency by influencing family factors. Over the last few years support is accepted as important for healthy child and family outcomes and has gained political endorsement in NSW’s Families First initiative. This has been strongly influenced by research into pre and postnatal home visiting that improves some outcomes for the mother and child.

Many successful family support interventions that have affected family risk factors for delinquency have been implemented during the prenatal or early infancy period. At this time of heightened stress, parents may be more open to outside support than later in their child’s development (Crockenberg, 1987). Single parents, adolescent parents and parents with already low levels of social support may benefit particularly from support during the perinatal period. Beginning early intervention before birth would ensure prenatal care, which, as discussed previously, may be crucial in reducing the incidence of perinatal risk factors for chronic delinquency. Moreover, prenatal care has been shown to have a greater protective effect for low socio-economic status families than for higher SES families (Greenberg R, 1983; Kotelchuck et al 1984; Telzrow 1990). (Cited in Yoshikawa, 1994, p42)

4. STRESS IN PREGNANCY

The factors discussed above are all potential sources of stress for the pregnant woman. The effects of stress on the human organism are well documented. Stress and trauma are implicated in many nervous, endocrine, neurological, cardiovascular problems (Ornish, 1998). The foetus is bathed in the hormonal cocktail circulating in the mother’s body due to nutrition (or its omission); emotional experiences of love or fear, anxiety or depression, joy or sorrow; and almost any substance that the mother takes including legal, illegal and prescription drugs. These experiences contribute to the physical development of the foetus - to the formation and development of its nervous, neurological, endocrine, cardiovascular systems. Carter notes that:

Even genetically identical twins ... have different brains by the time they are born because the tiny divergence in the foetal environment of each is enough to affect their development. The cortex of human twin babies is visibly different at birth, and structural variations inevitably produce differences in the way brains function (1998 p 21).

The environment of poverty impacts very significantly from conception, especially if linked to a range of other factors.

...there is reason to believe that a disproportionate percentage of the young children involved in these situations are likely to be difficult to care for, especially if they were born to substance-abusing mothers (Halpern, 1993, p78).

98 Catano & Catano, 1987; Perry, 1997; Perry et al, 1995
Family instability, marital discord, father's absence, poor parental mental health, 'legitimacy of the child', no adequate substitute caregiver for the child in long term separation from the mother, increased the correlation between perinatal stress and incidences of official delinquency (Yoshikawa, 1994). Not surprising really, since early experience is mediated by relationship.

...perinatal trauma may relate more to violent crime than to property crime ... Mednick et al found that the proportion of adoptees with perinatal risk arrested for violent crimes was more than four times greater for those with early unstable family environments (Yoshikawa, 1994, p.32-33).

Peterson & Mehl (1984) document studies that indicate the powerful biological effect of anxiety, stress and attitudes on the woman's system, the foetus and thence the increased risk of birth complications. It is clear that there are significant relationships but the authors stand strongly for a wholistic approach and a personalized understanding of these findings in order to offer effective preventative and treatment assistance. They are highly critical of the way such findings are used and increase maternal stress.

We can begin to understand how the uterus might not respond well to the hormones which initiate labour if its muscle tone has been chronically increased through alpha-adrenergic stimulation. A maximally tightened muscle can contract no harder regardless of how greater the concentration of oxytocin becomes. What Levinson and Shnider and the other writers on the biological aspects of anxiety have not helped us to understand is the experience of anxiety and stress. The positivist, rational perspective inevitably leads us away from the individual woman's experience of life in which she feels anxious, lacking and frustrated...toward the woman as laboratory container, filled to a measurable level with a coloured fluid called anxiety (1984, p.87).

This thesis explores subjective experience. I also fear that it may be used to induce guilt, blame and control women as incubators of society's future.

5. CONTINUITY OF PRENATAL EFFECTS

Those exposed to curries prenatally take to them more easily post birth; newborns suffer withdrawal from addictive substances (Carter, 1998). After amniocentesis, there are measurable physiological changes indicative of shock in the prenate consistent with patterns of very sick or drugged babies (Teixeira et al 1999; Chamberlain 1998, p.55). Do these reactions affect development? Lipson (1994) cites work by Hunter (1782 - yes 1782), Turner (1956), Ferreira (1962) that support the link between extreme emotional distress in pregnancy and babies who were hyperactive, irritable, with feeding, digestive and sleep problems (ie. dysregulation).

Piontelli (1992) has done interesting work with single and twin foetuses using prenatal ultrasound observations:

My findings suggest a remarkable continuity in aspects of pre-natal and post-natal life. Each fetus had characteristic ways of behaving which were to some extent and in some form or other continued in post-natal life... the interplay of nature and nurture begins much earlier than is usually thought and that certain pre-natal experiences may have a profound emotional effect on the child, especially if these prenatal events are reinforced by post-natal experiences (Piontelli, 1992, p.1).
Each twin and pair of twins were different and experienced the intrauterine environment uniquely (Piontelli, 1992; Carter, 1998, Lipson, 1994). Some pairs cuddled and touched; others kicked and recoiled from each other. One twin may be more active, the other more still. The role of experience in neurological development, and the capacity of the foetus to actively initiate in the womb could explain these differences.

Prenatal experiences have a direct impact on the mother’s emotional and physiological state and the foetus, and can continue to have an impact post birth. Factors in pregnancy that correlate with later risk of neglect or abuse include: high levels of perceived stress and poverty, (highly correlated with risk of child abuse); unwanted or unplanned pregnancy (highly correlated with the risk of neglect); the loss of a previous child (moderate correlation with risk of child abuse). Tension in primary relationships (especially with one’s partner) impact strongly on infant outcomes.

Yoshikawa (1994) reviewed literature and reported on three longitudinal studies in which low socio-economic status, large family size, low maternal ability and poor family relationships made up the family adversity factors that distinguished between babies who were small for gestational age with or without problems.

Perinatal risks such as prematurity, low birth weight, anoxia, and other medical stresses at birth have been associated with (a) persistent parent-teacher-rated behaviour problems between the ages of 5 and 7 (McGee, Silva and Williams, 1984) (b) official delinquency at age 18 (Werner, 1987), and (c) violent official delinquency (Mednick, Brennan and Kandel, 1988). Perinatal risk was found to interact with characteristics of the early family environment (Yoshikawa, 1994, p35).

De Chateau (1995) and colleagues interviewed mothers one month before their due date and then compared holding patterns one week post partum. Previous work found 80% of rooming-in mothers held their infant on the left side regardless of a number of factors including handedness. They concluded that mothers holding on the left side differed in pregnancy from those who held on the right side. He refers to other studies that indicate right-sided holding increases in mothers who have been separated from their infants and related to increased levels of anxiety. They also had more contact with child health and home nursing visits than left holding mothers. Right holding mothers reported

...that it had taken a longer time to relate to and to accept their feelings toward their growing fetus or newborn (De Chateau, 1995, p41).

Robson and Moss found mothers

who experienced immediate feelings of warmth and love for their infants ... were described as being extraordinarily high in their investment in the fetus during pregnancy (cited in Cranley, 1981a, p82).

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Fonagy et al (1992) found that the more self-reflective parents are in pregnancy, the more secure were their child’s attachment at 12 and 18 months of age. This correlation was stronger for mothers and stronger than their own adult attachment rating.

Thus, parental capacity to accurately identify psychological states appears to play a crucial role in the child’s emotional development (Fonagy et al, 1992, p982).

Minde reports a study showing the development of the mother’s prenatal image of the infant and its implications for premature infants.

...a mother’s representation and fantasy of her baby increase in richness between the fourth and seventh months of pregnancy. After this time, maternal thoughts about the growing infant become more vague (1993, p94).

This is assumed to leave the infant freer of expectations to develop uniquely. A mother of a premature infant may have more difficulty forming a positive relationship with her infant because she has not been able to move far enough into this state of openness or vagueness (Tracey, 1994).

However, others, investigating the link between prenatal perceptions of the foetus or infant and how the infant is after birth, have found prenatal perceptions correlate with the real postnatal infant. Whether this is a self-fulfilling prophesy (the mother sees and responds to her image rather than the ‘real’ infant thus conditioning him/her), or whether she is accurately picking up the child’s nature, is hard to say. Maternal identity and representation of the baby evolve in complex ways during pregnancy.

Zeanah and colleagues (op cit) have extended and applied Bowlby’s notion of internal working models (Bowlby, 1979a & b), proposing that intergenerational transmission of abuse or attachment is due to the process of internalization of the patterns of early relationship. Thus an internal working model of self and other is cerated. This then influences the way a mother will respond to her foetus or infant, and in turn, the way the child will respond in her/his relationships. The psychoanalytic tradition ascribes the process to maternal projection of parts of herself onto the foetus and infant which then determines her response to disapprove and punish or admire and permit. The work of Chamberlain, Verry, Grof, Lipton explain processes of direct transmission (described above.) My work found that ascription is part of the development of prenatal relating.

Males exposed prenatally to a severe earthquake in China were more likely to suffer depression as adults (Watson et al, 1999). The 1940 German invasion of the Netherlands gave van Os and Selton (1998) an opportunity to see the long term outcome for those in the first, second and third trimester of life. First trimester exposure to maternal stress increased the chance of schizophrenia. Males were more susceptible than females in the

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103 Ammaniti, 1992 and undated work.

104 Parker, 1995 gives a fresh perspective on psychoanalytic theory and motherhood.
second trimester exposure implying gender related effects from prenatal exposure to stress (van Os & Selton, 1998; Ellis et al., 1988).

Dorthe Hansen (2000) used Denmark’s extensive population registers over thirteen years to explore the link between stress from serious life events (sudden death, illness) and congenital malformations (cleft palate, eye, ear and cranial malformations). After controlling for a range of factors, she found, a very significant positive, dose related correlation if incidents occurred in the first trimester.

(Women who had been exposed to these severe life events, death or acute myocardial infarction, or cancer, they had an increased risk of 50%. And if the woman had been exposed in two consecutive pregnancies, then her risk was almost three times as high as the control group’s. ... if women had been exposed in the first trimester of the pregnancy, then the risk increased to almost five times as high. And if the death was ... an unexpected death, then the risk was eight times as high as the control group (Hansen, 2000 no page number).

Norman Swan (Hansen’s interviewer) explains the first trimester link.

These structures originate in a thin layer of cells in the embryo called the neural crest which, at what will be the head of the embryo, spread out to form a variety of organs. So something which affects this tiny number of cells can have disastrous consequences later in the foetus’s development (Hansen, 2000).

Cranial neural crest cells are hypersensitive to hyperglycaemia and increased blood sugar, which affect their migration. In stress, cortisol and blood sugar levels go up.

6. PROCESSES MEDIATING MATERNAL EXPERIENCE

New technologies (Positron Emission Topography scans; Magnetic Resonance Imaging, ultrasounds) have brought the moment to moment functioning of live brains and prenates into view. The physiological processes are still unfolding. (Vallee, 1997; Void et al, 1997; Schore, 1997). Glover (1999) notes that anxiety impairs uterine blood flow and perhaps accounts for the tendency for anxious mothers to have premature or small for gestational age babies. Cortisol levels increase in both mother and foetus, which he speculates, may affect foetal brain development and later stress responses.

Because the immunologic and endocrinologic systems regulate each other extensively, there is potential for corticotropin-releasing hormone to regulate inflammatory responses and vice versa. The cytokine interleukin 1 stimulates production of corticotropin-releasing hormone, and corticotropin-releasing hormone in turn regulates cytokine production by immune effector cells. Because maternal stress is associated with preterm birth, abnormalities in the regulation of corticotropin-releasing hormone and the production of inflammatory cytokines may be a mechanism that could form the pathophysiological basis for this association (Dudley, 1999, p251).105

Lipton has another view about the process which is compatible with the understanding of genetics described by Lamarck, a contemporary of Darwin’s, (Steele et al 1998.)

(!)It is now recognized that the regulation of gene expression, that is the switching on and off of genes, is not a property of the genes themselves, but is controlled by environmental signals (Nijhoul, 1990). We are also now

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aware of the fact that organisms under stress are able to actively alter their DNA and create new genes in an effort to accommodate environmental challenges (Thaler, 1994). Rather than being genetically predetermined, organisms develop in balance with their environment and purposively select, or if necessary rewrite, what they perceive to be appropriate gene programs to ensure their survival (Lipton, 1995 no page numbers).

This fits with the fact that the brain structures responsible for basic physical regulation and emotional processing are developing prenatally, and that the foetus can be habituated to certain experiences as part of the preparation for post natal life.

However, merely experiencing an event in pregnancy does not necessarily mean the child will be affected. Much depends on how the mother subjectively experiences the event, makes meaning of it and comes to resolution. The Adult Attachment Interview (Main & Hesse, 1990) found that the degree of resolution of experiences was critical in the nature of a child’s style of relating. Transmission to the foetus is even more direct.

The mother’s emotions, such as fear, anger, love, hope among others, can biochemically alter the genetic expression of the offspring. Our perceptions of the environment, and their attendant emotions, elicit physiological responses in the body by releasing “signal” molecules into the blood. Blood-borne emotion-related signals activate specific receptor proteins on the surfaces of cells in tissues and organs. Activated receptors serve as molecular switches that adjust the metabolic system and behavior of the organism, so as to accommodate environmental challenges. Physiologic responses to environmental signals include regulations of the nervous system, endocrine organs, and the cardiovascular, respiratory, digestive and excretory functions.

During pregnancy, the parent’s perception of the environment is chemically communicated to the fetus through the placenta... and effect the same target cells in the fetus as those in the parent. ... While developing in the safety and confinement of the uterus, the child is provided a preview of the environment as it is defined by the parent’s perception and behavior. Parental behaviors ... when repeated ... serve to habituate the developing behavioral chemistry in the fetus. ... Behavioral “memories” are in part related to the appearance of specialized cell and tissue protein receptors which serve as “filters” in remembering past signals. Behavioral “filters” acquired during pre-and perinatal “programming” are Nature’s way of preparing the neonate to function in the parent’s environment. Technically, these “learned” filters would enable the child to adapt more quickly and successfully to the home environment. The parents’ experiences help “preprogram” the behavior of the child, so that it may more effectively deal with environmental exigencies. ... It is specifically “chronic,” or continuously held emotions that prove to be detrimental during pregnancy. ... In utero, the child acquires “attitudes” about life as it decodes the “behavioral” signals relayed in the blood (Lipton, 1995).

Bowlby’s (1971) attachment theory drew heavily on ethology, and LeDoux (1996) says that the neurological systems underlying basic behaviours are similar across species. These systems also operate to pick up and respond to stimuli largely out of awareness including that of the foetus. The gender of the foetus alters the mother physiologically (Carter, 1998). Pregnant pig-tail monkeys carrying a female foetus are attacked and wounded by other monkeys more than those carrying a male foetus.

Fetal gender thus appears to influence both the mother and the social group even before birth. The implications of these results is that a realistic psychobiological theory of primate development cannot ignore genetic and prenatal variables as these factors may be crucial in determining apparent environmental effects. ... What seems

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to be needed, in addition to work on basic biophysical mechanisms, are multifactor studies designed to understand, rather than hide, the individual differences that we consistently ignore in our statistical 'error terms'. These factors may include traditional variables that are less readily available for manipulation and measurement, such as differential effects of the fetus on its mother (Emde & Harmon, 1982, p11).

There may be prenatal foundations to the notion that the prosperity of a nation depends on how children are handled 30 years before (Mustard, 1998a).

More work needs to be done but Patterson et al (1992) and Emde and Harmon (1982) echo Joffe's call (1969) for early intervention without waiting for the detail. The sections on resilience and love (see chapter 1) highlight the importance of supportive relationships - an understanding fundamental to the handling of pregnancy in many cultures. Evidence drawn from a variety of sources indicate that life begins before birth and is the foundation for the future; that there are mutually co-creative processes flowing between foetus, mother, family, neighbourhood, society that continue across the life cycle; that we can and must understand and support human development from conception (at least) through pregnancy, birth and into postnatal life. The following diagram portrays layers of interconnecting forces and relationships that affect the foetus which is embedded in the mother, embraced within family relationships that exist in neighbourhoods, influenced by cultures, operating within social/political forces all grounded in the well being of the planet.

Diagram 1: Interconnecting layers of Prenatal Influence
7. PRENATAL RELATIONSHIP

The foetus has capacities developing in utero that, without ‘scientific’ knowledge, mothers often begin to relate to. The kicks and stretches of the foetus are part of the dance of relationship. Pregnant women can learn what the prenate likes and dislikes, who and what s/he responds to, the sounds that calm or excite.

For a mother and her child, pregnancy is the time when they were in the closest partnership, intimately joined together in an experience, which is rarely discussed, and often forgotten (Kitzinger and Nilsson, 1990, P5).

Verny and Kelly (1981) suggests that the mother and newborn at birth are like old, loving acquaintances impatient to reconnect. People under hypnosis have described loving the mother before birth and being devastated at being separated (Chamberlain, 1987, 1998).

Though there is a strong body of literature (especially attachment) about the nature and importance of the parent-child relationship, (see chapter 1) there is less work done on the origins of that relationship prenatally.

While the capacities of the foetus described in this chapter reveal the potential for prenatal relating, assessing it requires approaches that are still marginal. (John Bowlby similarly had to step away from the accepted methods of his time to describe infant attachment.) Extra-sensory perception, hypnosis, LSD, pre-birth and past life memories, meditation, access levels of consciousness that parallel quiet alert wakefulness to deep sleep states also evident in the womb and supports the possibility of prenatal communication despite an immature brain.\(^{107}\) Communication is much, much more than spoken language and understanding is growing about the capacity and power of the mind during altered states of consciousness via hypnosis, near death experiences, meditation (Chamberlain, 1998; Ornish, 1998; Singer, 2000).

A host of new discoveries show that even preborns are intelligently organized long before the brain has had a chance to develop. ... You will communicate more easily with your baby if you can set aside the myth that language is the foundation for thought. We are only beginning to understand that thought and communication are more fundamental than language (Chamberlain, 1998, p185 -186).

LSD enabled Grof and Lake (cited in Singer, 2000) to record fetal experiences.

The mother’s general responses to her own life situation before she knew she was pregnant appear to be “discovered” as the subjects relive what comes through to them from their first contact with the womb... The image that the mother has of herself, her sensations, her movements, her anxiety level...affected the fetus...(who)...experiences the mother’s affect as it is chemically transmitted through the umbilical cord (Singer, 2000, p201).

The capacities of the prenate, though immature, are not of a different order to those of the infant, making it more likely than not that attachment behaviour, so extensive

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postnatally, also operates in immature form prenatally.\textsuperscript{108} This is consistent with Bowlby's (1971) ethological analysis of development of behavioural systems across the life cycle in most species.

During ontogeny, the supersession of simple behavioural systems by increasingly sophisticated ones ... is the rule. The advantages in terms of adaptedness and efficiency are obvious. So too are the dangers ... for a faulty transition to occur and the resulting behavioural system to prove less efficient and adapted instead of becoming more so (Bowlby, 1971, p 197).

There seems to be (Bowlby, 1971) an optimal environment, neither too restrictive nor too aroused, and a timeliness (sensitive periods) necessary for healthy postnatal attachment. It appears this is similar for healthy physical and emotional prenatal development. The many features common to both pre and postnatal development indicate that birth marks a transitional phase of continuous development rather than the start of a radically new process (Cranley, 1981a & b.) Attachment systems don't suddenly begin at birth but have their origins prenatally. Mothers (55.5\% in Cranley's 1981a study; 100\% in Carter-Jessop & Keller's, 1987 study) reported or demonstrated attachment behaviours prenatally. Both studies investigated only in the last part of pregnancy, but

In Frank Lake's maternal-fetal distress syndrome we have a theory and model that takes the origins of personally and its disorders back to an earlier stage of human existence than most other workers have done (Moss 1987 p 207).

- back to the first trimester which is supported by Raphael-Leff (1991, 1993) and this study. Prenatal relating, like the transition to parenthood (Parr, 1996) and postnatal relating, is more complicated and variable than generally considered. Some studies\textsuperscript{109} have assessed, through observation or self report, the occurrence of specific attachment behaviours now included in assessment scales. Some\textsuperscript{110} have tried to assess the mother's awareness, perceptions of, attitudes or tie to, the foetus through methods such as narrative, drawing, listening.

Muller (1992, 1996) reviewed literature on prenatal attachment, which resurfaced in the 1970's and 1980's. Some see interaction with the foetus as the start of the postnatal relationship (Rubin, 1984 and Leifer, 1980 both cited in Muller 1992). Pregnant women interact and communicate with the foetus.\textsuperscript{111} Eight of Lumley's 30 subjects reported feelings of attachment from eight weeks. Zeana and colleagues found that most parents "attributed positive qualities to their foetus and newborn babies" (cited in Stern, 1995, p35).


\textsuperscript{110} Lumley, 1980; Stainton, 1990; Bloom, 1995

The notion of representation\textsuperscript{112} describes similar phenomena. Stern (1995) proposes that a Mother's representations have a regular pattern of change through the pregnancy and beyond.

There is general agreement that between the fourth and seventh months of gestation there is a rapid growth in the richness, quality and specificity of the networks or schemas about the baby-to-be (Stern, 1995, p 23).

He found that there is not one dominant theme shaping all interaction, but a variety of schemas influencing momentary interactions. This is similar to the fluid schema I have proposed but the onset of attribution was not limited to this period.

After seven months Brazelton (cited in Stern, 1995 p 23) found that positive attributions drop and negative fears remain to prepare for the possibility of deformity or death. Stern (op cit) suggests that representations begin to unwind, becoming less specific, clear and articulated due to an intuitive changing of the imagined baby to the real baby. However, Olkin (1987) & Kestenberg (1987) actively promoted prenatal attachment which appears to have remained strong even in the face of still births. From comments made by participants in this study, I suspect that changes of representation at the end of pregnancy have to do with the birth taking over the woman's emotional preoccupation as discomfort intensifies (usually). For example, Lea wants 'to get that final turn off' so she won't want to get pregnant again. The desire to 'be done' started early for Rowan who had an early birth. Abbey's ambivalence related to the impact of pregnancy on her social life, community attitudes, physical discomfort and the desire to stay young and not grow up.

Attempts have been made to measure the quality, continuity, development of parental prenatal attachment and the factors that promote or inhibit it. Cranley (1981a & b) developed the Maternal Fetal Attachment Scale which has been used in a number of studies reviewed by Muller (1992). Validity is limited and results mixed about the correlation between maternal characteristics and prenatal attachment (Muller 1992; Cranley, 1992). Quickening and gestational age were the most consistently correlated with prenatal attachment (Muller, 1992). Koniak-Griffin (1988) found that for adolescents, prenatal attachment correlated with a planned pregnancy, intention to keep the baby, their total functional support and size of their network. Preliminary development of instruments and concepts may account for contradictory results and Muller cautions against strong conclusions at this time saying

personal and situational variables may influence prenatal attachment (1992, p 17).

Cranley is sure that

researchers have measured 'something' which is valid but have yet to find the rest of the framework.... The time may be at hand for a more open-ended exploration of how women themselves define the beginning relationships with their children (1992, p 24).

This study contributes to that goal.

\textsuperscript{112} Zeanah & Anders, 1987; Stern, 1995; Bowlby, 1971, 1979a; Egeland and Erickson 1990.
Condon (1985, 1993, 1997, Condon & Corkindale, 1998) has also developed a questionnaire and describes four positive subjective states as indicative of strong parent-to-infant postnatal attachment: 1. Pleasure in proximity; 2. Tolerance of sacrifice or difficult behaviour; 3. Desire to protect and gratify the other's needs; 4. Curiosity about and wish to know the other. Indicators of prenatal attachment are:

- a desire for knowledge about the foetus, pleasure in interaction with the foetus (both in fantasy and reality) and a desire to protect the unborn baby and meet his/her needs, even at the expense of the mother's own.

Underlying these indicators are two factors 'quality of attachment' and 'intensity of preoccupation' (Condon 1997, p.359-360).

Comments reflecting these indicators and varying degrees of intensity of preoccupation, both positive and negative, emerged from my study. However, Condon's tendency to equate positive feelings with quality of attachment is too simplistic. Attachment is more complex than the simple approach that says positive = attached; negative = non-attached.

Kohn et al. (1980, cited in Muller, 1992) found mothers who feared problems with the baby were more positively attached immediately after a disconfirming ultrasound. Cranley (1992) frames this as a capacity to withhold attachment feelings but to me it also reflects the way grief and fear of loss block the expression of attachment (Bowlby, 1971).

Raphael-Leff (1991, 1993) describes transformational changes through pregnancy in three phases. In early pregnancy the woman registers physical changes and "emotional disequilibrium" and adjusts to the implications of being pregnant. The middle phase begins with quickening

- When the emphasis shifts from the 'pregnancy' to the extraordinary idea of a separate and unknown being growing inside her (Raphael-Leff, 1993, P.17).

The final phase occurs when the mother realises the baby is real, able to exist independently even if premature.

Thus, over the three trimesters, the focus shifts from pregnancy, to fetus, to baby (her italics 1993, P.17).

She notes that physical and emotional changes accompany these phases and that fantasy is a critical part of prenatal relating.

Even before birth, parents begin to ascribe characteristics to their baby, partly based on discernible fetal rhythms and responses and partly on fantasy (1993, P.35).

These changes and processes were evident in the participants in this study but in a less linear way.

Carter-Jessop & Keller (1987) suggest maternal bonding develops in two phases a) prenatally to 4 days postnatally and b) the first postnatal week on. Questions and observations of behaviours (smiling, stroking, vocalising, cuddling), thoughts and feelings indicative of bonding and interaction, were similarly present in my study.
While parent’s can communicate with the intention of forming a relationship, can the foetus? Rene Van de Carr has set up the ‘Prenatal University’ which offers programmes to teach the ‘preborn that action can become communication’ (cited in Chamberlain, 1998 p51).

A look at the first thousand ‘graduates’ indicates that they cry less at delivery, often have their eyes open when sliding out of the birth canal, are more alert, are more easily calmed by patting, rubbing, or music and have superior levels of physical functioning. After birth these babies seem to turn more quickly, talk earlier, act more independent, and can concentrate for longer periods of time. An experiment with a control group showed that this simple program of prenatal communication had a significant effect on mothers and fathers as well as the babies. Mothers in the program had more positive pregnancies, were more attached to their infants, understood the babies’ responses better, felt the birth process was easier than expected, and had a lower rate of C-section than mothers who missed the program. Discovery that newborns are able to remember and learn, making full use of their physical senses and an obviously good brain, comes as a happy surprise (Chamberlain, 1998, p52).

Though I have attempted to show the continuous threads and similarities evident in the literature, it is difficult to truly know the nature of the prenatal relationship. Most of the aspects of prenatal relating discussed were evident in my study. Because I went first to the data rather than the literature, I have developed a more complex schema (see page 136) which, though tentative, allows more variability. Since most studies of prenatal attachment have been of white, middle class people from industrialised nations, generalisability is limited.

Given the vast differences in belief systems and pregnancy experiences, a universal prenatal attachment process may not occur, although all women may have some experiences in common (Muller, 1992 P14).

So, the literature shows childhood is a potent time for development and is vulnerable to the effects of individual, family and social risk and resiliency factors. There are powerful links between infancy and later child, adolescent and adult dysfunction and one of the most profound effects, positively and negatively, is the quality of relating experienced between child and primary caregiver. However, this does not account for the many infants showing signs of difficulty at birth. Prenatal life is also potent, and similarly influenced by risk and resiliency factors. The stress or support experienced by the mother during pregnancy affects the environment created for the foetus and the mother’s capacity to relate to him/her. So now to my work, which, within this wider context, looks specifically at the development of prenatal relating, the stresses and supports experienced during pregnancy that facilitate or inhibit it.
Chapter 3

METHODOLOGY

Even the grandest theories start as seedlings in the soil of human beings efforts to survive and produce their own identities and futures through a multitude of trivial labours. The Platonic idea of knowledge which contends the necessity of transcending the everyday, the mundane, in order to arrive at things which can be universally known, has blinded us to this simple experiential fact (Anne Oakley, 1992 pxxi).

Scientific habits of mind are incompatible with passionate advocacy, strong faith, intuitive conjecture & imaginative speculation ... The cold & aloof scientist is a myth (Scheffler, cited in Albury, 1988, p10 ).

Materialism, and a way of thinking which, without being directly materialistic is purely quantitative in its conceptions, are justified and necessary methods of understanding the world... Their tragedy is in claiming to be the whole, or in rejecting all other ways of thought as without practical significance... preconceptions do creep in... for example, the conviction that a quantitative description is in some way more real than a qualitative one... The negative aspect of modern science has been its failure to recognise that it was not always asking selflessly, "What does Nature reveal?" but often rather, "What kind of knowledge will give me the greatest power over Nature?" And what it was seeking in this way it has found in abundance; as indeed we always find in the end what we look for (Adam Littleston, 1975 p25-26).

From the beginning I knew I wanted to hear people speak freely about what happens on the journey through pregnancy to parenthood - to hear the unedited reality of the ups and downs, the stresses, doubts, joys and pleasures of this powerful time. But I struggled throughout the process with the voices, both inside me and outside in my life, that reflect the debates about what is 'good' research. I was well aware of the qualitative vs quantitative divide, but have now become aware of rich critiques of research and the construction of knowledge that have supported, elaborated and stretched my understanding of why I wanted to do what I did and in this particular way. I was confronted directly with the reality that Research, its methods as well as its content, is a social-political act. This has been a difficult journey, so let me speak a little about living the research experience.

I grew up (intellectually) in an era when "hard" science was God and "soft" science was often deemed inferior; when social science/humanities (psychology, sociology) worked hard to emulate the methods of those branches of science concerned with physical matter (physics, chemistry).

Notions of objectivity, discrete measurement, statistical procedures, validity, reliability, generalizability, control, belief in the rationality and value neutrality of science, dominated. Interesting and often useful ideas were annihilated on the grounds of methodological unsoundness. Whether the methods were appropriate to the questions, able to reveal adequate insights and produce relevant knowledge seemed not as important as being rigorously 'scientific'.

I did my best as an undergraduate, particularly in the school of 'rats and stats' psychology, to master views that at times didn't seem sensible, feel right or fit with real life. The need of the social sciences to assert their scientific validity in the terms of natural science appeared defensive and driven. Even so, my thinking was deeply affected by

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113 Carmody, 2001; Horsfall, 1998; Albury, 1988; Caplan, 1988
This research paradigm - evident in the depth of my inner struggle around methodological issues. Interestingly, several people in my life facilitated the internal debate.

The psychologist said -

There is no methodological debate. You should have an hypothesis to prove statistically or it is not real research, does not constitute evidence and is a waste of time.

The social scientist said:

There is a long tradition of ethnography in sociology, anthropology, even psychology, that has generated much knowledge. It has been rigorous but not quantitative and experimental.

Psychologist:

Science is about testing hypotheses with experimental design, necessary for objectivity, validity, proof and reliability.

Social Scientist:

The social sciences are too young and the variables still too complex and unarticulated to be at the stage of proving hypotheses. It is valid, in fact essential, to generate hypotheses out of people's stories and build meaning together so that understanding is deepened.

AND, the feminist researcher adds,

objectivity is delusional. Even the choice of questions researched is biased by the gendered structure of society.

This is an on-going conversation so, back to the '60's and my undergraduate days.

The social work school, concerned with applying ideas, building skills and effecting change in individual, group, community, organizational and societal levels, was the Cinderella of social sciences and marginalized by its brothers and sisters for being 'unscientific'. It is significant that sociology at about this time disowned social work, casting it adrift to the bottom of the campus, despite the belief of at least one sociologist that Social Work was a practical application of sociological theory (Dexter Dunphy personal communication, 1996).

I, like many of my colleagues, and typical of oppressed groups, became defensively critical of my profession, de-identified with it and distanced myself. Social Work as a profession suffers from the symptoms of an inferiority complex typical of marginalised people. However, looking back I realize that what I learned in the Social Work Department enabled and informed much of what I've done in my life. I acknowledge gratefully that each discipline contributed. Sociology opened the context of the person on which psychology focused, while social work bridged the two, weaving them together embracing and extending them through practical application at the real life interface of people in society. I now openly value my social work training especially when I discovered that some of the practitioners of excellence in my local area were social workers practicing under other labels.
As a community social worker in local government in the early 1970's, I developed a range of participatory, social action research projects investigating community issues with the aim of facilitating people's voice and power and enabling social change. I apologized for the lack of 'hard' data but was happy to sacrifice that for participation, community action and change. I called it "social action research" and was surprised when revisiting research literature in the '90s to find the term had already been coined and developed into a specific research method (Taylor, 1994).

I am encouraged by others who are seeking to find other ways to understand the world. I am reminded that the knowledge we take for granted as being a reflection of the-way-the-world-is, has survived a history of intellectual oppression and physical bloodshed. So many breakthroughs and quantum leaps in understanding have been by people who were seen as heretics and/or mad, and dealt with 'appropriately' (Daly, 1990). Clinging to the established order and resisting new ways seems to lead much of history's horror. For example, the persecution of races, heretics, witches, religious wars, cultural destruction and repression of knowledge - the classic book burnings by conquerors. Daly (1990) gives a particularly vivid review of some of these issues, as do the newspapers of the world. Perry gives the neurological basis for widespread resistance to things new (Perry, 2000a).

The story has not changed. I and a colleague have both experienced the suppressing of research results which were not supportive of the dominant view and thus not acceptable to those in power. He was more fortunate than I in that at least he received a letter thanking him for being so honest about his results but telling him his report was to remain confidential. Mine just disappeared into the system in deathly silence. In doing this work I have encountered sharply the coercive pressure to conform to dominant psychological positivist research. I am immensely grateful for the support to hold to another course and bear the struggle.

Research IS a social-political act
despite positivist assertions that it is objective and neutral.

I am now more conscious of the major philosophical, paradigmatic struggles of which these personal experiences were a part. Beliefs about the nature of reality (ontology), the nature of knowledge and the relationship between the world and enquirer (epistemology) and the way of knowing things (methodology) influence the why, what, who, where and how of research. Over the last 20 years the dominant positivist approach to research has been systematically critiqued and alternate approaches articulated and, in their turn, critiqued.

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This is a major task undertaken admirably by many, and only necessary for me to pursue so that I could come to grips with the inner and outer challenges from the positivist paradigm, quiet my inner critic and feel affirmed in my quest to research outside this paradigm.

Social ecologists, and feminist scholars present the issues clearly, but the debate weaves through the history of science and philosophy.

Though preparing for the research, I did not know for a long time where this work belonged. I am primarily a clinician seeing the research process itself as a potential therapeutic tool. My background in community social work, Buddhism, and social action research, influence me. Theories, newer to me, of Process Work, change management, social ecology, critical theory, new physics and feminist theory, give me supportive models to combine my research curiosity with my clinical interest in social and personal change. My sense of urgency about the need for change is fed by awareness (subjective perception) of the social, ecological and political mess in the world.

Real life is complex. Efforts to prove causality do not seem to have been successful in the field of human life. I have always been fascinated by the exceptions, variance, data that didn’t fit. Why, I ask myself, does the fact that a majority conform to a certain relationship suffice as proof of the general truth of that relationship? To transfer causal relationship from the physical sciences to the social sciences has, in my view, been as inappropriate as applying the strategies that work on an assembly line producing widgets, to the health, welfare and education systems’ that deal with complex human issues. Interestingly, chaos theory and new physics challenge the validity of cause-effect relationships even in the physical sciences (Wilber, 1996; Davies, 1987). It is not possible to isolate factors nor attribute causal power in complex social systems (yet), as demonstrated by the chapter on child development in this thesis.

Joanna Macy challenges the foundations of a linear, discrete reality.

In the epistemology of mutual causality, both the what that is known and the who that is knower are elusive. Neither can be fixed or pinpointed as static, self-existing entities. Shifting and dancing out of reach as we seek to grasp them, they suggest... that there is not knower or known so much as ‘just knowing’ (1991, p137).

She gives a thorough account of Buddha’s insight into the nature of reality as it relates to modern systems theory. Both consider all parts of a system to be

116 Byrne-Armstrong, Higgs, Horsfall, 2001; Stuart Hill in presentations at research residentialists.
118 Denzin & Lincoln’s introduction, 1994; Tony Donovan, 1996; Wilber, 1996; Davies, 1987; Mary Daly, 1990.
interconnected - what happens in one part affects all others. Being interconnected, there is an eternal interplay between elements in a dance of co-creation and constant flux.

...the world is not substance but process (Macy, 1991 p145).

Mindell (1982) also draws from ancient traditions and modern psychological and scientific sources to present a similar view of reality as a shifting, interconnected manifestation of processes that encompasses all possibilities. To know this aspect of reality requires a different approach to that used to penetrate a world perceived as matter operating according to fixed, objectively knowable, truthful laws.

Rational attitudes repress and frustrate dreambody processes just as a doubling, judgemental onlooker may inhibit a person's spontaneous behaviour (Mindell, 1982, p.14).

These ideas remind me that the process of research, and the presence of the researcher, changes what is being considered. The theories presented by Mindell (1982), Macy (1991) and others have come to life for me through meditation practice revealing that the invisible can be perceived by paying close attention to the visible.

Accepting the world as inter-connected, co-creative and in constant flux supports mutual, non-linear causality. Part of me wants to know what causes the emotional and behavioural difficulties in children in order to prevent them. But from clinical work and the work on resilience (see chapter 1) I know that the event is not the critical factor. Resilience and the capacity to make meaning of events will lead to different outcomes for any number of people.

Accompanying women on their journey through pregnancy, attempting to see the invisible - the deeper links and connections between events and felt experiences, the growing relationship and feelings associated with these experiences, requires close attentiveness and engagement. It had to be a qualitative approach.

The actual meaning and importance of individual experience emerges from its context (who, what, when, where, why, how). I as a researcher or therapist become part of that context for the participants through our relationship. Oakley (1993, 1981), Peavey (1994) and Friere (1994) describe how the mere asking of questions aids reflection, new insight and social change. Interviewing women, Oakley (1993, 1981) says, must be a genuine interaction NOT a detached one-way intercourse (which has some parallel to rape.)

It requires, further, that the mythology of 'hygienic' research with its accompanying mystification of the researcher and the researched as objective instruments of data-production be replaced by the recognition that personal involvement is more than dangerous bias - it is the condition under which people come to know each other and to admit others into their lives (Oakley, 1993, p242).

To comprehend and explore the beginnings of love, I needed to be admitted into participants' lives, to engage, relate and at some level be (exist) in love. I knew my presence and the research process would change what they experienced and what I learned, and this
was in fact noted by several participants. Hence my results are narratives and thematic indicators confined to specific contexts and not designed for generalization at this stage.

In sociological and anthropological research the process of questioning, listening, reflecting back, re-questioning, enables a reconstruction and understanding of meaning, issues, possibilities to emerge.\textsuperscript{120} Fran Peavey, (1994) suggests ways of questioning, reflecting, listening that assist meaning to emerge. These are the methods of grounded theory (Strauss & Corbin 1990), phenomenology,\textsuperscript{121} feminist research,\textsuperscript{122} ethnography, (Bowlby, 1971), participatory social action/soft systems methodology.\textsuperscript{123}

I stumbled on van Manen's book "Researching Lived Experience" and my heart said 'yes'.

The point of phenomenological research is to 'borrow' other people's experiences and their reflections on their experiences in order to better be able to ...(understand)...the deeper meaning or significance of an aspect of human experience, in the context of the whole of human experience (Van Manen, 1990, p 62).

1. PHENOMENOLOGY

Phenomenology has become a broad stream with many currents (Chamberlain cited in Ehrich, p198 1996)

The philosophy is complex and filled with jargon (try reading Kockelmanns, 1967!) but Lawlor (1998) describes four main forms - transcendental (Husserl's search for pure, objective consciousness of phenomena); interpretive (Heidegger's interest in how people construct meaning from life experience); existential (the French school emphasised the personal, embodied, subjective, emotional aspects of being and experience); heuristic (the reflections and personal experience of the researcher in the research process).\textsuperscript{124}

Overall phenomenology aims to perceive and describe phenomena by 'thrusting aside our interpretive tendencies' (Heidegger, cited in Crotty, p273 1996) and encountering the lived experience directly.

While phenomenology does not purport to get at the 'ultimate' truth, it does seek to illuminate and transform lives through such illumination (Borbasi, 1996 p258).

Penetrating one's own experience by removing all preconceptions and beliefs and becoming absorbed in direct perception of the phenomenon via its impact on oneself is the transcendental phenomenology of Husserl.

Pure phenomenology claims to be the science of pure phenomena...they are processes of experiencing, ... of intuiting that grasp the object in the original.... If higher, theoretical cognition is to begin at all, objects belonging to the sphere in question must be intuited. Natural objects, for example, must be experienced before any

\textsuperscript{120} van Manen, 1990; Pease & Fook, 1999; Wadsworth, 1991.
\textsuperscript{122} Richardson, 1997; Roberts 1981, 1992, Reinharz & Davidson, 1992; Broddribb, 1992.
\textsuperscript{123} Kemmis & McTaggart, 1988; Taylor, 1994; Dick, 1993.
theorizing about them can occur. Experiencing is consciousness that intuits something and values it to be actual (Husserl, 1917, web access, 2001).

Crotty (1996, 1998) supports this traditional approach represented by Husserl, Heidegger and Merleau-Ponty, in which one attempts to confront a phenomenon 'in its stark immediacy' (Crotty, 1998, p207). It is, he says, extremely difficult to put the raw experience thus gained into everyday language. I realise in retrospect that I have taken the easier and more modern way of phenomenology (according to Crotty 1996). I had sought to understand prenatal phenomena through the experience of others and so, while still approaching the issues with openness, unencumbered by pre-reading and theory, I found the approach of van Manen (1990) and more recent phenomenologists more useful. Giorgi (cited in Ehrich, 1996, p202) translated the philosophy of phenomenology into a methodology for psychology and was closer to what I had done. I asked people to talk about their subjective experience of pregnancy and allowed the issues to emerge.

2. METHOD or what actually happened?

Not what I initially intended! The method grew through the constraints encountered during the journey and decisions made on the way - a process different to that presented in many research texts, however supported by those who have attempted to describe the real rather than the theoretical research process. Differences with key people in the Health system about the usefulness of what I was studying and the qualitative methods proposed, (despite having ethics approval), constrained this work. Support was actively blocked. This is particularly frustrating given that, some six year later, Families First, the Federal government's recent funding initiatives and the new NSW Child Protection Act, are promoting the importance of support in the perinatal period. I am aware that this too is not new in research experience.

a. PARTICIPANTS

Health Department staff were unable to refer people, so I approached non-government agencies, doctors and obstetricians for referrals and put up posters around the villages and towns. Eleven of the twelve women who contacted formed the sample and all completed the research. (One withdrew before beginning.) The study conforms to the ethics approval given by the University ethics committee. Ethical considerations include the use of pseudonyms to protect confidentiality, respect of participants privacy and sensitivity, care in the storage of data. (See appendix A for consent forms completed by all participants.)

b. DATA COLLECTION

Initially I was seeking to understand how stress, trauma and support played into the perinatal experience. I believed that prenatal stress would, if great enough or unresolved, show itself in the infant's postnatal state but, as I was charting fairly unknown territory, I needed to stay very open and gather hypothesis generating data rich in detail. At this

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stage I had not left the positivist paradigm behind and so included the Edinburgh Postnatal Depression Scale and a record sheet with a likert scale in an attempt to quantitatively rate the subjective experience of stress.

Interviews, arranged at a time and place to suit participants, averaged 1½ hours. There were a total of 92 interviews: 57 prenatal interviews (plus three with individual fathers not included here) plus 32 post partum interviews. Table 3.1 shows the number of each participant’s pre and postpartum interviews by the week of gestation or postnatal age and the week of birth.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>born</th>
<th>Difference #</th>
<th>PP+1</th>
<th>PP 2</th>
<th>PP 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alyson</td>
<td>23</td>
<td>29</td>
<td>34</td>
<td>39</td>
<td>40</td>
<td>-2</td>
<td></td>
<td>4 weeks</td>
<td>6 weeks</td>
<td>13 weeks</td>
<td></td>
</tr>
<tr>
<td>Rebecca</td>
<td>12</td>
<td>22</td>
<td>30</td>
<td>34</td>
<td>39</td>
<td>40</td>
<td>+4</td>
<td>5 days</td>
<td>6 weeks</td>
<td>18 weeks</td>
<td></td>
</tr>
<tr>
<td>Abbey</td>
<td>21</td>
<td>26</td>
<td>32</td>
<td>37</td>
<td>40*</td>
<td>41</td>
<td>+5</td>
<td>10 days</td>
<td>6 weeks</td>
<td>17 weeks</td>
<td></td>
</tr>
<tr>
<td>Rowan</td>
<td>15</td>
<td>20</td>
<td>25</td>
<td>29</td>
<td>32</td>
<td>35</td>
<td>-27</td>
<td>3 weeks</td>
<td>6 weeks</td>
<td>17 weeks</td>
<td></td>
</tr>
<tr>
<td>Charly</td>
<td>19</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
<td>39</td>
<td>-7</td>
<td>7 days</td>
<td>5 weeks</td>
<td>20 weeks</td>
<td></td>
</tr>
<tr>
<td>Kate</td>
<td>15</td>
<td>22</td>
<td>28</td>
<td>32</td>
<td></td>
<td>38</td>
<td>-15</td>
<td>13 days</td>
<td>6 weeks</td>
<td>21 weeks</td>
<td></td>
</tr>
<tr>
<td>Lea</td>
<td>13</td>
<td>18</td>
<td>22</td>
<td>27</td>
<td>34</td>
<td>38</td>
<td>-10</td>
<td>13 day</td>
<td>8 weeks</td>
<td>21 weeks</td>
<td></td>
</tr>
<tr>
<td>Margaret</td>
<td>15</td>
<td>21</td>
<td>25</td>
<td>30</td>
<td>35</td>
<td>39</td>
<td>40</td>
<td>-1</td>
<td>4 days</td>
<td>17 weeks</td>
<td></td>
</tr>
<tr>
<td>Joanna</td>
<td>14</td>
<td>22</td>
<td>27</td>
<td>32</td>
<td>36</td>
<td>37</td>
<td>40</td>
<td>+2 OR -6</td>
<td>8 weeks</td>
<td>17 weeks</td>
<td></td>
</tr>
<tr>
<td>Beth</td>
<td>15</td>
<td>20</td>
<td>27</td>
<td>31</td>
<td>35</td>
<td>39</td>
<td>41</td>
<td>-8</td>
<td>14 days</td>
<td>17 weeks</td>
<td></td>
</tr>
<tr>
<td>Kylie</td>
<td>14</td>
<td>20</td>
<td>24*</td>
<td>30</td>
<td>34</td>
<td>41</td>
<td>+10</td>
<td>-</td>
<td>8 weeks</td>
<td>17 weeks</td>
<td></td>
</tr>
</tbody>
</table>

Table 3.1 WEEK OF PREGNANCY OR INFANT AGE WHEN INTERVIEWED

* Telephone interview # number of days difference between due and actual birth date +postpartum interviews

Table 3.2 shows the months and trimester of pregnancy of participant interviews.

<table>
<thead>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alyson</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Rebecca</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Abbey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Rowan</td>
<td>*</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Charly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kate</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Lea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Margaret</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Joanna</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Beth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Kylie</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

- The first interview explained the research aims and process and gained informed consent (see appendix A).
- A form was left for participants to complete which elicited general psycho-social and historical data (see appendix C).
- Thereafter participants were interviewed approximately monthly through the pregnancy (appendix B).
• Fathers were encouraged to participate with their partner, and special one-off interviews were also arranged. I only present data on mothers as fathers were less involved. (See Table 3.3 for partner participation). Interestingly, Beth volunteered for the research on her partner’s suggestion. Children were present at times but were not formally included.

<table>
<thead>
<tr>
<th></th>
<th>Table 3.3 PARTNER INVOLVEMENT IN THE RESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jack &amp; Kate</td>
<td>Totally involved - at all interviews; equally contributing</td>
</tr>
<tr>
<td>Chris &amp; Rebecca</td>
<td>At many interviews &amp; actively contributing</td>
</tr>
<tr>
<td>Martin &amp; Joanne</td>
<td>One interview with him plus brief input another time</td>
</tr>
<tr>
<td>Phillip &amp; Charly</td>
<td>At several interviews and contributing secondarily</td>
</tr>
<tr>
<td>Tom &amp; Margaret</td>
<td>One interview with him</td>
</tr>
<tr>
<td>Brian &amp; Beth</td>
<td>Present in the house at several interviews; respond if asked</td>
</tr>
<tr>
<td>John &amp; Lea</td>
<td>Around at times and brief responses to questions</td>
</tr>
<tr>
<td>Jonathon &amp; Rowan</td>
<td>No input</td>
</tr>
<tr>
<td>Matthew &amp; Alyson</td>
<td>No input</td>
</tr>
<tr>
<td>Abbey &amp; Kylie</td>
<td>No partners</td>
</tr>
</tbody>
</table>

• At each interview a sheet was left for the woman and the man on which they were requested to record the key events over the following month and to rate the degree of intensity (positive or negative) of each event (see appendix D).

• At the second interview, a time line was completed which added to my understanding of each person’s life experience. This proved a most useful tool.

• The Edinburgh Postnatal Depression Scale was completed at the second prenatal interview and the postnatal interview closest to the infant’s being six weeks old.

• During each trimester, the mothers completed a drawing showing what they thought was happening inside their uterus. The aim of this was to access less verbal more unconscious perceptions the woman had of the foetus and her relationship to it (Lumley, 1980). The amount of data collected meant I had to be selective and narrow the focus.

• After the birth, interviews and a video of the parent and infant interacting, were arranged as close to 2 weeks, 6 weeks and 4 months as possible. This varied, especially for first postpartum interview, as some women were not accessible. I did not have the resources necessary to process this material for this thesis.

• Participant’s were interviewed at home (mostly), my place, in a car or outdoors.

• I attempted to audio-tape all interviews and also wrote as closely as possible, what was said as they spoke. Obviously I had to summarize to keep up.
I looked at interview schedules and formats that may have been relevant but in the end decided to develop some guiding questions based on clinical experience and my current knowledge of the literature about what may be significant or relevant (appendix B). Rosabeth Kantor, in standing up for asking her own questions rather than resorting to previous questionnaires, says:

The justifications are familiar in a lot of the literature and probably accounts for why so much of it seems so trivial, like ‘the following ten past researchers asked these questions so I guess it’s all right for me to ask them too.’ In other words, such researchers avoid personal responsibility and I’m saying I take personal responsibility when I ask my own questions. That’s how you learn something new (cited in Kulka, 1982 p59).

I wanted to leave the participants very free to cover what they wished to cover so I could listen freshly and allow something unexpected to emerge – I aimed to accompany the journey rather than lead the expedition. I sought natural, emotional and behavioural descriptions from participants of their experiences during pregnancy, birth and the first four months of parenthood. I stayed close to the lived experience and what it was like for participants to have those experiences and how they drew meaning from them – a phenomenological process (van Manen, 1990). I attempted to lay aside preconceptions, did not read specific literature until after preliminary data processing in which I listened for and gathered together essential themes, issues, meanings and was guided to the focus on the prenatal relationship. The process is an hypothesis generating one, which fits nicely with phenomenological principles.127

c. PARTICIPANT DATA:

Though a small, self-selected sample it represents a reasonable cross section of people drawn predominantly from the middle class but with a mix of income, education, employment and class. This data, gathered from the background information form (appendix C) and interviews, is presented to give you an overall picture of the sample. Table 3.4 shows the majority were aged 26-30 but spread over 16-40 years.

<table>
<thead>
<tr>
<th>Table 3.4 AGE OF MOTHERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 - 18</td>
</tr>
<tr>
<td>Abbey</td>
</tr>
<tr>
<td>Kylie</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Table 3.5 indicates the number of pregnancies and miscarriages for each participant.

Table 3.5 NUMBER OF PREGNANCIES

<table>
<thead>
<tr>
<th></th>
<th>first</th>
<th>second</th>
<th>Third</th>
<th>forth</th>
<th>miscarriage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kylie</td>
<td>Abbey</td>
<td>Alyson</td>
<td>Lea</td>
<td></td>
<td>Beth (recent)</td>
</tr>
<tr>
<td>Rebecca</td>
<td>Margaret</td>
<td>Joanna</td>
<td></td>
<td></td>
<td>Abbey (recent)</td>
</tr>
<tr>
<td>Kate</td>
<td>Charly</td>
<td>Beth</td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

Social standing is related to

- the amount of money one has to access the privileges of society,
- the level of education that enables access to society’s privileges, status in one’s own or other’s eyes and job opportunities (it is not simply a matter of more education means more work.)
- Employment or lack of it and the degree of choice one has about work.

Tables 3.6 and 3.7 together give a picture of the socio-educational position of participants.

Table 3.6 gives a broad-brush, impressionistic picture of participant’s socio-economic situations based on source and level of income, lifestyle, self report.

Table 3.6 SOCIOECONOMIC PICTURE

<table>
<thead>
<tr>
<th></th>
<th>Income level</th>
<th>Primary income earner</th>
<th>Social position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alyson</td>
<td>Average</td>
<td>Father - ft</td>
<td>Accepted - middle</td>
</tr>
<tr>
<td>Rebecca</td>
<td>Average</td>
<td>Mother - p/t</td>
<td>Accepted - middle</td>
</tr>
<tr>
<td>Abbey</td>
<td>Below average - benefits</td>
<td>Benefits</td>
<td>Marginalised - lower</td>
</tr>
<tr>
<td>Rowan</td>
<td>Average</td>
<td>Father - ft; mother helps with book keeping</td>
<td>Accepted - middle</td>
</tr>
<tr>
<td>Charly</td>
<td>Average</td>
<td>Father - ft; at times mother</td>
<td>Accepted - Non-mainstream</td>
</tr>
<tr>
<td>Kate</td>
<td>Above average</td>
<td>Father - ft; mother small p/t supplement</td>
<td>Accepted - middle</td>
</tr>
<tr>
<td>Lea</td>
<td>Above average</td>
<td>Shared - father ft; mother p/t</td>
<td>Accepted - middle</td>
</tr>
<tr>
<td>Margaret</td>
<td>Below average</td>
<td>Father - ft; mother helps with book keeping</td>
<td>Accepted - middle</td>
</tr>
<tr>
<td>Joanna</td>
<td>Average</td>
<td>Mother - p/t; father supplements</td>
<td>Accepted - middle</td>
</tr>
<tr>
<td>Beth</td>
<td>Below average - average</td>
<td>Shared - father ft; mother temp p/t</td>
<td>Accepted - lower</td>
</tr>
<tr>
<td>Kylie</td>
<td>Below average - benefits</td>
<td>Benefits</td>
<td>Marginalised - lower</td>
</tr>
</tbody>
</table>
Education and intelligence promote resilience (see chapter 2) and Table 3.7 indicates the educational status of participants. Several participants had done well at school and had leadership roles. One was head girl in High school.

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Studying currently</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mother</strong></td>
<td><strong>Father</strong></td>
</tr>
<tr>
<td>Alyson University</td>
<td>University B.Ed pt external</td>
</tr>
<tr>
<td>Rebecca University</td>
<td>HSC No</td>
</tr>
<tr>
<td>Abbey Yr 10 N/A</td>
<td>TAFE - pt N/A</td>
</tr>
<tr>
<td>Rowan HSC ?</td>
<td>No No</td>
</tr>
<tr>
<td>Charly College ?</td>
<td>No No</td>
</tr>
<tr>
<td>Kate University Tertiary qual. in army</td>
<td>No Accreditation</td>
</tr>
<tr>
<td>Lea TAFE ?</td>
<td>No No</td>
</tr>
<tr>
<td>Margaret Tertiary</td>
<td>? No</td>
</tr>
<tr>
<td>Joanna College; TAFE</td>
<td>University pt external</td>
</tr>
<tr>
<td>Beth TAFE ?</td>
<td>No No</td>
</tr>
<tr>
<td>Kylie Left school early</td>
<td>N/A No</td>
</tr>
</tbody>
</table>

Table 3.8 describes each participant’s primary relationship status. All were married except two young parents. They were not in relationship with the fathers of their baby and relationships had been very unsatisfactory, including domestic violence. There were relationship stresses through the pregnancy for Joanna, Rowan and Charly. Absence of, or stress in primary relationships went with the 5 highest positions of stress (table 5.13)

<table>
<thead>
<tr>
<th>Not in relationship</th>
<th>married</th>
<th>Married - Non traditional eg kept own name</th>
<th>Re-partnered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kylie</td>
<td>Beth</td>
<td>Rebecca Joanna Charly</td>
<td>Alyson's 2nd marriage &amp; partner's 1st</td>
</tr>
<tr>
<td>Abbey</td>
<td>Lea</td>
<td>Kate Rowan</td>
<td></td>
</tr>
</tbody>
</table>

**d. DATA PROCESSING**

The lived experience descriptions are data or material on which to work (Van Manen, 1990, p.55). Phenomenology begins in silence (Spielgelberg, cited in Crotty p278, 1996).

**I listened**

I listened as the words were spun from the depths of the Beings before me.

I listened to the taped interviews while driving, doing the dishes, sitting by the fire.
I listened again as I struggled to decipher the web shadows of black, blue, red or graphite writing-tool flying across the paper - already selecting, summarizing in the effort, unsuccessfully, to capture each precious expression.

I listened again as I colour-coded, summarized and drew together selected experiences, phrases that seemed to encapsulate the themes of each person's experience of being pregnant, birthing and parenting for the first months of a new life.

And I listened again as I distilled further from the summaries and sortied back into the tape or original scribblings, to draft and rewrite the stories.

I wanted to be faithful and true like Horton the elephant hatching the cuckoo's egg, but faced a similar dilemma - sit too heavily and the meaning-egg gets squashed; sit too lightly and the warmth released from the close, intimate space, escapes; fly away prematurely so as to reflect and soar to my own meaning, and the egg gets cold and dies before it is born (Brew, 1998 speaks eloquently re truth).

I worried

The notion that it is the research question that determines the most appropriate approach, not the methodological commitment of the researcher (or funding body, University Department) makes most sense to me. Of course, who I am influences the kinds of questions I ask and thus the methods I am most comfortable with and likely to employ. Even while trying to take an holistic view, who I am influenced to which parts of the myriad bits of their world I paid attention. My being is not separate from the data.\(^{128}\) Research, like life, is embodied experience from which the myth of objectivity cannot separate or free me - how can I know or re-present another's experience?\(^{129}\)

How much a researcher has input into the interpretation and how much subjects speak in their own voice without reference to externally formulated theory is a major debate between, and within, the qualitative and quantitative poles. Poiner (cited in Chambers, 1992) discusses this in relation to feminist research. It was also an inner debate.

One client serendipitously was randomly selected to participate in another positivist research project paralleling mine. She told me how difficult and different, the experience was and how little of her could come through in response to the well-designed, structured questionnaire. It is significant that she was able to share this in this research process but not the other. Curiously, I later applied for a job in this same project and very narrowly missed out because they were concerned that I may respond too much to the subjects and not hold rigidly enough to the form of the research thus compromising its objectivity and quality. My own research design intentionally encouraged the participants to speak for themselves as freely as possible.


\(^{129}\) Lawler, 1998; Crotty, 1996; Richardson, 1997.
By engaging people more consciously in the process of making meaning of their situation, I hoped for deeper levels of understanding beyond the bones of objective analytical knowing. But was I objective, accurate, getting the 'real' picture well enough?

Albury explores in depth the values behind objective knowing in a challenging way and comments that "...we cannot assume that scientific observations of the world represent anything more than a deviant, minority viewpoint when compared to the rest of humanity" (1988, p 12). This is because knowledge is affected by personal psychology, experience, accepted community views, and thus, the assumption of objectivity ignores the effect of minority perceptions, some of which are created by the training of scientists so that they see what they have been taught to see (theory laden observation) whereas someone else would see something entirely different (Albury, 1988, p 11).

Hence phenomenologists' dedication to putting aside "prevailing assumptions and meanings and look afresh to the phenomena" (Crotty, 1996, p276).

Psychological research tends to use predominantly objective methodology and thus the knowledge generated frequently lacks full bodied understanding of complex social and human issues. While I believe the bones need to be fleshed out and given life with the addition of subjective, personal meanings of lived experience, using a relational approach that places importance on individual rather than collective experience, risks accusations of bias and particularity. It also risks facilitating change.

While people do not have a voice, it is easy for others to attribute motive, intention, feelings, thoughts, reactions, beliefs onto them. (Freud's classic notions of projection and transference.) I notice this particularly in my work with children and families - it is often amazing to hear the misunderstandings that co-exist in intimate, family relationships where it is easy to assume that the close contact would enable frequent opportunities for reality testing. How much more likely is misunderstanding between groups in society who lack contact, or between researcher and researched who live in different strata of power and privilege?

Looking at people's lives from a distant, objective position won't penetrate the surface constructions of understanding and get to the lived experience. I think of looking into a lake - I may see the reflection of myself and the world in which I stand; if I look deeply the fish and plants may be revealed; if I put my hand in I can feel my experience of the quality of water. It's not until I dive in that I can look up through the water and see my own world from the perspective of the fish. Even that does not give me an understanding of how the fish makes sense of it all.

Patterson et al (1992) describes a process of developing a model that begins with clinical and observational data - the particular - and progressively builds theory. First he formulates a tentative model which is progressively checked in different circumstances

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130 Richardson, 1997; Higgs, 1998a & b; Brew, 1998; van Manen, 1990; Oakley's work, Brown et al, 1994, discuss these issues further.
and then adjusted to fit the new data. He suggests that each context may actually need a
different model (in his case for anti-social boys) but that a broader model may develop out
of the overlaps of the sub-models. My model of prenatal relating is tentative requiring
further checking and development.

Dunphy (personal communication, 1999) differentiated between generalized and
contingent theory. Contingent theory, because it attempts to explain variance, specific
factors and conditions of applicability, can penetrate more complex situations and create a
more finely tuned theory. This is most helpful when attempting to understand personal,
organizational or social change.

Jo Milne-Home lends support for parochial theory that stays close to the grounded
experience of the subjects. She notes that what is accepted as parochial or universal is
not free of political and gender influences and quotes John Paul Sartre:

...knowledge flows between parochial realms, but when it is written by academics the parochial is paraded as the
universal (1992, p21).

As an example, the results of psychological research

..conducted by Harvard Professors among male colleagues.. friends...first year psychology students, could be
paraded as patterns of 'human' conduct or development. However, a similar sample size of in-depth interviews
conducted in East Port of Spain would be regarded as exotic, particularistic and parochial (Milne-Holm, 1992,
p21).

Generalising and personalising are both useful ways of knowing but produce different
layers of information and meaning. Jan Fook brings them together:

Postmodern critical theory is clear on process and values, but uncertain about specific expressions and
strategies - these later will be determined by place, time, players and context... the challenge of
postmodernism is not so much the uncertainty it entails, but the very radical change in forms of thinking and
expression, in accepted notions of standards of academic theorising, in accepted methods of teaching, in
accepted ways of establishing professional authority - indeed, in all the accepted ways of maintaining existing
power relations (1999, p 206).

I feel validated in valuing and gathering personal experiences.

I wrote their stories

Telling stories is an age-old way of constructing and conveying events and their
meaning. Stories give rich text-ure, (layers of meaning) and allow the shifting and shaping
of data to create thick descriptions that are 'as close as we can come to experience'
(Clandinin & Connelly, cited in Willis, 1996, p 223). Hence, the popularity of narrative in
phenomenological research.

The stories give context (background), events (foreground), feelings and attitudes (a
phenomenological or rich description). Their purpose is to give voice to the participants and
insight into the people - their lives and attitudes - in whom the significance or meaning of
this work is embedded (Willis, 1996). The stories present some data - only a selection of
that contained in observation, audio, video and written text. I wonder myself, what made
me select these few words from the myriad spoken? I can only hope I intuited well (Crotty, 1998; van Manen, 1990).

It was then that the women and some men, 'listened' to their stories. I gave them the draft of their own story and asked them to make sure I was accurate, if there was anything they wanted excluded and for any other reactions. Like Borbasi (1996), I found that the participants confirmed and were confirmed by their stories and responded with feedback that validated my selectings (see results "Research and support" page 169).

e. HEARING BEYOND

Throughout the process the positivist research voice kept asking, with some despair, so what? All this information on 11 families, so what? Like Ehrich (1996) I struggled with guilt.

Old woman is watching, watching over you
in the darkness of the night she is watching
she is watching weaving gathering the colours she is watching over you
So weave and mend weave and mend
gather the fragments close and win the sacred circle sisters,
weave and mend weave and mend old woman weave and mend.

For some reason this song comes to mind as I write. Could it be an articulation of my deeper sense and experience? I am after all a therapist wishing to heal and mend. It is the spinning of stories, weaving of interaction, gathering of meaning, that are essential practices in the process of mending - of healing. But it requires someone to hear.

f. MAKING SENSE

Is it sufficient for the subjects to speak in their own voice? What role does the researcher (listener) have in bringing context and form to the material? I would rather err on the side of the former given the power of the dominant view to overshadow or distort (Daly, 1990) but both have a place.

A similar difference in approach exists in therapy - psychoanalytic and Rogerian counselling tend to let the person speak without much interaction; in cognitive behaviour therapy, gestalt, family therapy the therapist is more active. I form an interactive relationship in which the person can speak in their own voice and create context and meaning by interacting at times with me and my knowledge and experience. The balance is determined in the moment but requires me to be able to let go and listen openly with consciousness of power.

131 Crotty, 1996; Richardson, 1997; Higgs, 1998a and b; Borbasi, 1996; Marshall, 1981; Renfrew & McCandish, 1992; Belenky et al, 1986, in Women’s Ways of Knowing, gives an interesting account of the possible process involved here and Strauss and Corbin, 1990 raise the issue in the context of methodology and grounded theory.
My voice appears as commentator and participant observer in the stories in this thesis, but on the whole my reflections appear separately. I hope this allows you to approach the women's experience more directly. It allows me to remain truer to each woman. It also reflects more accurately the actual process of the research and the processes of the women's lives. Mostly we live, experience and then reflect to make meaning. In writing the stories and presenting a tentative compilation of the experiences, I have attempted to keep the data related to context and not assume universality or proof. It was through really listening to write the stories that the themes emerged and the schema took shape. It was then that I went to the specific literature on prenatal relating to weave the bigger picture back into the stories. I think this reflects Campbell's view that

the ownership of the narrative remains with the parties, the analysis and interpretation belongs to the realm of the researcher (1996, p267).

Crotty (1998) highlights the difference between phenomenology that explores one's own subjective experience (the transcendental or 'first person' phenomenology of Husserl, 1917) and that which searches for critical, objective understanding of humanity through the subjective experience of others - through the capacity to put aside self and be with the experience of others. Both approaches attempt to get to essential experience, but one as purely subjective and the other by 'objectively' finding the truth through the subjectivity of others. Both require an effort to put aside culture, pre-conceptions and theories and to

'intuit' the phenomena or let it 'impress itself upon us ...to gather the experience of others in a way that safeguards its subjective character (Crotty 1998 p155).

I aimed to surrender to the women's experience and listen deeply. This was assisted by a sense that I didn't really know what it was all about. It was like following animal tracks through the bush. My earlier reading took me to the bush (so to speak) and then I could only follow the tracks (deeper into the women's stories) and see where they led. I had neither the time nor the inclination to read while data gathering or during the initial analysis - a blessing really, as it allowed me to be lost in the material and be true to the phenomenological approach.

9. REFINING THE FOCUS

Out of despairing overwhelm I then took what felt to be a radical refocus. Early on I realized I did not have the resources to process the video material for continuity of pre and postnatal experience or relationship. I excluded the fathers' data as limited participation weakened it's usefulness. Now, realising I could not even do justice to the complexity of what remained, I chose to go to the material again but this time paying attention only to the mothers' comments relating to the preborn. Why did I not see until now that the thesis title, The Beginnings of Love, chosen intuitively at the beginning, stated clearly that all along I was researching the growth of the prenatal relationship??
I began listing their statements and found themes emerging which I roughly grouped together. Five continua crystallized which have formed the basis of my ideas about the facets of prenatal attachment.

Once the key themes emerged from the fog of chaos and confusion I began to read specifically about prenatal bonding/attachment/relationship included in chapter 2. From the literature and my clinical experience, I began to consider the sociological background influencing the foreground performance. This approach is consistent with Ehrich’s (1996) description of Giorgi’s steps for data collection and analysis.132

As I sought literature, it was suggested that I should have others read the data to validate my themes, their definitions and meanings. Again, I meet the clash of research cultures but now with more confidence. I did not pick up this suggestion, despite its merits. Someone who was not part of the lived experience could only decide validity of meaning by drawing on their own preconceptions and interpretations of the words used - important for the iterative process (Taylor, 1994; Wadsworth, 1976, 1991) required to refine this work, replicate and enable generalization. But that is premature given the stage of knowledge in this field, the hypothesis generating nature of this work and its phenomenological method. I myself found that the notes weren’t sufficient at times to penetrate the meaning. I had to go back to the tape for tone and inflection to really understand what was being communicated. A video would have allowed access to the rich texture of body language and context. I feel validated by Marshall:

Whatever methods are used to make sense of data, in the end it turns out to be a very personal and individual process (1981, P395).

Gretchen Poiner (cited in Chambers, 1992) notes that the way of developing knowledge by referencing and placing it within an existing body is problematic if its development has not been inclusive. She quotes Pat Caplan,

...a style evolves with its own questions, evolutions and standards as the circle of those present builds on the work of the past, and women have not been present in these circles (1988, p15).

Men have studied the male aspects of societies and then often, inappropriately, generalized that to the whole society. The women anthropologists, on the other hand, rightly admit that they are focusing on women only and are therefore unable to generalize to the whole. Poiner sets out themes that have emerged persistently in the feminist methodological critiques (and attributable to Eichler cited in Stanley and Wise 1990).

1. All knowledge is socially constructed
2. the dominant ideology is that of the ruling group
3. there is no such thing as value-free science and the social sciences have so far reflected and served men’s interests
4. because people’s perspective varies systematically with their position in society, the perspectives of women and men differ.

132 See also Moustakas, 1981; Marshall, 1981; Richardson, 1997; Fook, 1999.
It is also true that there is nothing new in the general orientation of these propositions. The sociology of knowledge has been hammering them home for decades (cited in Chambers, 1992, p11).

This analysis applies also to the silencing of voices not acceptable to a variety of mainstream views. Post modernism and critical theory challenge the grand narratives used as the measures of what is 'normal' and attempt to include or tell the stories of those on the margins by shifting the location, point and process of observation (Bainbridge, 1999).

I have attempted to take this critique into account by following the format outlined so that the participants' voices are heard directly. I am, like Brown et al (1994) keen to be a conduit for women's experience, rather than seek what professionals think about women's experience. However, I do attempt to articulate general themes that present a bigger picture that may assist the development of understanding of the importance and process of prenatal relating.

Sadly, the voice that is persistently unheard, except in some of the work reported in chapter 2, is that of children and especially the foetus.

Recall that chapters 1 and 2 have established the sources and role of stress in the aetiology of childhood problems and in the capacity of parents to parent effectively. Support and loving relationships help ameliorate the consequences of stress and dysfunction and promote resilience. These same processes operate prenatally and the capacities of the foetus indicate a potential for relationship. This research is attempting to understand prenatal relating, what is stressful and supportive for mothers.

So, let me introduce the participants through their own stories and invite you to join the research process by reading the stories with the following questions in mind.

Do you get an impression of the preborn? What and how?

Do you sense a relationship developing? How? What indicates that?

What, from the past or present, influences the mother's capacity to relate to the preborn?

How stressed and how supported does this mother feel?
Chapter 4

THE STORIES

REBECCA AND CHRIS

Her immense beauty of both form and spirit has always struck me. Telling her about my thesis, she said, blushing,

I would love to be part of it - I'm 12 weeks pregnant - I think!

My gut tightens with excitement and anxiety. It is Rebecca's first pregnancy and she is my first volunteer. There's no turning back for either of us. I feel as unready, and excited, to embark on the research process, as she feels for the journey into pregnancy.

Rebecca and Chris entertained the possibility of children but

he felt we had to be settled with the house done etcetera. I had a goal - either have a child or go overseas. We stopped precautions ... and let it happen. ... I should find out about conception and discovered that one of those risky times had already passed.

A pregnancy test 4 weeks later confirms she is pregnant and raises a key issue.

I've never had a consistent doctor - I find doctors quite invasive actually ... I phoned a birth centre and found I didn't need a referral. I felt relieved - perhaps I can get through without having a doctor involved. It's really hard to tell I'm pregnant - I feel non-emotional about it ... I wonder if I'm responsible enough. It was the same as when I got married - there was a lot I had to deal with in myself driven by the fact that I was saying I'm not part of you - I'm me and I make the choices in my life ... I get doubts about myself at work too - I didn't feel right to go into a position that gave me a lot of power and responsibility - I had to feel ready.

She moves with grace in a large body protecting her, I suspect, since two traumatic, but hardly stated, abusive experiences at 13 and 17 years. She speaks hesitantly, as if searching for understanding and deeper meaning. Weaving ideas and experiences together as a newly pregnant ardent feminist is a critical part of her journey to parenthood.

She comes to the first interview late from a demanding job that requires a capacity to listen deeply to the pain and trauma of others. I wonder how being pregnant changes her relationship to her clients and their pain. Initially she is "somewhat detached from it" but later, when the pregnancy is obvious and she is in the very emotional process of finishing with clients, she has mixed feelings.

one client did all this incredible work when she realised I was going on maternity leave. Another was worried about the effect on the baby of the distressing stuff she was telling me.

Work pressures were stressful throughout.

Mum is very supportive - she had me accidentally in England and continued to travel. She said if you don't have it now I'll be too old to be a grandmother .... I'm thinking about my mother a lot since being pregnant. I really need her. I wish she lived closer - though if she did she'd drive me crazy. She's always been, and still is, very important to me. My mother's a hard character that people can't imagine being soft but I receive the softness and

133 I have included only partners that were interviewed and all names are pseudonyms.
encouragement ... She’s a rebellious stirrer, strong feminist, very intelligent woman. I got my views from her. She pushed me to the maximum - ‘No daughter of mine is dropping out of school at year 10!! No girl gets anywhere without going to school!’

Rebecca said provocatively with a touch of defiance “I could have got a trade!!” as if catching her mother out in an intellectual inconsistency. The relationship between mother and daughter is very close but has its difficulties. Rebecca feels she has come to terms with her Mother's difficult sides.

She has a poor memory of childhood and thinks she remembers what she’s been told. My mother was travelling. She thought she had an ovarian cyst and wouldn’t believe the doctor that she was pregnant so ignored it for months. She felt neglected in her pregnancy - ‘when I was pregnant your father had me pushing a car out of the bog.’ Her waters broke at the ballet in England and after it was over, she went to hospital.

Rebecca was blue and taken away. They resumed their travels quickly.

There's a mystery round Dad – he was never a big part of our lives. He left when I was about 6 or 7... ...He's different to Mum who communicates every thought. He's older (67yrs) and distant from people.

When he finds out she is pregnant he is thrilled but low key.

He’s so calm and lovely on the phone but my sister says he’s so excited about my pregnancy. It’s cute to see that side of Dad. I had a very wonderful relationship with Mum’s mother (Nana) – a very soft gentle person – very different to Mum – more the traditional wife thing. I lived with her for a year. When Mum entered a lesbian relationship, women took on the nurturing caring roles. I’ve had a lot of love in my life - very lucky

The pregnancy seems unreal initially.

Other people’s reactions and comments reinforce that I’m pregnant and help me connect with it.

By 18 weeks so many critical decisions clamouring as, with the exuberant support of family and friends Rebecca is freed to be vocal about her own excitement. The birth becomes more prominent in her conversation. The implications of pregnancy emerge from the mists of the future.

Major, major stress has been deciding where to give birth and who to have there. I don’t want my mother but how to tell her? I need to be gentle and not rejecting. I want Chris there - not on his own ‘cos I’m afraid he won’t cope. I need someone who can step back and support. My sister, one of my best friends, has asked to be there - she wants to take pictures - she’s never been to a birth before

A tangle of feelings about her mother, feminism, images of women in pregnancy, birth and mothering roles, Childbirth and the medical connection, confront her.

I've been really surprised at Mum's care ...it's a new side to Mum. She sees this pregnancy as being women's business – it's nice but not relevant to me. I think Chris & I are the most important people.

He is a gentle force and I want to share it all with him. The whole thing of feminism and pregnancy, I feel, is twisted. I’ve been let down by the notions. Mum preaches more than she practices – she’s there for herself not me – my sister is starting to realize what I realized some time ago about the emotional abuse. Mum confuses and hurts the people she loves. For me getting married was an escape to independence.
She reflects on Feminism and Motherhood - one part is sterner, the rough tough character of her mother. The other embraces maternal instincts, the gentle side. There is a dialogue between the two and she is caught between.

In motherhood, I'm looking forward to letting go of toughness and getting in touch with the gentle side — the feminine side of me. It's good to be a bit distant from Mum for this. Mum's lesbian friends have been really reassuring which has freed me up to enjoy pregnancy and family life.

They choose a birth centre wanting midwifery care.
I don't like doctors and the medical side. I considered a home birth but have picked up the fears of society and don't want to risk too much. Minimal medical contact is OK. At the birth centre, the midwife does the basic check but I do my own urine sample and records — I like it — its less medical. They're good and explain everything — there's good communication with the midwife. In the medical model of antenatal care they're keeping an eye on you — you're not keeping an eye in yourself.

Rebecca is disappointed at one appointment where the midwife is exhausted, seems to want to go home, and is uncommunicative. It turns out that this midwife came from the labour ward not the birth centre. Rebecca is disappointed when they don't manage, as planned, to meet all the midwives before the birth. She's more excited at hearing the heart beat then the ultrasound.

I've seen the room in the birth centre — I intend to use the bath. We booked into classes, saw a TV programme about birth - the unknown is becoming known. I'm starting to feel more like what women talk about being pregnant. I'm amazed at the whole thought of something being in there.

She struggles with physical discomfort and awe about pregnancy.
At about 9 weeks, I felt movement — amazing — But I can't share it with Chris because he can't feel it yet from the outside. I hope I'm not stressing out ... at least I have big hips (anxious laugh)

Bad back pain is exhausting and makes moving difficult. Though it never goes away entirely, yoga, walking and baths help.
I have a high pain threshold but wonder - the bigger it gets - it has to come out one day!!

Pregnancy changes relationships.
We're first in our circle to be pregnant. They don't realise my lifestyle has changed by moving to the country where it's a simple pace .. pregnancy amplifies that. Some friends ... forget and treat me as a young energetic person with time and freedom to give them. I tend to relate by meeting other people's needs but they've not noticed me changing. I find myself focussing inward. I feel my partner is not realizing just how exhausted I am. I feel a distance growing and he doesn't understand — he's trying but caught. This second trimester he's been more conscious and speaks more.

I meet Chris at 7 months. They take the process very seriously and we talk for hours.
Rebecca is showing more — Oh my God you are pregnant - it crystallises that the child is coming — it's real. It's not a problem — I notice her breast development and find I'm fascinated with the pregnant woman's body — so attractive - curves accentuated.

He talks about the process of sculpting 'bulging feminine bodies' as a personal response to Rebecca's pregnancy but fears feminists' reaction.
Prenatal classes reinforce the reality of pregnancy but raise an unexpected issue for Rebecca - who has primacy in this process?

In the class, I experienced him (Chris) as attention seeking. It's a time to focus on the mother and baby and he took the attention away from me. We talked about it and next class he made me feel special though still clowning around. He spoke about 'us' instead of himself. I relaxed more too. He's excited - I'm more low key on the outside but excited on the inside.

The small, active birth classes are “brilliant” teaching that “the goal is to have a child not a birth experience” and not to be missed despite an hours drive after work. Rebecca doesn't want Chris to cut the cord but doesn't want to hurt his feelings.

It is the symbolism of it ... it's like cutting across the Mother-Infant relationship and just doesn't feel right.

He is upset at the thought of cutting the cord but wants to do the 'right' thing. Rebecca's sister, Freda, will be the support person. Seeing a birth video is powerful.

Reality hit me in the face and made me speechless and distant. It was a miracle and yet I'm a practical person and miracle sounds too mystifying and less practical. It was also distressing - I'm fearful about an episiotomy - I tell myself to snap out of it - people survive. I feel awe - the body is amazing - the whole process blows me away. How can it be so intelligent - then it hits this atmosphere and hits dumb mode and we have to train it for 20 years!

Family roles, responsibilities and relationships are the focus of the interview. Rebecca is excited about giving herself a break from work. Career has lost some importance. She adjusts maternity leave to 6 months so that she can go back and work part time.

I've worked since I was 16 years old. ... I'm nervous about juggling two roles and the impact of loss of sleep and a baby on my goals and practice.

Chris is accepting he needs to work and provide financial security during her leave.

I've not worked for awhile. I hate the pressure from a boss but I've come to terms with it now.

Parenting is an increasing pre-occupation. The baby's needs are the priority. They seek and discuss ideas. They want parenting classes. Chris reflects.

I have the concept of being pregnant ... thinking about the varnish I'm using and making blocks for the child. (It) seems trivial but I feel a mission to make the world aware of child safe varnish.

He thinks of a 3-year-old 'child' and never uses the word 'baby'. Both are increasingly excited and anxious. Rebecca giggles, embarrassed saying she is clumsy, nervous and not as conscious as usual. Information about endorphin and hormones reassures her.

Thirty-four weeks pregnant and they move from her in-laws home into their almost finished cottage on the same property - a huge relief, especially for Rebecca. The pregnancy is real and Rebecca has embodied it. She is radiantlty beautiful.

I feel pride about showing. I'm told I'm waddling.

More people touch her stomach (including someone she hardly knew),
yet it felt right to touch and I was strangely not offended. Work is coming to an end. I’m really looking forward to reducing those demands.

Her sister’s presence and sharing are important.

I feel the relationship strengthening – we’re more faithful to each other as friends not just sisters. I’m having trouble with the notion of a birth plan ‘cos I don’t know what will happen.

Birth is like a door blocking the future and it feels inappropriate to try to open it. They talk of soft lighting, access to shower, importance of being consulted, concern that midwives not pressure Chris to cut the cord. She fears feeling exposed.

You’ll be kicked out if you laugh– I know I won’t be able to be private but I don’t want to feel uncomfortable - I want to enjoy it.

The pregnancy was real for Chris too.

the 9-month buffer zone is almost gone – I’ve used up all the credits. Are we ready? Can I hold up my responsibility and provide an income? Have I enough energy to hold her

Rebecca speaks about loss of lifestyle, the infant’s intrusion into the sacred preserving realm of adult sleep patterns and parenting issues. Both are very tired.

I’m getting bigger and bigger, my back is easier thanks to yoga and I’m incredibly tired... The baby rests a lot when I’m resting – it seems to understand I need a rest. I worry because ...if I don’t accomplish what I set out to and then get in a bad mood... I don’t know I’ll cope with lack of sleep and constant interruption... I want to motivate and nurture this child – I’m looking forward to re-learning things with this child that I ignored when I was young.

I am very moved listening to them talk, half to me, and half to each other, about their relationship – its strength, their hope and faith in the future together. The pregnancy is confirming them and bringing the relationship into focus, reaffirming their rightness for each other. The pregnancy and birth have increased optimism, faith and hope in the future together.

Chris wants a baby shower but Rebecca doesn’t. Negotiations were intense. How to include men, lesbians, the many cultures in the families.

It turned out to be small, lively really simple but lovely. There were jokes, good food, mothers telling stories, including my mother, purple and green colours.

Rebecca finds herself occasionally stroking her belly in peaceful moments

I imagine it can hear noises and pick up on my emotion. Today a client wondered how much is transferred to the baby. One client said she felt uncomfortable about the baby hearing the gory distressing detail of her abuse.

There is 1 week and 5 days to go. Both are dealing with grief and shock. A friend (always a daredevil) overdosed on nitric oxide. Rebecca observes how many people at the funeral wanted to focus on the birth and the baby - that coping with the emotions of death and birth are related. She fears his spirit “somehow coming through the baby and the baby ending up like him.”
Rebecca’s focus is now on birth. She is uncomfortable and extremely frustrated - everything takes twice as long. The reassurance is paper-thin. Her fears and anxieties about the birth are high (nitrous oxide is given in childbirth). She is expecting a long labour and is working to get it to turn while reminding herself not to stress out.

I’m really nervous now about the birth. I had had an intense fear of it being posteria and it is. Fear can bring about what you fear. I’ve spoken to a nurse who had a posteria birth and she managed OK. Things have ways of falling into place and I am of the opinion that if I’m active and follow the principles all will be well.

The pregnancy has “thrown a wet towel on” sex says Chris. He feels uncomfortable intruding on the baby’s space so they find other than standard sexual practices and affection for each other is growing.

The birth is induced (Rebecca has had strep B, which puts the baby at risk). Maternity midwives were disappointingly different to those in the birth center. Intense labour brought out the animal in her (unexpected) and with Chris and Freda’s encouragement, she delivered Garnett without the interventions offered. She speaks with real strength in her voice but she is unhappy about aspects of the birth and is considering writing a complaint. She is really in love with Garnett and struggles to feel confident.

I’ve been in tears like the first night... I spent all night up and down because she wouldn’t settle. So Mum took over for awhile and I got up again at about one when she started crying again; then she slept through until about five which really surprised me.

Breast-feeding is not easy and she books herself into a mother-infant facility fearing loss of breastfeeding on top of the losses around the birth. However, the video shows an attentive, though tentative mother and a quiet content infant interacting with warm sensitivity.

I’m very excited and very happy. Already I’m thinking will I go back to work in 6 months or will I sit here and ..? (laughter) The time that they are in that stage of being very much dependent on you is so small....

POST-SCRIPT: Rebecca returned to work with mixed feelings. It was hard to leave her daughter with whom she has a strong bond. Her partner settled into work and parenting. The enormity of her job, the cold rationalization of services and lack of support were very stressful. Her mother was diagnosed with a life threatening illness. Just after Garnett’s first birthday, Freda died tragically overseas. Rebecca’s world temporarily fell into deep, consuming grief. She resigned, lived partly with her mother in the city and partly with her partner in the country. The strong support network, quality of the relationship and resilience of this couple got them and their baby through a tough time.

BETWEEN THE LINES: Rebecca, within a supportive network, reflects and engages with the struggles about motherhood, work, her past, the physical effects of the pregnancy. The baby inside slowly and tentatively comes to warm, but uncertain, consciousness.
ALYSON

Out of the blue, a stranger’s voice says she wants to share her pregnancy with me. The first to respond to my posters – I feel incredibly excited.

Adopted at 10 days - much wanted, only child to older parents.

I have met my biological mother and father and some siblings. I was always told I was adopted - from about 6 years old, I knew but I was lied to for many years. She said my father was in gaol and my mother had died....I considered myself very lucky ... a very special child until I reached teens when Mum and I were having great problems - then I got the urge to go and look for my biological parents.

She grew up possessively loved with protection that tightened into frightening, critical, maternal control against which she ultimately rebelled.

She never approved of anything I did or my friends ... The only thing I did right was to head off to teacher’s college and get a certificate ... I was still at home... they didn't want me to work ... they knew I didn’t have enough money to buy a car or anything substantial enough to move out.

She speaks in a calm, even voice about an accident at 12 years old after which there were operations and long hospitalization.

I was in the back seat of our car. I still remember the look on the boy’s face as he saw what was happening. The boy was a passenger in his father’s semi - the truck virtually ran over the car.

I was deeply moved, as I listened to her talk about her near-death experience and the peace and understanding it brought her. Her life line records in brief the journey of a capable, achieving person who travelled overseas regularly with her mother (only once with her Dad), finished school at 19 years - the year she was allowed to go out on her first date. She sold her car for the deposit on a house and for her wedding. Conflict saw her married, but hurt by her parents’ absence. It was a volatile time.

You couldn’t pick him (partner) from one minute to the other - he’d suddenly explode ... at first I would scream back but (then) I just kept quietly out of the way - grabbed the children, left the house and went to my Mother’s until he calmed down. ... It was pretty stressful.

Four to five years later her husband left her with a 2½-year-old and a 10-month-old baby, for another woman.

My world fell apart – we were seen as the perfect couple. I suspected it but feared the truth.

She worked: Lachlan, the baby, was diagnosed with febrile fitting; an apprehended violence order was issued for her ex-partner and she feared for the children with him. Finally, over a 9-month period she was divorced, remarried and pregnant for the third time. The past rarely comes up beyond the first interview. She is very busy studying for an upgrading of her teaching qualification.

Assignments are a pressure but its challenging mentally – you can only go so far watching Playschool. Passing is all I ask and to finish the semester. ... It’s something about proving myself – building my confidence
Building extensions are smoothly completed in time for the birth. Her amazing organization, immaculate house and discipline to study confront me strongly with my own chaos as I struggle to work, manage as a single parent and do my research.

Her husband’s work is out of area and stressful but she feels spoilt.

He is interested and supportive. He does the weekly shopping, cooks, washes et cetera. He doesn’t expect me to take out the garbage. His bachelor days were good training and his mother raised him to be self-sufficient. It’s not done to my liking I try to turn a blind eye - I appreciate the help but I am a perfectionist.

Access visits fortnightly to the children’s father give them time together but it also highlights that they are not Matthew’s children. She says her prime responsibility is the care and development of Nicola 5 and Lachlan 3.

They’re not demanding children but (I’m) on call 24 hours. There are trying moments when Lachlan is wanting 100% attention - everyone is busy and he’s bored. How am I going to cope with three??

Despite his busyness they go to classes together.

Matthew had tears in his eyes when a newborn was bathed (on a TV) ... Through the pregnancy I’m realizing I have a baby and am responsible and how life will change. The movement brings this. I always wanted children - I have a great love for children and a strong sense of responsibility as a teacher.

As the pregnancy progresses and her back gets worse it’s hard to drive. Oh for a cheap taxi service!! Alyson fears losing independence and becoming a burden.

Things just keep piling up. I get frustrated, stubborn, and just keep going and then pay the price. It took 1 hour to vacuum - felt satisfied but ached all night. I feel guilty to ask for help. I need to sleep for sanity - otherwise I yell at the kids and then feel guilty. I need time to myself - gone are the days when I can have a bath alone. You become egocentric when you’re pregnant. The pregnancies have got harder and the births easier. I feel I couldn’t do it again physically - also financially. We want to be able to have holidays.

The children are fully included in the pregnancy. At 36 weeks their excitement and interest is growing. Conversation overheard:

3 year old: Daddy will have a baby.
5 year old: He can’t he can only make one.
3 year old: Does he have the ingredients and instructions?

The children are excited - Lachlan often puts his hand on my tummy and feels it kick. Nicola has discovered the hard and soft parts of the baby and that if she presses it kicks back. She talks to my tummy - I don’t hide anything though they’re not up to the act of conception. Lachlan asked: ‘when the baby comes out your vagina will it hurt? Will you scream?’

Lachlan is more demanding as time goes by while Nicola becomes more affectionate, especially in the last few weeks. They have mother-daughter talks in the bath and talk in detail about the birth over breakfast.

I’m worried about her telling news at school!! We’re very open and it’s information she needs to know – some mothers disapprove. Lachlan’s only concern is can I lift, carry and nurse him once the baby is born. All want a bit of me. I find myself short tempered, less patient – harsher than normal. I tell myself to sit down and smile more.
Her mother’s knee operation late in pregnancy and her aunt’s hospitalization the week before the birth demands Alyson’s energy and reduces the support available to her from her father. The baby is present each interview. At 7 months...

I love the connection I have with the baby. I can’t explain that to anyone – a special bond and no one can take that; it kicks before meals as if saying feed me or else. I’m wondering if these will be the patterns when it’s born? If I sing a lot and loud the baby kicks – I wonder if bub can hear? We went to a large event with 300 people – it was loud and baby was going berserk. I think I’ll have a whopping nine pounder; not sure how I’ll cope with small dependent baby. I feel it’s a girl but have no preference.

Both parents hope for a girl and keep secret the names chosen.

I hope it’s healthy. I spend a lot of time thinking about the baby - how it’s developing; it’s size - if everything’s all right. It must be cramped; how it copes with my physical activity - when I’m quiet it starts; if I’m stressful, raise my voice, get cross, the baby kicks and makes me feel sick – they’re more than the normal kicks. I wonder is it fearful that it’s got this mother who rants and raves? It may get a fright. I don’t talk to it but I think of it often. If it kicks, I rub my stomach and it kicks back.

At 34 weeks, she feels more connected to the baby who is more real.

My whole stomach moves like a tidal wave – the baby must be uncomfortable. It feels more like a baby, not a foetus. I can picture this bundle inside will be a girl or a boy. Not knowing makes it real exciting. I’m so pleased that I didn’t find out but Matthew doesn’t like surprises. If it’s deformed, he wanted to know. We changed names recently. The whole thing is exciting, daunting, miraculous.

By 38 weeks, she is keen to have it out.

You’re big enough to push yourself out - get cracking - it’s not that hard. I know life will be busier and I’ll be housebound for awhile, but I’ll feel better, lighter. I’m thinking about this baby and its future - will it take after Matthew? Me? The other children? I’m tuning in and reflect that this is what being a mother is about. I’m excited that the birth is coming. May be it’s too big to get out – the obstetrician said I have a roomy pelvis. The baby has an attitude. It kicks like it’s having a tantrum then goes quiet. It’s active and on the go.

Physical problems become stronger and more debilitating each month. The pain in her hip is constant and requires her to wear a brace for the last few months - very uncomfortable - not designed for a pregnant body.

I should do aqua aerobics but 5.30pm is a bad time, so I just put up with the pain. I’ve got a high pain tolerance. I just hope my hip will cope with engagement. There’s pressure on everything everywhere – back ache, varicose veins in legs and vulva - very painful – I feel bruised. Going to the toilet is painful. Sitting’s a problem. I’ve got carpal tunnels disease – it’s really annoying and due to fluid retention – quite painful. I had it before – it will go after the birth but I can’t use my right hand sometimes. Before the other children I had to have someone cut my food. I know I should walk properly but it’s easier to waddle. It’s hard to get around up stairs. Normal things take twice as long – I get tired easily. I’m often at the end of my tether – how am I going to cope??

Gradually the deeper currents of anxiety break through the order and organization. Stress, though managed, mounted - ‘little’ things are major.

I feel cheated because we’re all on a low fat diet so I can’t have the full cream things I enjoy during pregnancy. I’d forgotten what it’s like to be pregnant – a bigger baby means increased weight; two kids
to run after. I'm frustrated with myself and looking forward to the end. It's so painful I'll be glad when its out ... but then I will lose that connection. I packed stuff away with Lachlan - this time I want to toss them and get on with life. But I enjoy pregnancy - but it's stressful and difficult.

Alyson cancels our last interview 2 weeks before the due date. Matthew is in hospital after a routine blood test detected unknown blood and liver problems.

I was picturing funeral arrangements. Matthew was adopted so his history isn't known. ... It's very stressful – I didn't need this on top of everything. I've got an assignment due Monday - it won't be done. I'm very tired ... hoping that (the birth) will be soon.

It appears externally that she is well supported, but somehow as I listen I don't feel she's supported. Alyson admits that it's hard to ask for and receive help and that deep down she links support with loss of independence. One comment stands out and encapsulates both the personal and the political. She is talking about asking her parents for help with Lachlan.

I have to fib – it's not enough for me just to need a rest. They (meaning society generally not her parents) insist on a stress free pregnancy, but I feel that they imply he's my responsibility.

She wants another day to be available at preschool so she could rest: a taxi service, peace, a long shower without the children there; more time to talk with other pregnant mothers; housekeeping done. But there is ambivalence – she should cope alone.

Contractions beginiggling irregularly and continue for several days and after an intense labour, Kate is born.

My body was still pushing but I didn't realize it was blood. My first impression was 'don't tell me there's another baby!' ... Matthew went out and found a Doctor. It was nasty - one hand was internal and one on my tummy and he pumped (3 litres of) blood out. Matthew was horrified. Shocked to see me in agony. It was severe pain - blood was filling the cavity ... I was thinking 'if I'm going to die let me die now.' Once the pain went that feeling went. ... It was very unexpected and traumatic - I expected problems before not after.

She had birth photos taken for the children, which horrified some people.

I have a distinct memory of the smell of her - warm comforting not offensive or unpleasant. It's remarkable - that life came from me. Matthew is in awe. She's an angel from above - can't believe two people can create life like this. She's my last - she took a toll.

Kate is 4 weeks old and the family is adjusting with tension.

He's been very snappy and tense... it's more intense now than before. I can't dish out attention and be on call as before. I hate to feel resentment setting in. I've heard of it happening but if anyone misses out its me. I do take time every day - 5 minutes to bath or shower alone. I lock the door with a cup of tea. I start at 5am. Nothing's changed but we've got this little person & everything falls out of place - but I can get around faster because I'm not pregnant. ... Nicola holds Kate on the sofa and puts her to sleep while I do things. I said "do you have to go to school because I need you?"

Kate was very unsettled, screamed and could not be put down but chiropractic treatment has helped. Kate was loosing weight and so is bottle-fed. Alyson was admitted to hospital at 4 months. Abdominal pain and bleeding heralded a retained placenta.
Alyson hopes not to work until the baby is 3 or 4 years old and then only part time. Except for a tight budget, she prefers being at home with the kids. Lachlan is defiant, demanding “give me... I want...” and it is hard to manage him.

I enjoy being home... I've never been so busy in all my life - study is impossible. I find it hard when people say, "I don't know how you do it". I don’t - the strings just snap.

Alyson fails her last assignment - a disappointing surprise that shakes her confidence.

At 5 months, Kate is happy, learning to roll rapidly and the family is forming, helped by a family holiday. Sleep and routine make Alyson "more human." Parenting is a steep learning curve. What worked for the boys doesn’t work for Kate. Alyson has resumed studying and still feels 'up and down.' It fascinates me how parents are able to be simultaneously content and down: exhausted and happy.

Now I feel that there's nothing I've not achieved. My career is on hold but that's OK. I feel very fulfilled as a person and mother... feel very happy and content in myself. I have no longing to get out and prove myself. If I died, I have achieved what I want to have achieved.

**BETWEEN THE LINES:** There are difficulties but her clear desire for the baby, love of children and motherhood support a strong prenatal bond. This prenatal is quickly part of the family.
MARGARET AND TOM

Angus is fascinated with the budgie and wants to play with it each time he comes to town to visit. He is two and lives with his Mum and Dad quite a distance away in a small cottage on his paternal grandparent’s farm.

Tom works extremely hard with very little actual pay - the farm is going through hard times which, throughout the pregnancy, gives an enormous amount of worry to Margaret who does the books and administration. She longs for her mother-in-law to offer to look after Angus for a few hours each week so she can concentrate on the books.

This doesn’t happen unless I ask – I find it very hard to ask.

She has known her in-laws since she was young so in some ways it’s like family. Margaret and Tom have been together 12 years but had a great deal of difficulty getting pregnant.

I turned to acupuncture after everything else failed – after 8 treatments it succeeded with the first pregnancy. This time it happened by itself. I expected it to take much longer.

It was a pleasant surprise and, at 4 months, she is happy and excited.

Margaret, bright and bubbly, grew up in several different countries and moved a lot due to her father’s position - 17 times in 25 years. On her lifeline she wrote NO MORE MOVING! EVER!! Moving was

... not so good. The longest we stayed in any house was 5 years.

They have been where they are for 5 years, but it is geographically very isolated. Despite this Margaret feels totally supported by her partner, her parents and somewhat by in-laws and friends. To gain more support

I need to start asking!

She is an active member of the Nursing Mothers Association – a source of friends and social activity.

Her first pregnancy was very strange for her, though good. She never had contact with babies so was at a total loss, and being induced, it took some time for her to feel.

I didn’t fully appreciate him ...fascinated and cared but ...he was almost like a product. He was clingy ...I carried him everywhere for 6 weeks. It was like him saying ‘look I need you’ – it forced me to focus on him, maybe because I wasn’t fully involved from the beginning.

This pregnancy is different

Everything’s getting bigger. I’m thinking more about the baby this time – before I focused on the birth. It’s easier to imagine it’s going to be a person – I’ll enjoy each stage.

Her own childhood had not been easy with a father who was extremely stressed and took it out on the family.
He created a lot of anger and unhappiness in the family due to his emotions – I didn’t want that for Angus. I made a conscious decision to break the cycle.

She is calm about the pregnancy but very upset about the farm. They are working extremely hard but well below the poverty line – a major and intense stress. She negotiated to prevent foreclosure and bankruptcy. Tom and her parents-in-law are often away and also stressed. She and Tom have a good relationship based on a long-standing connection.

She is distressed at possibly needing to access welfare and housing services. Should they cut their losses and leave the farm? The housing options available to them are depressing – rough neighbourhoods or walled in “brave new world” estates – raising issues of class, social justice, influences on children. Poverty has layers – they lack money, but have personal, social and attitudinal resources.

The doctor says the heartbeat is earlier than he’s experienced before. She hadn’t wanted an ultrasound but it, and movement, make it more real. The gender remains unknown. All the change in her life taught her to handle change with a wait-and-see attitude and be comfortable with uncertainty. Life continues relatively untouched by the pregnancy.

I’m not thinking about it much – just going along. I expect – hope – it’s healthy. With Angus I just expected it would be because I didn’t know about problems. Now I know ..., which makes me less confidant.

She’s booked into the hospital but doesn’t want a whole lot of information about problems unless something can be done about it – just increases stress levels. She thinks previous classes needed to focus more on the baby and less on the birth.

At 24 weeks it’s her birthday, the loan is approved, she takes a big step and asks her mother in law to mind Angus – optimism reigns. She decides not to feel guilty about not using all the time for the farm paperwork.

I used to think of myself as a career woman but at this point in my life I feel I had a lot of time to do what I wanted – a lot of freedom. I may eventually feel bypassed but now I don’t feel like I’m missing out. People who have reared children have more skills to bring to the workforce ... I’m definitely more tolerant.

The connection to the baby is growing – it is moving a lot and making its presence felt. It responds to sunlight, music and voices. Music is important to both parents – at a band practice Angus turned right over. She’s thinking about the gender and the differences between boys and girls. Tom would prefer a boy but both are open to whatever.

I talk to it more for Angus’s benefit and I’m thinking about how it will fit in our life. It’s already part of the family. Tom talks to it too – he’s not as fascinated as last time.

She is very child focussed – the baby’s needs will determine what happens. Preparing Angus is a key issue but other than no alcohol or hot baths (not good for the baby) life hasn’t changed. She thinks deeply about many issues, such as the degree to which genetics or environment influence a child’s development; how to give him the best foundation to his
future. She accepts information from people she trusts but, from experience with the first child, won’t go along out of a lack of confidence.

Food poisoning gave her strong cramps and then contractions just before 30 weeks and she went to hospital afraid of an early delivery.

It was pretty stressful – the baby might be born. Would it survive? It was a terrible thought.

Preparations are beginning - baby clothes being sorted - is it a boy or girl? On top of this, there are major financial problems again which have implications for other people’s pay and livelihood. It is straining the relationship with the in-laws and she feels angry all the time. A long trip on the train to her parents was encouraging. She feels strongly supported by her parents and wishes they lived closer.

A week to go. Tom made a point of being home next interview and we sat on the verandah in the sunshine talking about his experience of becoming a father.

Everything is organized – I’m tired of waiting. There’s an urgency – I’m not procrastinating because I don’t know if I’ll be around in an hour to do it. Hanging around is not me. The life of pregnancy is so short. It’s more and more real the closer it gets.

She told me about a tribe in which, in order to have the baby come out, they tell stories about a long, long journey - it’s such a long tale that it has an hypnotic effect, so when the story is ended, the woman goes into labour.

Tom feels that it’s a father’s job to make the mother feel relaxed and ready to give birth. He’s not apprehensive about it and has been supportive and helpful. He gives massage, which really reduces the aches and pains, which she’s never had before; does the dishes because standing hurts. Angus wants to do everything with Tom, which gives her a break and is also helpful. Tom is working very hard and so she believes she should do the rest, but shopping and pushing the trolley is very hard - isolated living makes it harder.

The prenatal refresher course is good but Tom couldn’t go. She valued sharing with other parents about such things as helping toddlers adjust to a new baby. Her mother will be there for two weeks giving Angus lots of attention - helpful for his new tantrums.

(There’s) a transformation overnight into a monster. I’ll have to relax about it – it’s not his fault. I’ve never hit him but I got close (one) time.

Sophie came with the cord around her neck, little black curls and an APGAR of 9. Unfortunately Tom missed the early labour (they sent him home and she worried he’d not get back in time due to the distance). One staff member was insensitive and one just right. After Angus there was an early discharge programme but funding cuts have stopped that which is a real shame. She had to go in for tests.

They do the best they can in an institutional setting like that but at home you have control... in hospital you have absolutely no control – even the temperature and climate in the room you have no control over. To be forced to stay in hospital I’m sure I would end up with postnatal depression because it’s just really depressing. People seem less surprised by having a home birth than having a hospital birth and coming home after one day. I had
my mother to help... I'm more relaxed and so is Tom. The birth was long and difficult but I've been pretty lucky with all the support and everything. When I got home (brother-on-law) had mowed my lawns – it was incredible.

Being rested, having a supportive partner and being prepared were important.

I'm not sick of talking about it either – it's helpful to talk – you think of little things.

She did some work for the business the day she got home and then had a couple days break before picking it up again. She's not keen to go out too early for Sophie's sake.

It was a mistake to go to the supermarket when she was three days – the noise and the lights.

Sophie didn't settle as easily as hoped and at 10 weeks she is feeding all day and all night and putting on lots of weight. People have given some advice that she feels stronger now to ignore. She read about oversupply and made her own adjustments to solve the problem.

She still has trouble opening her hands... maybe she still feels vulnerable. She sleeps, much longer on her stomach – I know you're not supposed to. I've never been angry with her – sometimes with Angus but Tom took him so I had a break.

Unlike Angus, Sophie has not caused significant changes in their lifestyle.

People see you differently – one child means you're not quite serious about it... 2 children and you're clearly in a different camp of people. You're a mother who can't get out on time to anything. You look as if you're not so well kept. Now we really are a family. I've lost control of things being tidy all the time. You become more earthy about things like poo like "oh I've got poo on my shirt." Not, "OH my God!" - kinda relax about things.

Margaret worried about her irritability with Angus who copped some of her stress and frustration about leaving the farm and coping with the on-going financial strain. She worried at 4 months that the pressure was beginning to affect her relationship with Tom.

I feel something really bad is happening right now but I hope it won't destroy our relationship.

Margaret assessed the situation realistically and spoke about it very honestly. Her capacity to cope with change and bright optimism continue to shine through. I drive off the farm thinking how larger social and economic policies play into the lives of individuals, and find myself wishing them well in the transition they face as a family of four. Post script: They moved to a country town. Margaret is not so isolated and glad that Tom has weekends now like a 'normal family.' She is pregnant again.

I think my experience supports your thesis. It took Sophie over 12 months to settle because of all the stress during the pregnancy. She just wouldn't sleep in a cot and had to be in our bed. She was much more demanding than Angus and she was much harder to settle. She's OK now but a strong little personality. This pregnancy has been much better, so I'm expecting this one to be quite relaxed.

BETWEEN THE LINES: Despite intense financial trouble clouding maternal preoccupation, there is evidence of resilience and capacity to resolve issues.
KYLIE

Kylie is sixteen, five months in the refuge and thirteen weeks pregnant when Robyn, the youth counsellor, asks “Are you still looking for people for your research?”

Kylie wants her there when we meet in Robyn’s office - an ex-garage roughly transformed with air conditioner labouring to keep the intense heat at bay. I can’t help thinking that the minimalist funding of critical youth services reflects society’s disavowal of disadvantaged young people.

Talking is not easy for Kylie - she answers questions briefly - often VERY briefly. Over time, and through gentle but persistent questioning, I glimpse bare details of a very sad story. Much is never spoken, remaining a mystery to me. What did her step-dad do to her before she was two? What happened between six and ten years that was so devastating and unspeakable? Who looked after her between eleven and fourteen when her mother left? What were her dealings with welfare? What is her Aboriginal heritage?

My voice dominated the tapes as the questions and prompts broke through the silence that flowed loudly but comfortably around us. Her voice is extremely soft and reluctant, speaking as few words as possible. Trust seems elusive. She looks like a fragile child. I find it hard not to want to protect her but she is determined to cope independently and not risk vulnerability.

Kylie is the second eldest of four children aged 14, 15, 16 and 18.

I don’t have many memories. Mum said I didn’t like my step dad but I don’t remember – he left when I was about 2 – he knocked the fuck out of my Mum (said with great intensity) He came back and stalked Mum. We were all scared. He came to get my sister, which is his anyway. Mum called the police and I was lucky cos I didn’t have to go to preschool. When I was three Mum found a new boyfriend – scary – that he was going to do the same as my step dad did but Mum seemed happy. Happier at home then – new step dad was nicer. I never knew my Dad. Mum left us when I was 11, came back when I was 14 then kicked me out when I was 15, I’ve lived in the refuge, moved from house to house and place to place - you get used to it after awhile.

Kylie longed to have her own place for her baby.

I don’t know what went wrong with my family.

She looks at Robyn who suggests alcohol got in and wrecked the family.

Not so much like that – My Mum didn’t like me very much. I don’t know why, ... I was 6 weeks early because Mum smoked. She had a 14-hour labour. I was 3lb 15oz. Jaundiced. It was a dry birth. She was going to give me up for adoption – she was only 20 – my step dad convinced her to keep me.

Getting pregnant “was the last thing on my mind.” Initially Kylie is shocked

Should I die now or later! ... You gel FAT. My boobs were sore, missed period, headaches

- then becomes excited and keen to have the baby. The first ultrasound showed conception was earlier than she thought, making it a different father. (His mother was very supportive after the baby was born.)
Being pregnant is emotionally difficult throughout. Early on the 'hormones' make her yell at the boys in the refuge (makes her feel powerful, assertive perhaps?) and later very emotional and distressed (not reflected in Kylie's Edinburgh prenatal depression scores of 7 prenatally and 10 at 4 months).

Though physically her body adjusts relatively easily her shame about her changed, 'fat' body grows. Kylie understands about smoking, cuts down but feels bad that she is unable to give it up. I have to guess that she is not going breast feed because of inverted nipples. She has a female doctor but

I hate going there – checking me out all the time – it's embarrassing!

The first ultrasound reveals it is a boy, and despite clearly wanting a girl, she adjusts quickly naming him Luke immediately. Her images of the baby fill out over time but consistently she thinks he will be like her - physically dark ('dark dominates light'), and with a cheeky attitude. She doesn't want it to look like the father but says she will still love it if it is blue-eyed and blond.

Kylie, with the worker's help, moves to The House, a supported residence in the city for pregnant teenagers. It is extremely hard for her to leave the few supports she has and she's slow to adjust. The young women care for themselves and it is not always easy for the girls to deal with each other. (Difficult hormones, says Kylie). They go to weekly prenatal classes and can stay at The House for up to 6 weeks post delivery.

It is extremely painful to sit with Kylie in the second interview as she does her lifeline - short line of 16 years but all of it "difficult". She gets stuck for 10 - 15 minutes at age six and seems unable to move past this point or to say anything about it. Gently I coax her to move on. Finally, she says very softly

Six to ten were bad...but it gets worse. But it doesn't bother me!

Said firmly, defiantly. Kylie never does tell me what happened but its effect is powerful and unresolved. Her primary wish is to change the past and her family be happy together. At 26 weeks, though she still does not want to talk about it, her past involuntarily comes to consciousness. Her mother leaving had a huge impact.

I don't really care. My Mum can go to hell as far as I'm concerned,

But it is said with a hard defiance holding back the depth of pain, sorrow and longing for her mother to be present and available to her. Her intense care comes through her commitment to do better for her own child and the very strongly, frequently stated intention to really give her child the absolutely best love and care... that you didn't get? "Yes!"

The relationship with her Mother is a theme running through all Kylie's interviews. In our first meeting, it appears the pregnancy has helped the relationship to improve despite the clear message that Mum is not pleased about it. From then until the birth she
fluctuates between extreme hurt - nights of sobbing herself to sleep - and defiant, angry expressions of not caring

Mum's a bitch! Don't want to talk about the past.

Once she says sadly
If she told me just once that she loved me.

but trails off, the hope unattainable and too painful to contemplate. There are occasional contacts, which Kylie finds very stressful but, as Mum lives near The House, the lack of contact is more hurtful.

I spoke to her once – I asked her to come to the baby shower – she said she'd think very hard about it but she doesn't want to - she doesn't agree with me being pregnant. I hope she will. I said well at least come for my birthday (it's the same day) ... I cry on the phone to my Mum cos she doesn't talk. She yells at me. (You look sad) yeah I am. She helped my sister so much when she was pregnant she won't help me at all. ... she doesn't want anything to do with the baby – it's her decision but it makes me upset; it's her way of making my life hell. ... she doesn't really care (feel you've got to do it on your own?) yep. (Said quietly and sadly)

When she first goes to The House she thinks really hard about an abortion but

I couldn't do it. I'm going to try my goddam hardest. I don't think I'm going to love it what other people think – I'm just going to love it and let them change their minds when they see how much I've grown up and see that I'm a good mother – I hate to brag but I know I will be.

The birth and parenting scare her – it's a huge responsibility, she may drop the baby in the bath or not manage well. One of the girls has a very difficult labour.

She's having so much trouble – she's tired all the time and doing the washing all day and the baby’s screaming - I think it's having withdrawals because she was a drug addict.

Kylie learns a lot from being with other young women, pregnant, birthing and parenting their babies. She talks, in her brief way, about information from the weekly classes. The hands on experience of helping with the other babies, which she seemed to do very well, teaches her "heaps" and increases her confidence. The baby and parenting begin to take on more reality. The birthing video really scares her

You see everything and I thought Oh My God! I don't want to go through that - seeing made me sick. I want a caesarean.

By 21 weeks movement became characteristic of her descriptions of Luke.

And he's kicking - doesn't stop kicking (she raises her voice as if talking to Luke so he will pay attention). He goes crazy - won't stop swimming around all the time. I can actually feel it. I went out last night - real good party - said to my friend 'feel this' and she said 'it's got to be a bloody soccer player Kylie- it kicks so hard - I can really feel it.' ... It feels like an alien - no it's exciting special. It'll come out doing cartwheels.

Kylie has two explanations for the baby's movements depending on her mood.

It's trying to get comfortable; ...it's being a shi.
At about 30 weeks, I manage to catch Kylie on a visit to the local refuge. She is brighter and more positive about The House, but upset that people in the street look down on her for being so young. Kylie’s shame about her ‘fat body’ has not diminished, and does not. She is especially excited that it’s only 10 weeks to go and shares a poem.

I have a baby boy but still not born

He is still growing and forming body parts. He is due in exactly 4 months from today

Every night I pray that my baby boy is born healthy and not a single thing wrong with him

My baby’s name is Luke

I can’t wait until he is here so I can share my life with my little bundle of joy

Love always, Kylie

It’ll be great having a baby – a little bundle of joy to give to what my Mum didn’t give me. I’ll give it everything – I won’t spoil it but I’ll give it everything. I know I’m only young but still I’ll give it what it wants and needs.

Domestic violence, which she has experienced in at least one relationship, comes up in classes. She says intently

You would know if DV was likely – if there was alcohol or drugs – then I’d just get out of there.

Information is not sufficient to change past patterns or protect her or her child - after the baby is born, she lives with domestic violence.

Her mother is still not showing any interest and though she diminishes the importance of this - “I’m getting used to it” - she tells me she cries herself to sleep but can’t share it with anyone because she has no reason to cry

I’m glad having baby as part of me - I’ve got something that I can keep - something special; mine. I’ve never had anything I can hold onto - not like this - it makes me appreciate it more. When I’m down, I think of the baby and how it feels. This helps because I know if I’m upset it’s upset - it feels what I feel.

She tries not to be so upset all the time for the baby’s sake and early in the pregnancy

I do talk to him and say you’re so beautiful – I’m looking forward to his company once he’s born and everything. I talk to him – like normal conversation – I feel like an idiot but I know it has to be done – it feels lovely and Luke gets quiet.

But in the last trimester she is

Too busy to talk to it. ... I think when I feel sad he feels sad ... but I think it will be a happy baby. ... It can hear I know that much. It probably knows what’s going on outside like at night when I’m trying to get to sleep and I feel his foot kicking I say ‘shut up’. When I’m calm, he’s calm. He settles when I settle the other baby.

She dreams of crawling around on the floor playing with a baby and comments

I don’t want it to be a little shit - don’t want it to go to school with a temper or attitude - pull little girls hair or anything; if I bring it up the right way it won’t.
I sit at the edge of the pool getting wet. Luke, six weeks old, is shivering in the swimming pool with his Mum. The birth was long and difficult (induced after two full day's labour)

I had a lot of support - Mum was there and my sister – it was good having Mum there considering she wasn’t interested before…. I had my midwife in there and she was good. I went to her all the time before; she had to leave about 10 minutes before I had him and then I had another one. I felt a lot upset that she had to go. She was much more helpful than the other midwives and Doctor. She tried to calm me down - got lavender and put that on me; she was just fairly good with words. .. He came out distressed – you know – with stuff in the fluid. He had the cord round his neck. He couldn’t breathe he was in the oxygen tent. I got to hold him not even 5 minutes – for about 2 minutes - after the birth....They kept him in intensive care (6 days) but I went up twice a day to see him.

She is disappointed that she missed out on holding him. She doesn’t know about APGAR scores but tells me with extreme pride that he was 9lb3oz, 55cm long and 35cm head circumference. Knowing these statistics was like a badge of honour – perhaps affirming her status as Mother.

He’s excellent!! He’s very alert and feeds a lot. He’s more like me everyday. I imagine he’ll look like me but be tall and have broad shoulders like his Dad. He’ll have a real attitude like his Mum - cheeky. .. love him heaps most of the time – I’m excited, tired but so happy. Each day I love him heaps more than when he was born (Any doubts?) I did at first because its heaps hard – didn’t expect it to be so hard – I expected babies to sleep all day and eat but they don’t do that. I’m used to it now. I’ve become more mature – you find out what parenthood is really like when you have a baby - more responsibility. I like that

Three times Kylie has felt like throwing him when she’s tired and he’s screaming.

I leave the room and tell someone else to calm him down;

Kylie has to leave the House soon and is looking for somewhere to go.

(I’ll) be scary at first but I know I’ve got support – refuge workers, Mum, everyone here, counsellor; all my friends and family. … I always thought I wouldn’t be a good Mum but now that he’s here, I think I’ve done well. I didn’t think I could give birth to him - I was huge and knew it was all baby - not much fluid. I’m so happy that I could do it - so surprised. Just so happy, I love it - I love him dearly now - ooh (she cooed to the restless baby. How do you imagine you’ll go for 21 years?) It won’t be that long - 18 and he’s out!

She moves around for awhile then gets a flat. She tries hard but Luke ends up being cared for by his paternal Grandmother as Kylie struggles with domestic violence, drugs and her confidence about being a mother. There is a fire in the flat and I, sadly, loose contact with her.

Throughout the research Kylie forgets appointments, refuses to talk when I ring, virtually never contacts me, but always warms up once we connect. I learn much later when she comes to the service I manage, just how much she really valued our meetings. I wonder if continuing contact could have made some difference for Kylie and Luke?

BETWEEN THE LINES: So many ghosts here driving her desire to do better for her child but with few supports and great obstacles. How will this baby fare?
KATE AND JACK

They're 18 weeks - excited, curious, but not "obsessing." Both recall happy, stable childhoods with no dramas. She has a solid network of relationships with mother, sister and best friends. His mother died when he was 21 and his father when he was 28. He and his elder sister grew up in a small country town. It was a happy childhood with a father who was

of the old school - hard but fair. Approachable. He gave little lectures on life. My mother was more gentle. Both were very practical people, grew up in rural Australia in the depression. We were smacked but not after 6 or 7 years - never beaten.

He left home at 16 years to join the air force.

Became on my own - had to look after myself and have my own goals - a good thing.

Kate says her childhood was

much the same as Jack's - happy, practical people. They struggled to give us the best ... we didn't want for anything.

Kate has two older brothers. It was secure and happy, though

...a little sexist. I always hated doing the girl oriented stuff with Mum ... we're very close friends still. I was always good - they were the rats and got the beatings ... one was a monster.

Though new to the area, neither feels isolated or unsupported. They are repainting their own beautiful, old Federation house. Jack had just returned after a 10-month absence. Pregnancy was on the agenda but they were shocked when it happened immediately. Though tired, she suffers little physically and hardly notices she's pregnant.

Jack chimed in.

I definitely did - she was erratic, moody, short tempered. It's unlike her - but only for a week.

They are best friends and communicate very openly so are a little concerned that the baby may affect their relationship.

...but we feel as ready as we ever will. We're comfortable in the relationship so it's not threatening to introduce a third person.

They have chosen a calm, female GP who is less interventionist.

I'm not wanting a total home birth scenario nor a full on intervention birth, so this is between. I'm happy to go with her judgement. I'm not afraid of the medical system because I know it.

The ultrasound was fascinating and they choose not to know the child's gender.

Hearing the heartbeat was nice - reassuring and confirming ... something tangible, though I felt movement last week. My mother made a little jump suit and it was a jolt of reality - made me realize something that big is going to come from me.
They feel somewhat prepared by friends and relatives who are parents. Kate particularly is determined not to ‘obsess’ as she feels she’s been ‘through the mill’ with friends whose ‘brain turns to mush’ with nothing else in life but the baby to talk about.

(I feel) ripped off because the sharing friendship is no longer there. Everyone is excited and receptive. We’re not a couple to obsess – we’re happy to talk about it if asked.

Jack says

We’re aware of it (obsessing) so are more laid back.

Avoiding obsessing is a theme throughout. Both are clear they want life and relationships to continue as normal but recognize pregnancy realistically as a major life change.

that requires them to be realistic about their needs. He needs extra personal time; she needs support and friends.

Jack is observant of men in relation to pregnancy. Some are outstanding fathers; some very work focused, neglectful

and prioritize incorrectly. A lot of men take more time buying a car than with their wife’s pregnancy. It’s sad to see guys unaware or disinterested and women left alone with kids. Guys are more into the discipline side which is fine and dandy but they should help with chores, get up in the middle of the night, respond if the child has a need or want, help with anything that makes the other partner exhausted – give them a break.

Kate took up the theme.

Sometimes people don’t think they’re stereotypical of gender but are when a child is on the scene. The mother gets up when the baby cries and the guy stays there sipping on the beer. Often they’re away a lot and so the child goes to the mothers. So you can see why they stand back but then it becomes automatic and leads to a distant relationship.

Jack again.

Often the spouse is tired and needs a break but isn’t getting it. It’s just an observation – I’m not judging it but it must strain the relationship. Men feel the pressure of responsibility and pressure for support. Men might get the really nice house and boat but in the end, their relationship with their wife and children is non-existent – that’s a pretty lonely existence I think – pretty lonely.

They agreed that this wouldn’t happen

I would speak up and he’s also more sensitive to women’s needs.

Jack took a less secure job in order to be at home more. He seems fortunate, perhaps unusual, in his ability to share and be very open with men in his workplace about becoming a father – some of whom reciprocate. One man has given him a book and he’s interested in other material – especially about bringing up boys.
A theme of concern is how the baby's arrival will influence their friendships, especially with childless couples. They said they felt intimidated by toddlers and anticipate that women are likely to be OK but that the male partners won't want unruly toddlers around.

Ours won't be like that of course.

Said, partly with tongue in cheek and partly seriously - like most new parents.

They have quite strong, shared views about parenting and children. They see themselves as being more disciplined than many of their friends and want to help the child be respectful, not fearful, self-directed, able to work towards something good. Their role is to give guidance and discipline; to expose them to a lot of things and

Not give them your prejudices. A child is their own distinct person and you need to respect a baby as a 19-year-old or an adult. That's the game plan. (Said with lots of laughter.)

There is a wonderful communication flow between them as they listen to, and check their views out with each other. This persists throughout the research process.

By the second interview the physical changes are more pronounced - tiredness, back pain and sciatica are worrying Kate. They are both looking forward to Jack feeling it move.

Jack has been away a lot and she feels lonely and emotional at home alone. He worried about her driving to her family 2 hours away and she worried about him catching the train so early to get to work. Kate does not want to talk much to other people, not even her mother who is disappointed about that.

It's between Jack and me - I talk to him about everything. Perhaps we're trying to get used to it ourselves.

The implications are deepening.

A loss of identity is coming up. I've been career oriented ... Now I'm in a brain dead job. I value family and child but still look at what I can do after. I'm apprehensive. I used to be judgmental about a part time mother who was not totally serious and disrupted the rest of the team. Now I'll be in that position. ... I'll be just a mother. My perspective will probably change.

They've booked into prenatal classes and the private hospital. The set booking in time and aqua-aerobics clash with her work. Jack is looking forward to the classes and anticipates a very clear training programme - somewhat like he would get at work.

By 28 weeks, pregnancy is breaking through the order of their lives.

It's the first time customs have ever opened my bag and there it was - sitting right at the top - a little yellow rubber duckie! They gave me a severe look - it was a funny kinda incident.

Both notice the physical changes now.

Kate's getting bigger - it's a real deal. It's good - not a huge shock - normal. I'm pretty happy. I expected her to be more sick but it's been very trouble free. Kate is extremely mobile and active. She doesn't complain.

Kate:
I anticipated I'd have to put my feet up and rest but I'm very lucky. I feel heavy and my back's a problem – it's very tight. The physio is great. The baby's moving up and if I hunch over, I squash it.

Sleeping problems are new to Kate causing worry about sleep deprivation post birth. Her body image is changing.

I felt like a big puffer fish or a frog. I always thought I'd love being pregnant but... I'm probably over-reacting. I'm not interested in buying clothes though I don't have much. Nothing will make me feel good – I've got overalls. I can see how people who don't feel good let go of their appearance and don't bother.

Preparations begin

... It's a Cadillac of a cot! It helps make it real. I don't want second hand stuff but really nice things – probably more for us then than the baby. (Laughter)

Under the casual talk, Jack is stressed about a critical appraisal exam. Issues around the birth surface. Jack has to give 4 weeks notice for leave. What if the baby comes early or late? Should they have Kate's mother at the birth? She's a strong person and may overshadow Jack who is the most important support person.

It's a private thing between Jack and I. ... I don't want an epidural. We're not stressy people but I know too much. I don't like the idea of anybody putting anything in my spine. I bring it up every appointment. I don't like being a patient – not looking forward to that. I probably need control. I can't believe that you build rapport with the doctor and obstetrician but not the anaesthetist. I asked if I can pick an anaesthetist - I'm not happy to have one rock along when I'm contracting.

Meeting the anaesthetist is just not the way things are done and she feels blocked. She doesn't remember a lumbar puncture at 7 years, but it could account for her greater than usual anxiety about the epidural.

By 32 weeks, the exams are over and that stress is gone for Jack, but he's still away a lot. Kate is finding it harder to pack up and visit family and friends in the city. She particularly is becoming aware of how life will change.

He doesn't understand. I'm not a loner. I may be isolated because I'm a people person but can't cart the baby around like a doll. It could be an issue to be here alone with no work and no local support. The baby isn't there to fill a void left by work - though it may.

She doesn't think much about the baby, but believes she should. This changed a little after reading a story about a kidnapping. She realized being pregnant would limit her ability to jump and save herself.

I have a very protective urge towards the baby – I'm more careful.

Her nursing knowledge feeds her fears about the birth and though needing reassurance, can't ask questions in the class which is not really meeting her needs. Kate disagrees with the emphasis on demand feeding and some of the ideas discussed. She wants facts and technical detail to manage the baby properly, not opinion. The doctor and a midwife friend are helpful.
Mothers get themselves into a pickle by putting the baby on the boob all the time. If feeding more (than 3 hourly) then there’s a problem and you’ll be drained. NMAA can be a great support but also dangerous — being very earthy and having a baby hanging off the boob all the time — that’s not me.

She realizes she has quite a negative image of mothers. Loss of work and the need to make a difference in someone’s life are important.

How many times do you hear ‘just a housewife’ or ‘just a Mum’? I think other people have this image of mothers and that’s what they’ll think about me. Jack thinks it’s an important job — he’d quite happily stay at home because he sees it as more important than his job.

Jack

I sense snobbishness of women bagging mothers who stay at home — God it’s an important job. With young children, it’s me, me, me. So what’s more important to a young child than to have mother there?

At 36 weeks, Kate is hospitalised for 5 days with high blood pressure. They want to hold off induction till 38 weeks. Kate is anxious at home knowing the health risks and so is relieved when the decision is made to induce her immediately. Jack is shocked.

But I’m not ready. Can’t we wait til tomorrow?

Within a few minutes she is given an epidural to bring her blood pressure down, the cervix is ready and prostaglandin gel applied. Jack described the labour in detail noting how calm, controlled and focused Kate is — he seems very impressed and notes that it would be traumatic to see one’s partner screaming. In 10 hours Ben is born, purple, with the cord around his neck but otherwise fine. Having no birth plan or expectations they are not disappointed — in fact Kate now advocates epiduals.

Ben is 13 days old. I feel privileged to be there as they are avoiding visitors.

It’s good to have someone to talk to about it all — to say things and get it off my chest.

Her emotions have been very up and down — worrying about not feeling maternal.

I thought what do I do with it?... Is he OK? What will I do with him? How am I meant to feel? I didn’t feel anything — no instant love, mothering, nurturing feeling. I suppose you think you’re going to have that... I don’t want him to think he wasn’t wanted. I would have preferred a girl when I was pregnant but once he’s born it’s not a problem. I can’t imagine anything else now. ... The first day I didn’t spend much time with him. Then I spent time with him and had a little cry. Jack felt it all along I think — he would get teary whenever he spoke about Ben. ... Later on down the track, I realized how beautiful and wanted he was — I’m looking forward to him being part of our life.

On day 3 Jack’s uncle (sister is only remaining relative) died ushering in a very stressful time for both Jack and Kate. Ben is significant — to continue the line. Jack was torn between managing the death three hours away AND trying to be with Kate and Ben. Kate struggled with high blood pressure and strong emotions — worry about Jack’s exhaustion and stress; hurt and anger at him not being there. Jack, in characteristic understatement says, the last 10 days were “a bit of a headspin.” Hence the wish to just be together “caveman like,” settle into routines, which Kate feels is unlike her.
We didn’t know the sex of the baby and so didn’t have formed opinions. We’re beginning to form those ideas now. It’s better to let the baby make an impression on you rather than judge it before it’s born – it’s a nice way to be. Perhaps that’s why it takes a bit longer to bond with it.

They hear about the difficulties (including infant death) of several of their prenatal classmates, so feel grateful despite their problems. Things have changed less than anticipated. The difficulties of accessing public transport and shops with a pram have made them very aware of the needs of disabled people. Kate noticed mums struggling with prams before but is now passionate about access issues.

Despite some sleep and feeding adjustments, Ben settles reasonably well and becomes a strong little personality, placid but knowing what he wants.

He’s not serious or super happy – he’s his own man – focused on eating and sleeping – I understand that he’s got to look after himself. ... He’s not a display item – we need to protect him and let him develop (Jack)

Post script. Kate starts social work training. The family is going well and they plan to adopt - there are so many children in the world suffering without parents, we don’t need to bring another child into the world.

**BETWEEN THE LINES:** Potential privilege and perfection, few stresses and a lot of thought but an air of detachment.
CHARLY AND PHILIP

I have a friend who is pregnant. Does it matter that she is going overseas for several months soon?

Umm. Life challenges methodological purity. Charly rings. A broad German accent gives me directions. The drive through open paddocks, a tiny village and tree lined country roads ends at a small, very small - 2-roomed shed. But it is a shed with a difference - art, photos of sculptures line the wall; flowers bloom in the garden and the simple setting has a creative, rustic flair. The cottage is on the property of her in-laws - very nice and supportive 'but not the same as family.' A very independent self-reliant child, whose pregnancy had been perfect, played around us, speaking to her mother in German.

I thought I might have children if work didn’t go well. I was working well and didn’t want to leave to come here but he is Australian and wanted to. ... I hardly knew her in the first few months till she could look - eye contact - then it was fine.

Charly’s partner, Phillip, expected postnatal depression after the first birth, but the arrival of family created lots of distractions. It dawned on Charly suddenly that she was a mother and the baby was hers. Bonding developed rapidly once the baby was more interactive and responsive.

This one wasn’t planned either – funny really; a friend was visiting both times. I drank and smoked a lot and then noticed my body was pregnant.

Charly is sick, lying around, no motivation, unable to work for three months but feels movement earlier.

Not in a good mood. I was feeling a stranger here, I’m not making much money so I’m very dependent on Phillip– like a little dog following behind someone else – I couldn’t paint or sculpt.

Painting allows no distraction.

I am doing some craft but that’s not my real work. ... It’s a stupid idea maybe - birth is the biggest creation but paintings have always been my babies - I’m very attached to them. Maybe the strength of attachment has been broken ... but it would be like losing my eyesight - it’s part of my life - very sad.

She is happiest when working without distraction. The essential nature of creative work is a strong theme. She showed me some of her work: paintings: stunningly beautiful carvings completed when Phillip couldn’t work for a few months due to a melanoma: the free-standing bathroom she built - looking like Mexican mud brick. In the past Charly travels alone, courageous, curious, capable, working quickly and well in all countries - except Australia.

I’ve never had that here. Phillip is upset – he thinks I’m not open to Australia... I feel a stranger here. Here I’m lost – I’ve travelled all over the world painting every day for 17 years. My work is very important but here I can’t work.

Their relationship is not easy but she’s unsure why. Is it the relationship per se? Her loss of culture, family and friends? Her inability to find a sense of place? I feel how much
she has lost and recall Durkheim's 'anomie' - a sense of groundlessness that I myself experienced, painfully, in my mid life.

After the first child, I thought we would share but he did his work and I did stupid stuff - housework, nappies. I thought he would say 'it's your turn to work now!' but he didn't and I don't ask easily. I had just made a plan to have my time and work and I got pregnant again ... I'm so tired I can hardly keep myself up standing. I just lie around sleeping all day - I've never had this last time. Phillip doesn't react good to me. I want to be spoilt - massage, flowers, looked after. We're waiting for each other and watching - he does do little things.

Life questions are rising unbidden.

Do I expect too much of life?? Some other may say so. I'll be visiting family and friends for 3 months soon so we'll see. I've always wanted to travel with Lea so good to do it now.

She recalls childhood feelings.

I had a good childhood. I was the kind of person who drew away. I thought of running away. I was quite depressive as a child. I didn't know my parents were worried about me till they told me much later. They bought me a puppy when I was 10 because I was not coming out of myself. - I wouldn't speak much but I loved animals and was happy in the forest. I was calm in my own world. I have my father's sense of justice.

She quietly helped her class develop a community spirit but then left the convent for a big school. She felt hopeless until at about 20 years, through the care of two excellent teachers, Charly discovered painting and a sense of life - art is her "life blood."

My ideology was not advertising. I lived in Bavaria for 3 years learning wood carving - it taught me - what do you say? - patience. I'm not a patient person naturally.

My mother spoils me no matter what. - but the mother-daughter relationship can be difficult with hidden messages. When my brother left home I was 18 and my mother switched her attention full on to me.

She talks about a friend's baby with spina bifida and her brother's baby in Africa, disabled through streptococcus and fears a deformity.

Not so worried the first time - probably because I ignored the pregnancy. This time I'm 37 and everything says you should have tests.

Charly delays because of the risks. When a playgroup mother gives her a pamphlet about a new, non-intrusive test, she goes to the city at about 15 weeks.

We sat for 2 hours then the doctor... couldn't answer any of my questions. It was a great struggle deciding. It was too late for an abortion but the doctor said it would help us prepare if anything was wrong. So I did it. I was amazed they know how to do it without damage. But the next few days I got really paranoid - the baby wasn't moving. I asked the GP to check if the heart is still beating. Late test is hell - early test is better. I forget about it (being pregnant) except when I can't lie down - movement is new and fascinating. I was really worried before, that something is wrong with the baby - I'm calmer since the test.

She returns from overseas at 36 weeks pregnant. Painful events overshadow the pregnancy making the Edinburgh Postnatal Depression Scale irrelevant to her.

The thought of harming myself has occurred to me quite often but it's got nothing to do with the pregnancy. There is no one here I can turn to and even talk to. The ir-faws live on the same property and are lovely but I
can't tell them. I hardly know anyone here - there are acquaintances at playgroup and nursing mothers but I hardly ever go these days. My best friend here - how could she do that?? - how can I trust ever again? Even being here is it safe - what's happening?

She asks me to turn off the tape to protect confidentiality. She wants no judgement or blame attached to her struggle, rated way over the stress scale. We sat in the garden for a long time as she sought to tell me her feelings and protect, excuse, make meaning and find her place in the drama of this time. Her low, musing voice is made hesitant by the foreign syntax of an unaccustomed language - the intensity of her feelings coming through but constrained by being forced into unfamiliar phrasing.

I never had to deal with anything like this before - never thought it would happen - it nearly kills you... don't know myself now, I'm so open to everything - so vulnerable - suddenly starting to love again.... I can't take the pain inside. How can that ever get better again? Yet the whole relationship is stronger and I feel happier in ways. I hope it's not affecting the pregnancy or the baby too much. The first never moved - this one is sticking out everywhere and moving a lot. It gets hicups. My stomach is so big.

She speaks about other anxieties and phobias.

On the plane coming back I suddenly was dry and felt I was suffocating. I thought I would die and had to have oxygen and they gave me a wet washer over my nose and mouth. I was totally frightened - I don't know why.

Her first phobic reaction arose after a swimming accident at 29 going through a tough time in a very difficult, 4-year relationship.

As a child, I was always afraid of the water. Ireland was my favourite place - I loved the wind - how it comes against you and you can lean into it. I enjoyed it - that the wind should be my enemy is pretty weird. I can't go for walks too far...I'm afraid of suddenly being unable to breathe.

Fear of a panic attack keeps her close to the cottage. I find it hard to fit the phobic part into the courageous, independent life lived by the powerful woman before me.

It's impossible to get rid of it - I just have to live with it.... maybe there's a reason for it coming my way...maybe so I can't be so independent and have to stay put. I have a lot of friends but I always went away to foreign countries - It was never about the people...more about new experiences.

Pregnancy, isolation and lack of support amplified her feelings of dependence, isolation, vulnerability, inability to be herself or find her place in this country. A torrent of feelings swirled beneath the still, calm, even surface of her conversation - dramatic contrast to the freedom and happiness at home.

In Europe I feel so differently - I walked, worked, had contact with friends and family. There was no problems! I'm not looking for new friends here though I'm open to it. I want to do my work. I've more energy now - don't feel I need to rest. I'm doing more than usual to keep my mind busy - the midwife says I should rest.

Charly speaks little about the pregnancy or connecting with the baby.

I don't want to think about it much - so many things can go wrong. I'm the only woman who goes somewhere else to have her baby - stupid of me but I did it with Lea because (Phillip) wanted to be here. Perhaps this has affected me - I'm not full hearted or feeling right for me. It suddenly starts to matter having contact with family and friends.
Both Charly and Phillip think the need for extensive preparation is a myth and are keeping it simple - a few baby clothes and a bigger wardrobe. Charly's a bit worried about a restless baby.

If it cries it will disturb everyone because we're all in the one room. But if it's calm there'll be no problem.

I called to make a time for the last interview. Her mother in law answered and told me

Charly is asleep with the baby, ... he's a big boy - 3.8kg. She's pretty sore as you can imagine - lucky he came a bit early. She will call you when she can.

The return call came quickly. The baby is one week old and as I video she suddenly apologizes, more to him than me, for not dressing him up for the video. The birth was intense but quick (10-30 minutes to dilate from 1 to 8 cm.) and she felt, being her second, she knew what was happening. Hypnobirthing helped.

He had the cord round his neck - I got into bit of panic but he was OK. The midwives were good ... I'm lucky that it goes that fast for me - in a way it's too fast. I felt I don't want a baby in daylight. This time it was getting dark and I like that feeling. ... he is sucking at the end of the nipple and I got blisters. I could have asked but they were busy and assumed I knew because it's my second one - but its two and a half years and I forget. I looked good very quickly.. though I had disturbed sleep and was feeling tied down. .... it got me down a bit and got boring because there's not much family or friends to visit... There's something easy about him - no startle or colic - pretty strong. I feel very lucky. ...It's totally new (being a parent again). You never can imagine what it will be like. ...The first 24 hours was hard – he likes to be held.. It's good if he can go down because I'm not a person who can totally relax if the baby is close. I don't like to carry him because I like to do things. Once I got angry and pushed him away – there was aggression there – I'd had enough. He'd been feeding for ages and I was so sore I couldn't cope. Why so unfair from nature – all that pain before and then comes all that pain again after and no sleep. It's just not fair.

I marvel at the way they are getting to know one another. Seeing the tender newness of the relationship is such a privilege. His sister plays around paying little attention. She asks to have her blouse open so she can breast feed her doll. Phillip comments:

Most people want a nice house, to be financially secure first. We're more haphazard so emotionally we just let things unfold and it seems to work quite well.... Take time - its such a precious time - It's only a few years before friends and school condition them and then into the world. They make you aware of all the miracles of life - the unexplainable things. ... The only good advice is don't give advice.

He cries a lot through the day and she wonders if he's pretending for attention because he often settles if held. He seems to have a lot of wind and discomfort but is easily soothed and unlike Lea, can be put down more as he regulates himself reasonably well.

Other days she feels isolated, sits and can't do anything. Phillip is working all day and communication is difficult between them. It helps to go shopping or socialize.

At 4 months

I don't feel like a mother – I know I am. The days pass waiting for things to happen.
Postscript: She takes up painting landscapes with a small group of women and they hold an exhibition. Her passion and artistic talent push persistently into expression like water stubbornly finding a way through, over, under, around the obstacles in its flow; like the life force that drives conception, the swelling belly, birth, the insistent cry and compelling gaze of a newborn.

BETWEEN THE LINES: Loss and grief consume the space and the prenate grows moving, sticking out - not rejected but, like the mother, unsupported.
BETH AND BRIAN

I drive slowly through the thick, sliding fog, searching for the small wooden bridge on which my directions depended. The blurred outline looming dimly ahead leads me to the humble, old rented house. Brian is lighting the fire with Dylan's enthusiastic help. He’s 3 and distracted by my arrival. He is a beautiful child with his father's dark eyes and skin. Beth and I sit in the kitchen while Brian and Dylan move in and out, Dylan more in than out, fascinated by the tape recorder. Brian is very reserved and responds quietly, thoughtfully, when I speak to him directly. He suggested she ring me about the research.

This is a very different pregnancy to the last and the frequent comparisons seem to be a way of making sense of it. Beth miscarried 5 months before this conception fifteen weeks ago. Interestingly, Beth's mother miscarried just before Beth was born.

It wasn't all that traumatic at the time - not painful - just like a really heavy period ... I think actually Brian got a bit more upset about it than I did. ... I didn't go into a depression or anything like that. I just thought it was a natural thing to happen ... Miscarriage happens because there is something wrong with the foetus, ... it had been dead as they say for about 2 weeks before I lost it, so it had been a ball of cells basically - it wasn't even a baby. So in that way it didn't affect me all that much or at least I didn't think so. When I fell pregnant this time, I did worry about it. I wasn't going to get too excited until after I'd been to the doctor and he said everything was looking good and that's when I started to feel better about it.

Hearing the heart beat at 14 weeks makes her more confidant. She has faith in the obstetrician and asks if this pregnancy will be the same as the first one.

This time I’m having a lot of morning sickness. My skin is awful. It's breaking out in eczema. There's a lot of physical feeling. ... At one stage, it was hurting muscles every time I coughed. I did get worried about that, having had a miscarriage. The doctor said it was perfectly normal to have feelings like this in the second pregnancy. ... In both pregnancy’s I gave up smoking so I’m eating a lot more. I tend to grow quickly and show straight away. ... People with old-fashioned views tell me I must be having a girl because I'm so different this time around. Well, I think it sort of makes sense in a way. ... we'll just have to wait to see what happens.

The gender of the child is not an issue for either Beth or Brian. They planned all three pregnancies.

Her parents divorced when she was six years old. Her mother remarried when she was nine or ten. Beth didn’t like her stepfather who was an alcoholic and she has vivid memories of domestic violence and frequent police visits. She moved here with her mother, sister and brother when she was 14. They lost everything. She and her mother shared a love of horses but her little brother, currently living with his father, was more affected.

He sat in his room playing with cars all day. He was born without testes and had a lot of hormone treatments. As he grew up he got into a lot of trouble – he was very bright but expelled from school. He went away to live with extended family to prevent him ending up in gaol. He ended up with a good job...is into wearing black, long hair and loud music. To me he’s always my little brother. My sister is a party girl living in the city. I don’t think she knows whether she prefers men or women.
They can't say much about Brian's background. He is Koori, fourth born to a nineteen-year-old in Bourke. He has her name on his birth certificate.

I was adopted at 4 months old so I've moved on. I don't really want to know. It doesn't bother me - my sister is opposite. She had contact with Mum and Dad and went to see them. They're in Queensland - not still together.

...She's right into that - lives in the Aboriginal community in the city - involved with everything. The first chance she had of getting out of this place, she took it.

A white family with two children adopted him and his sister. Brian had 'quite a good childhood' and is content living locally with what he considers to be his real family. Beth values the diversity in their families as her children learn tolerance and to accept people how they are. There is a down to earth, 'unflappable' feeling about both Beth and Brian reflected in their quiet, unhurried speech, common sense and acceptance about life's difficulties.

Sometimes I forget I'm pregnant and lean over too far - it lets me know. I can't imagine not knowing because I feel so different.

She's 22 weeks. Her skin is improving and she is more emotional and sensitive than usual.

I can stop it (crying), but when I can, I just let it go. Brian laughs at me ... I laugh at some of the things I cry at!

There is pressure and stress at work.

I'm looking forward to leaving work. I feel I don't need the stress when I'm pregnant. It's hard to get rest with a 3-year-old. I wish I could be at home more with Dylan. I want to leave work and have at least one month off. I've no intention of going back to work after the baby's born - but finances are difficult if Brian doesn't get overtime. It's hard to save.

Financial stress is a continuing thread and the only source of conflict between them. He spends; she wants to save for a house and is planning a home based business. They talk together about babies and the future. It doesn't bother Beth to have to put things off.

The baby is already part of the family - all three interact with the baby, touching and talking to it. Dylan pulls her shirt up to give it a hug.

He says 'this toy is for the baby' - he has more relationship with it than me. The baby is very active - always letting me know she's there. The doctor was annoyed because it was moving so much he couldn't take photos. I didn't find out the gender but I think it's a girl because the doctor told me this pregnancy would be the same as the first but it's completely different. I get a sense of it because a baby with dark curly hair and dark eyes like it's father is often in my dreams. I'll probably be more outgoing than Dylan.

She's always wanted to be a mother and they both look forward to having more of a family - Brian wants five or six but she's not sure about THAT many.

There's lots of talk at playgroup about pregnancy and birth.

I share because I had a good pregnancy and birth and people tell horror stories when you're pregnant for the first time - being relaxed and not tense made it good. First time you listen to everything that everyone says and it's a bit of a mix up because you don't really know what's going on. But second time I guess you're a bit more
experienced so you sort of take everything and then filter out what you don't want ... I've got more confidence because I know what's going to happen.

The following weeks are very difficult. A child in Dylan's day care is rushed to hospital with meningitis, then there is a measles scare. Beth is very worried about risks to the baby but can't get information and reassurance. Finally, she phoned the hospital.

They made me feel really stupid and twice as upset.

Beth felt a help line, staffed by people with medical knowledge and counselling skills, is needed. On top of this, back pain almost cripples her. She fears a kidney infection and again worries for days about the health of the baby. She is prone to worry when pregnant because no-one knows what caused her brother's problem.

Though tired and stressed by work, Beth looks in glowing health. She wants to leave work earlier than planned. Last time she had 2 months off and was bored but this time Dylan is becoming difficult and demanding.

I realize I won’t have as much freedom as I have now. I’m thinking about all I have to do before the baby arrives ...and before I get too big or tired. ... I don’t like leaving Dylan in day care let alone a baby. Dylan went at 10 months and that was a good age because he was too young to understand what is happening but too old to be too clingy.

The house is very small but they plan to save for two years for their own place. It is important to her because Beth moved 15 times before she was 14.

Beth wants Brian to go to the refresher course - he isn’t keen but he doesn’t realize how close it’s getting.

She feels supported by family and reading about pregnancy and birth. She has vivid dreams and is very aware of and talking to the baby more.

At 31 weeks, Beth has to move house but is looking forward to having a bigger house to accommodate them all more tidily (important for Brian). Last time she moved house she went into labour. Braxton-Hicks contractions and fortnightly doctor’s visits make her realize it’s getting close. She’s getting herself into gear and looking forward to leaving work and having more time to think and dream. Beth feels more secure with Brian in permanent work for the last two weeks.

I’m starting to think about the labour – not really worried but I expect the baby to be bigger. Knowing about the stages of labour and what is happening in my body helps.

The baby is moving a lot and hopefully won’t come early because she won’t be prepared. Beth expects it will go overdue but primarily she wants it to be healthy.

Brian, hasn’t thought much about the baby but is starting to think about the birth.

I’m looking forward to it. First time I was very excited – not worried now. I’ll just take it as it comes. I’m more worried about what will happen to Dylan during the labour. I don’t want him to see his Mum in pain – that may upset him.
By 36 weeks the baby has turned, Beth finishes work, moves and tries to rest.

I'm exhausted but not stressed. I've got more time to think — worried about how Dylan will accept the baby and the effect on his behaviour. He's a handful — very active and disobedient. I understand that there's a lot going on for him with the move and everyone talking about the baby. I think I'll give him a present as soon as the baby is born. He thinks he'll have a brother. He's very close to his Dad, which is very good.

Brian took voluntary redundancy at 40 weeks, to pay bills and be home for a week but was offered another job in a few days. She's very tired, weighed down, has poor bladder control and trouble sleeping.

Spirits are still up — not depressed yet but I'm sick of it. I expected to go early. I feel everything's on hold waiting for this baby to arrive. Money is the only stress in my life — one basic wage means I have to decide whether to pay the rent or shop for clothes. Christmas is a terrible stress.

Dylan is very active and very aware of the baby.

Yesterday he said he's got a fat tummy and a baby in there too. I sometimes wonder what it will be like to have 2 children. I think about Dylan's birth and wonder about this one's personality. I don't have any picture in mind.

Brian rings everyday and Beth tells him everything.

I tried to talk him into trying intercourse to start the baby coming but he's afraid to get close to me — he gives me a cuddle ... He'd rather things go naturally. He likes babies but is stressed at the thought of having to support another child. I've read about men feeling the strain — one baby is fun but two is a responsibility. He's a good father though he never saw himself as a family man. He's definitely under pressure.

Eight days overdue he is induced, arriving eight hours later. Beth is pleased with the care and help she received from everyone. They didn't "whisk the baby away" and, as with Dylan, Beth felt an instant bond with Blake.

I knew exactly what was happening at all times. I liked the way they encourage you to get up, walk around, have a bath - no panic no rush. They didn't do anything without consulting you. I'm glad I live in the country where I got specialist care and treated like a person. Brian is stoked that it's a boy. It's no problem for me.

Blake was very alert at 17 days and the tiredness is starting to hit Beth. Dylan all day, and baby all night is exhausting — her back and arms ache.

I'm not dressed till 1pm - a friend caught me in my dressing gown but she's OK — she's got a 6-week-old baby. It's good being a mother again; nice at home but restricted and with no breaks.

As the interview progressed, I realized that Blake had a heart problem.

On day eight, I got teary. The paediatrician picked up a heart murmur and referred us to a city specialist. It was distressing to go for an ultrasound. One of the valves is not opening properly. We have to go again in 6 weeks. He may need surgery. He's a very alert baby — he's been here before. His development is advanced — he reaches to touch... smiles and babbles... He grunts if Dylan annoys him. He's patient and easy going, like Brian. He's a relaxed baby because we are relaxed. Everything else is fine but the heart problem is always there in the back of my mind — niggling.

Blake feeds frequently so he's in bed with them but Beth worries she may roll on him. Breast-feeding is settling down. He has Mongolian birthmarks, common in dark skinned
babies, which should fade. Brian has 12-hour days but is very supportive and lets her rest on weekends. Dylan, though a little rough, is not jealous. At 8 weeks, Brian is out of work but assures me he never has trouble getting more. Beth agrees but worries about finances. Beth looks relaxed and radiant though Blake is waking through the night, feeding a lot, has reflux, gets exhausted and breathless on feeding and demanding.

The specialist told me to keep a close eye on him but I didn’t know what to look for.

A chance visit to the GP got her an explanation and it is more serious than she thought. She wishes the clinic were open more often in the village – she doesn’t have transport to go to the next town. NMAA phone counselling is helpful but no one is actually seeing him. Beth worries a lot about cot death. She’s not depressed or trapped, not even thinking about work and loves being a mother to a baby. By four months, she is stretched through lack of sleep, managing Dylan, an alert active baby with a worrying condition and wishes she could afford a housekeeper. Still she appears to cope with quiet, accepting dignity.

Postscript: Blake had a successful operation for pulmonary valve stenosis at 4 months old. Once he recovered Beth went to a mother craft clinic, learned controlled crying and went home with a new person who slept through the night.

The clinic was wonderful for me ... having group sessions, social chats and just watching TV together with 6 or 7 other mothers all .. with the same problem ..made me feel ‘normal’ again.

BETWEEN THE LINES: Unflustered, down to earth presence; motherhood and prenatal embraced despite distraction.
JOANNA AND MARTIN

The first interviews are brief and intensely emotional – squeezed in between jobs. We laugh about my 'power' to release her tears. Joanna is a very competent, professional, friendly, fun loving woman – so well organized that she works two jobs, travels from a neighbouring Shire where she is active voluntarily in 2 community groups, studies and manages her family of partner and 2 young sons.

The pregnancy is two months earlier than planned. Her back is so bad sometimes that she can barely walk. She is thus dependent on her partner, Martin, who is out of work.

I broke the news and I guess because he was already feeling put upon he wasn't terribly warm to the idea. ... he wants to go back out into the work force and be home less looking after kids. It's good for me because I always wanted 3 children.

The relationship is under pressure because she wanted to conceive. They see things very differently.

She is very anxious about the health of the baby and uses her knowledge of, and standing in the health system, to have special tests.

It there's anything wrong with the baby it would put such stress on the relationship that it may not survive. Stress has become more difficult for him over our life together... inadequate work... lack of adult input and I live a very fast life... We do talk ... I love the kids immensely - 24 hours a day is not enough for me... there are a lot of issues about roles. The more he stays at home the more he feels that men can't be house-husbands. It's because our roles have been open that I've done all that I have. Our relationship is not traditional, so if I have extended time out of the work force it would be a problem.

Gender is not an issue for her but Martin is not keen on three boys.

He wants to find out the sex. I don't - not sure why. I like the element of surprise – I didn't find out with the others either. I'm more concerned about chromosomal problems.

She is the fifth of seven children – just telling me triggered deep crying and distress. A profoundly deaf child was born when Joanna was 2 years old, and though she felt closest to that sibling, she was on the receiving end of her intense, often physically expressed, frustration. I wondered if this played into her deep anxiety about the baby's health?

Despite fears, she won't risk an amniocentesis.

I was mother's little helper AND copped the frustration. ... I was sent to school when I was 4 years old because Mum couldn't cope. I've been emotionally blocked a lot of my life - had to because no time and space for me. It is what drives me now - trying to accomplish something to get recognized and rewards – I had to excel to be noticed.

Childhood was good, yet there are many blanks. She thinks her sickliness was psychosomatic. Joanna spent a lot of time struggling, puzzling and trying to recall the basis of her sense that her mother believed she may not be around for her.
That's interesting - pause - I think she had an ovarian cyst or something - she recounts a story of looking at me ...must have been afterwards... when I was 7 or 8 months old and she must have been told something critical ...definitely physically based. She had a deep feeling that she wouldn't be there.

Into the silence, I comment that having a profoundly deaf child perhaps meant that, in some ways, she wasn't.

Interesting interpretation.

Most of the pregnancy develops under the dark shadow of relationship stresses, the fear of the infant's health, the busy demands of her career, and challenges to her own physical and emotional strength. She is ambivalent about work - loves it but needing to rest. There is a conflict and distress - she sobs

I'm normal aren't I? Pass the tissues... Part of me is blocking the baby - I'm really keen to have a baby but there's a part of me that doesn't want to get too attached to it... there's not a whole lot of happiness about it - my happiness is being blocked. There's so much going on and I can't share it - it's a horrible phase - I feel nauseous, frumpy... having headaches, tired... not interested in sex, which isn't helping (the relationship). It's been different with this one - had happy hormones with the others - I felt euphoric - that hasn't happened with this one yet.

She speaks about support and her difficulty in accepting it despite her great sociability and extended network of friends. It's a pattern for her to cope and be a helper. Joanna wants 'support' from the research process. She really wants support from her partner and her own mother but thinks it's unlikely. Her sons, Wesley 6 and Ignatius 3 years, are enthusiastic.

I feel that today with my Mum - there's got to be a reason for her to be - she can't just BE. She's willing to help but doesn't see that just giving time without me being sick is good.

At 22 weeks, it's been a very busy, difficult time and her partner suddenly loses his job so finances are stretched. He wants more work and she wants less. It seems so unjust. Martin is stressed and unenthusiastic about the pregnancy.

I'm emotional and he's not. He went to boarding school at age 7 so it killed emotions - he has them but doesn't let them flow. His mother doesn't generate emotions either ... I hope he'll get more enthusiastic in the next weeks. I'm quiet ... don't want to draw attention to the pregnancy. I'm missing closeness in the relationship.

There's not enough space to think of names - not even the usual nickname (a shame, she says.) She shows the ultrasound picture, pointing out to me all the organs and the thumb in the mouth.

It's already learning to look after itself.

Early memories that had disappeared surface intensely and unexpectedly. She sobs as she recalls age 16 when she and her boyfriend were in a tragic, fatal fire. It affected her. It was a good relationship but she couldn't stay with him. Depression and bulimia arose. Joanna had never talked much about it before.
It happened Saturday night and I was back at school on Monday. You just got on with it. I had no option – I was the school captain so expected to be strong. The only outsider person we talked to was the police - to tell what happened, and the coronial inquest. They make you feel guilty because of the attacking way they question.

By six months she is happier. Martin has work - a huge relief for them both. He’s laughing again. He wants her to take more than 6 months maternity leave but leave conditions aren’t favourable. The baby is looming larger in her thoughts - it moves more and, from it’s movement Joanna is getting to know it likes music and her laughing.

I’m thinking lols about what sex it is - should have found out. I feel I don’t want another boy some days and others I think it’ll be fine.

Martin encountered giggling girls and said, “I hope it’s a bloke.”

The baby still feels like parts not a whole because bits are kicking and moving. It’s nice having the ultrasound pictures because you see it as whole. It actually all does come together at birth. It feels a bit ominous till they come out.

She is fearful about the consequences of Valium taken early in pregnancy for her back. Her professional training increases both awareness and fear.

There’s no history in the family - that worries me too. It’s the seventeenth grandchild so how can we not have one with drama. The odds are running out.

Has she forgotten her sister’s deafness? Is the impact unconscious most of the time?

Her obstetrician is professional but never asks how she is. She wishes for a midwives clinic, as even the booking in process and psychosocial screening is depersonalized.

They just sit at the screen and key in your answers. There was more distraction getting the computer technology right than listening and following up on the answers. Better to say, “here’s the computer work your way through it,” or, do a verbal interview and put it on later.

There are no tears. Martin’s work is going well and everyone is benefiting from having family time together. But the physical problems increase. Her frustration with herself gets greater as her energy drops. She is acting in a senior position at work and it’s a struggle getting through the day. The urge to get jobs done and be organized it there but the energy isn’t.

The ground is further away for picking up stuff.

The baby is becoming part of the family. It’s a big, very active baby - much more so than the other two. Her whole stomach rolls. She’s wondering about its personality and how it will fit in the family.

It’s hard to perceive of a relationship with the baby (and) to get used to the movement. It’s strange not having a direct connection – it’s close being inside and that’s a good feeling.
Everyone wishes for a girl. Joanna hopes she'll be accepting if it's a boy. A girl will be an opportunity to relive some of the things she did as a little girl. The children are very involved as the baby's activity is part of her every day conversation. They also relate directly by kissing her stomach between kicks. The boys are becoming cuddlier, not wanting her to go to work and to be with them more.

They keep asking when it's coming. The younger one saw milk in the breast and squeezed it. I'd love to be a fly on the wall at preschool!!

The birth features more strongly at 31 weeks. She thinks it will come on the 7th (the doctor thinks 11th) and that it will be a longer labour. Though she knows she tends to scream and want to be free to do her own thing, there are no shoulds - "what ever happens, happens." Living such a distance from the hospital is a bit of a worry for her. Her mother is visiting and doing helpful, practical things.

Next visit Martin speaks about his experience. It is a revelation for Joanna - their experiences of the pregnancy are so different. Martin enjoyed the interview and said he talked about stuff he thinks about but never mentions.

At 37 weeks, only 1 week of work to go and the birth is the prime focus. She cries about the birth as the 'climax of the 9 months.' Accusingly she said

I'm perfectly rational before I start talking to you! It feels big. I don't recall feeling like this previously - perhaps being the last child it's the last opportunity to have this experience. I value the closeness, the intimacy, the weirdness of a body moving inside. It responds when you talk in your mind to it - I actually feel it. I talk to it when I'm driving in the car alone - people would write me off otherwise... I like being pregnant. It's never such an onerous thing. It doesn't really interfere with life but it's life happening inside... Its no longer just mine (distress) - I've got to share it... It's the first time that I've had that feeling. I've only ever wanted three children and am quite set about that - but the reality of not doing it again..... There's a little bit of regret about it being negative at the beginning - a few months were lost. (Tears: You could go on?) NO! Nine months is more than adequate thanks! (laughing)

Joanna wants to know what is available at the birth and knows the medications to use.

I'm a bit of a control freak. I let go eventually. ...after the second child, things were too speedy. I felt pushed out. ... It's nice to be there for the energy that's been in there - the energy of the baby, and to make a slow transition.

How can you honour this ending of a special experience?

Fizziness, excitement, warm fuzzies. HAS to be champagne - that's what's there inside me because it's been more of a survival emotionally this time. I need to acknowledge it's been a difficult time.

Eliza arrived two days earlier than Joanna's prediction and took about 17 hours, as she intuited.

She was a bit blue when she came out - there was actually a true knot in her cord. She was so active, she'd done a 360 turn and it tightened as she came out. I was quite hysterical crying -'it's a girl'! .. I just cried and cried and cried in the labour ward. I didn't know what was wrong. Her APGAR scores were 5 - 9. ... My first thought .. *Gorgeous - he's a she!!*

There were some disappointments and her knowledge and assertion were assets.
Change of shifts ... more of a happy event with the first midwife. I felt a little resentful – the combination of people there is important. To have the midwife of choice would be a good ... It felt a pressure - not 'would you like us to bath the baby?' but we will bath the baby. I know the vernix is good and so said I would do it tomorrow. I just felt she'd been through enough and needed a rest. I didn't want her going too far away from me & I didn't want someone else doing it. We were there over an hour... really nice there just the two of us. Didn't feel like my champagne though. ... The worst part... they... were going to whisk her away again. I sent Martin to guard her. Funny - I was quite protective. It's all to do with control and knowing what I wanted and being able to direct. It's important because she's my child. She's spent nine months inside me and I know her best. ... The staff took her for a couple 4-hour stints so I could rest. ... we had rapport so it was OK for her to go.

Eliza is 3 weeks old and not settling; by 5 weeks Joanna is getting to know her moods and rhythms.

My brain's gone to mush! Everything is cruising along – a few flash points... no baby blues. ...friends are helping. ...She's a social beast. She knows what she wants and gives clear messages – or perhaps I'm a more clear receiver. – I feel I can talk her through if she's distressed. She used to move around a lot and I'd talk to her and tell her to calm down. When she's angry and her fists are going I can just see all that movement inside...I feel suspicious of how good I feel – heaps more energy than with the other two...not as besotted this time.

Joanna returns to work, a little sadly, and continues her full and busy life contributing at work and in her community.

BETWEEN THE LINES: Can the baby find its way through the stress and busyness? Being wanted at least by Mum, acceptance of motherhood and the children's curiosity provide for its presence.
ABBOT

I didn’t intend to get pregnant but I didn’t take precautions either... I always knew I’d have a baby before I was 20 years old. I always wanted a little girl called Manette. I don’t regret it at all. It’ll be hard but there’ll be fun times too.

Lyn saw my poster at the Doctor and rang. 
I’ve got a 17-year-old daughter who is pregnant and there’s nothing around to help her.

I wondered, as I ran up the TAFE steps, how would I recognise her? Nuggety, earthy, chatty, pregnancy hidden under huge sloppy jo, she smokes with several friends. Abbey swore, talking easily, with dry humour, above the layers of her life and only occasionally dropping below the day to day surface. We sat in the car as it gently rained talking. Every so often we got out of the car for Abbey to smoke. Pregnancy is no periods; you can eat weird foods. The worst is... all my friends are in skinny clothes and I can’t. When the baby moves it’s weird - My Mum can’t feel it yet. I get pissed off because I hate being pregnant as well -Mick (the father) is not with me. I thought having a baby was between two people... I’ve been up and down - round and round - some days are shittest - I’m going to kill Mick - it’s all his fault. Then I’m happy. Then the baby moves and I don’t want it to because it’s shity;

Her ambivalence about being pregnant continues till the birth. Her mother has stopped going to church because of attitudes. Abbey feels stared at, judged and isolated.

I don’t believe in abortion - nor does my Mum. We wouldn’t consider it at all. ... Friends in town don’t come over – they’re not allowed by their parents. It’s hard because I go on the bus (to TAFE) and everyone’s around (including Mick). People look at me weird because I’m the first one in my age group to have a baby. People glare or stare - all the guys look at me really really weird! Some mothers smiled sweetly at me – I like it if they don’t judge me. ... A friend was with me when I found out - we just were bolting round the canteen screaming. I nearly cried - I was so happy when he told me over the phone. Later I was shocked. What’s going to happen to me? My Mum’s going to kick my arse to the moon and back. I told her a week later. She’d been asking if I was pregnant and I kept saying ‘no’ because I didn’t know if I was or not. I had to get the Doctor to say. I’m just over 5 months. I don’t realise I’m pregnant yet.

She visits the obstetrician.

I didn’t know what to expect - I had to pull down my pants and I didn’t want to take off my pants - he didn’t explain to me. Having a doctor touch you like that - it really turned me off - I didn’t know what was happening. I went with mum’s friend - she was my support partner; now Mum is – it’s not the best but she’s all I’ve got. ... Mum came (to second ultrasound) and the lady explained everything. The baby had its hands on its face and the legs crossed. The first time Mick came, and he saw more than I did. I was happy he was there because he’s the Father.

Abbey changes doctors because she ‘hated’ the first one she saw (who actually ended up attending the birth). She felt she got no information and she really wants information. The GP, concerned about the baby’s small size, spoke to Abbey about her smoking and who would look after the baby post birth.
stupid bitch of a Doctor - judgemental dumb cow. She asked who’s going to look after the baby - I fear she’ll dob me into welfare. we’ll just smack her in the head. I know it chokes to death each cigarette. I’ve not smoked for 5 hours – it’s more alert and moves if I don’t smoke.

She wants to give up smoking but never manages and in fact becomes angry at times about the changes she feels she should make.

I’m trying to quit smoking for the baby’s sake – I’ve read... heaps can happen! I’ve gone off coffee and caffeine and have one drink only. ...being pregnant is a bonding with your body. I’ve got stretch marks; get eczema a lot. I get really depressed. The cat and dog know when you’re depressed – I just sit and smoke a lot. Sometimes I have a lot of energy but often not. Cleaning the house helps.

Abbey wants information and feels she has no one to talk to about the pregnancy and sees the interviews as filling this need.

I don’t talk to Mum about the pregnancy at all. I’m close to Mum as a daughter and Mother but not close on the emotional side.

She told me with some fascination and delight that

The baby moves in the shower sometimes – it’s like a nervous feeling - like being on cloud 9. It’ll be a bitch like me – I’m very anti-male.. it’ll be fun to watch it grow up. Parenting will be hard but fun at times. I know I won’t get much sleep. I screamed when Mum brought me home. Newborns have to be rocked and cradled to help them go to sleep. Sometimes it cries and you don’t know what’s wrong – that’ll be pretty stressful but then you get into a rhythm. They can’t do it themselves - you’ve got to coax them at the start. It’ll take about a couple weeks.

She describes herself as doing housework and meals for herself and her brother.

Mum is at her boyfriends a lot. ... I’m alone a lot - I get used to it ... She’s always in my face - I want her to get out of my face when I don’t want it but she won’t. Sometimes it really pisses me off and I have to lock her out – she belts down the door. She knows what I’m like ... but she doesn’t know me inside - the emotional bit. It’s a roller coaster ride - I’m confused about everything.

She curses the baby because the father is unsupportive. She left due to violence. He came to mediation to remove the apprehended violence order. At 37 weeks he is back in custody and continues to show no interest.

... (He) was really thrilled at the start of the pregnancy, now I’m all by myself. He used to sit and kiss my stomach and swear and scream at it (she giggled). I need him to ask how I’m going; to talk about our baby. I need to talk to him about it; it’s his baby. He now denies its his baby - he said ‘I’ll wait till it’s born to see if the baby is mine’... he can’t control anger – he’s stressed, depressed. It’s basically my fault - I provoked him and knew it. He already kicked me in the stomach when I was pregnant a few months ago. He accused me of sleeping with all these guys. ...I want him back but I’d prefer a non-violent relationship but he won’t change. ... He’s 15 years old... My mother had one (an AVO) on my brother and he learned to control his anger and mediation worked. ...I’m scared that we’ll get back together and he’ll hit me in front of the baby. I don’t want the baby growing up with violent parents - what will the baby think? My friends feel sorry for me because I’m young and pregnant without a boyfriend. I don’t feel sorry for myself - I deserve it; it’s my fault. I hate people feeling sorry for me.
She speaks about carrying 2 kg of mince in her tummy, about getting ‘humongous’, feeling tired, unmotivated, low on energy, having thrush and eczema. She tells me she feels suicidal and has written a poem on her true feelings about the baby - it’s not a happy poem.

No-one gives a fuck about me - I’ll take the baby with me. No one knows what it’s like but then I’ve got to realise that I’ve got a baby and have to grow up. It’s my responsibility – I can’t just go round and do stupid things – it would be very easy to kill the baby – I don’t know how many times I’ve punched myself in the stomach because I don’t want it in there.

At 32 weeks, her postnatal depression score is twenty one.

I want the baby to be born so I can go out and party and smoke as much as I want without harming the baby and so I won’t feel guilty and I won’t have to carry this weight around. I’m stressed by everything and everyone. I cry over the dumbest stupidest things – but I can’t cry any more. I’ve run out of tears - not had a decent cry in about a year. It doesn’t sort out problems – you just get more stressed. Sometimes I go ‘whooppee do da, fantastic’ but then it pisses me off totally - mostly the later because I’m the only one who feels it. No one else does. I feel alone with it. The movement pisses me off. I wish it wasn’t there most of the time. I don’t bond - there’s no point in bonding - I get told: ‘do you talk to your baby?’ yeah I swear at it. Life after birth will be shit. I want to go back to being a teenager but I’ve got to grow up - I got really drunk a few months ago - Mum doesn’t know - I still want cuddles - I’m still a baby. The magazines say most young Mum’s get PND; I think mine’s kicked in a tad early. I slashed myself last year but can’t do that no more ... Death would help. A tiny part wants to live - a major part is rat shit. I put on a happy face on the bus and with Mum - won’t share - can’t trust; I feel all locked up inside. I sing songs to feel happy - pathetic!

Give the baby up?

No! I’d never do that after all the pain I’m going to go through – I couldn’t even give my kittens to the pet shop. ...I don’t see myself as pregnant yet - it might hit me when I’m in hospital.

Abbey continues to go to TAFE, pleased that the staff support her to keep studying, though the baby is due 2 months before the course ends.

Me and Mum want me to stay at TAFE. I like to go – we’re allowed to smoke; the first week here I learned more than I ever did at high school. The teachers treat you like adults not little kids. They’re not busy screaming at the rest of the class or sulking. ...I’ll never choose between career and baby — you can still have a baby and do what you want.

Lyn influences Abbey a great deal - conversation is peppered with ‘Mum says...’, ‘Mum thinks...’.

Mum tries to support me and goes and gets information but that’s not enough. I’ve got no support. She never had any support with me.

Conversely Abbey struggles to find her own views and seems to resent her mother hassling about smoking, TAFE, housework, and, after the baby was born, how to mother.

I’ll be paranoid when the baby first comes home about cot death because smoking can cause cot death ... If I get back on pot I won’t smoke round the baby. I think I’ll be a caring Mum and there’ll be times when I want to throttle the crap out of the kid. My Mum brought me up as in get a warning as in NO- if keep mucking up then get a smack on the arse ... that’s how I’ll bring my kid up.
At 37 weeks, Abbey talks more about the birth

I’ll take it as it comes. I used to be shit scared but not now – I’m more excited - want it over and done with; I have a half-life now. don’t want information about giving birth – I’ll just swear and scream to get the rotten kid out like: ‘I’m going home’, ‘get fucked’. Mum will be there all through - she’ll see me naked .. I’ve changed since I was little. (giggle)

She shows me photos and the press clipping about her birth. She was born 14 weeks prematurely 20 months after her brother. She still has her doll sized baby clothes.

I was a science experiment baby - no babies survived at 26 weeks. I think of myself as a miracle... I’m more interested in this now because I’m pregnant...thats my dad – I should have bit his finger off – I don’t like my dad - don’t know why. Mum said he cried when I was born

Seeing herself in the humidicrib, she commented that she wasn’t allowed to be touched then. Her Mother said she didn’t get to hold her till Abbey was 9 weeks old. They believed she was blind, retarded and deaf. They had expected (from the ultrasound) that she was a boy. A rough start to life.

She thinks of the baby as school aged and does talk to it.

hello little shit head; how going shit head; none of that mothering crap.

As I listen to the tapes I feel caught in the currents and tides of surging feelings - hers and mine.

I don’t know what the baby needs - I’ll probably ignore it – it needs attention 24 hours per day; love and all that crap; feeding....This baby won’t have a life – it needs both parents. I don’t want it. ...This baby is innocent, dumb, stupid, smart in its own way - it recongises voices and colours....How the baby is will depend on how it’s brought up. After it’s born I won’t be angry, swearing and stressed because I’ll have cigarettes...I don’t feel ready to parent but there’s no choice. I’m excited but crying and stressed – I need to punch something - not the baby - a wall...I suppose I’ll have the mothering instinct. ... I don’t go to the breathing classes – it’s a bunch of old girls who stared at me with their husbands and boyfriends, so I won’t go back - should get my $10 refunded.

Fortunately, there is a young Mums group and four prenatal sessions for teenagers that Abbey attended. Her mother sees her as a survivor and thinks she will be a good mother.

One of the midwives showed videos and took me and Mum round the ward. I got pretty excited but now I don’t care – I feel shitty. I’m scared of labour - of pain. Glad to have Braxton Hicks because it helps me prepare. I feel clucky now but sometimes I don’t care. I told Mum ‘I’m going to miss my little tummy’ and she said ‘it’s not that little’ Mum still comes to the Dr with me. I’m going to always have my Mum by my side. By the way, Mum wants to know if you want to be there?

I am caught right off guard with my mind searching for ethical implications. I encourage her to talk and believe that behind the off-handedness is a genuine wish for me to be with her right through the process. “You can take pictures” she says, and with that, it is agreed. I feel incredibly honoured. Witnessing birth is a powerful privilege.
Lyn phones from the hospital - Abbey is in labour. After much difficulty, they are born - mother, infant and grandmother. Minka is whipped to the side for resuscitation. Abbey is upset thinking Minka will die and realises she really wants her. Despite her strong wish to breast-feed, Minka is bottle fed within 24 hours.

It was hard work but I enjoyed it. I feel really old - ancient now - like I know more than other girls my age because I've been through heaps in the last few years - feel sort of mature in a way.

Over the next months, Abbey struggles to pick up her role as mother, from the position of daughter, in her mother's house. She knew

Crap all about how to look after her when I came home.

There is conflict about what, when and how to feed, settle, dress and manage Minka. Abbey feels that Lyn is reliving the past and acts as if the baby is hers. No one is finding the situation easy. The baby is unsettled and left alone to cry for hours. Time in an infant care hospital during the first two months confirms Abbey in her ability to care for her baby but Abbey is 'kicked out' of home and goes to the refuge with Minka. They seem locked together in mutual dependence.

She is home for the last interview but saying little in front of Lyn. Abbey handles Minka gently - clearly a more skilled mother.

Postscript: Some months later their house burnt down and Abbey lived independently with Minka and a new partner. I meet her again now living alone with her baby having separated due to domestic violence. She reads her story and this is what she wrote.

Minka will be 22 months. Now I am 2 years older living by myself. I get along with Mum now that I don't live at home. ... My views on Minka's father have changed. He knows about her but doesn't do anything to help ... he has now move on (sic) with another newborn this year. In those 2 years, I have to grow up fast and a lot, go without things. Dealing with the house burning down and in that hole (sic) time I had my little girl with me. And wouldn't give her up for the whole world. Now I have started work training... and hope to study more or work. It's not a good move to have a baby younger but you have to support and care and love that little baby ... for the rest of it's life. Having a baby is very scary and serious thing and you have to grow up fast. It was the best experience.

BETWEEN THE LINES: An emotional roller coaster of despair, hope and rejection with the prenate along for an ambivalent ride.
LEA AND JOHN

Chatty, bright, the home (built the year she was 20 and they married), the children, herself are all immaculate. She has two responsible part time jobs, three boys under 4 years, a partner running his own business whom she met when she was 12 years old.

He's very quiet so sometimes you don't know what he's thinking .... But we've got a really good relationship... a lot of the same morals and values. We just don't see much of each other but that doesn't bother me ... he has (the children) Monday and Tuesday while I'm at work.

She is about 3 months pregnant

I forgot just how draining it is to be pregnant. I usually look good when I'm pregnant, but now I just look old and sick. I want to enjoy my last pregnancy but I'm not yet. I'm scared about our new family - I don't want to be the volatile, emotional person that I am when there's a new baby in the house. I don't want to overburden my husband too much. I vomit a lot. I've seen a good naturopath now

Naturopathy and chiropractic made rapid and dramatic differences to her brother's severe childhood problems and have helped her children too.

One child had ...failure to thrive ...I told the doctor about the history of bowel cancer. I felt he didn't listen - just thought I'm a neurotic reflux mother. I got a remedy from the naturopath. People say it's in the mind but it still worked on the children. All the children have food allergies and one has asthma... The chemist was very helpful - I ask him more than the doctor ...Tom ... was on all sorts of medications when he was three months old - in hospital with a barium swallow - it was all just happening again and you just get so overwhelmed - how could this happen to me? You know, three times!... my best friend would say 'I'd probably do this or that' and I thought, 'you wait till you have one! I wish you have a nice spewy one or one that doesn't sleep!' Its funny - I'm not a religious person at all .... but I'm learning a lot about what I believe in. ...I've had sick children to make me go and search more - I've learned a lot about ... the power of healing.

Lea is well experienced with postnatal depression.

...overwhelm. It was just absolute chaos - just too hard - the monotony. When I came out of it, it was like a 6 months cloud of my life that I can hardly remember.

Doing the Edinburgh Postnatal Depression Scale at the clinic

... was cold. You had a questionnaire and either you were coping or you weren't. There wasn't any levels - are you eating or not? How's your family? Sex life? How's everything? I realized already that everything was bad. ... I rocked Ben till he was 14 months. Many people say you're making a rod for your own backs but it was the only way we could get him to sleep. We had a rocking chair out in the middle of the room with every single light off - couldn't make a single noise - that added to the pressure too. I had a 14 months old - he knew - I would look at him, point to the lounge room and he'd know to move. People used to say, 'get him used to the noise it will help,' but it doesn't! Kids just don't - some kids just don't work that way. 'Nobody's listening too me!' ... after childbirth ... it's such a shock. Dealing with forces - like his was a quite a difficult birth ...I'm a very reserved person about my body too.

She explained with distress that she felt like hurting the children or leaving.

...I never would but I was just Yelling, Yelling at them all the time. I felt like I needed someone to come and help me (pause) to look good. I just couldn't be in my pyjamas at 10 o'clock in the morning ... I think that if I knew exactly what I needed it wouldn't have happened to me. ...Is it such a basic thing? .. that my husband gets home
at 5 o’clock and the groceries and toys are everywhere ... I know it’s a control thing. ... our house was always a mess. We had workaholic parents and ours was just one of those houses... I feel in control if my house is tidy. Occasionally my husband walks in and he’ll look at that buffet and he’ll swap something - just to tease me - and time how long before I notice.

It took time to bond.

... it wasn’t until Tom was about 6 months old and playing with toys and noticing things and was responding ... instead of just going waa. If was when they can actually give you little goes and gaas. We always had them sleeping in our room you know and they’d just wake up screaming like a machine that you had to grease, oil and change. I remember looking at him one day thinking, ‘I could say I love him now.’ I enjoy more of the hugs and kisses ... when they’re a baby and they want that attention - you know its so cold ... I don’t think that I bonded with him - it was so obvious with Jimmy ... I was still in hospital and laying there looking at him in those little plastic cribs and I sort of thought, ‘look at his little nose and little eyes’ - and just getting over the shock of childbirth and what it does to you and I just thought I love him - you know - in the moment....I must have had the chance to bond with him because he was so good for 6 weeks.

Lea is desperate for childcare one day but her Mother-in-Law won’t help despite caring for other Grandchildren. Lea is hurt and angry.

It’s unfair - I pay her and everything. I just thought rather than get someone else in I’d rather give it to a relative... so it was just like - aahh. Later (she) said, ‘I’ve been thinking. It’s really slack that I just look after one person’s children - sure I’ll have him once a fortnight.” But I’m not doing it!

Asking is so difficult for her that an ambivalent response is intolerable. Part of her wants support but part of her is afraid of losing control.

“You’re not going to give me any help.” “I don’t need any help.” It’s a bit of that. A friend’s husband who is great with the kids offered to mind them - he meant well but... I just don’t happen to be like that. ... If children aren’t invited, we just don’t go out. We’re a family, we decided to have a family, and that’s what we are.... I can’t help it ... it was made worse by the fact that they were... very sick - I was just sooo tired... you know if someone had just got the baby up at 5.30 and let you sleep till 7.30 I’m sure I would have been ready to go another month. ... other friends would offer to come around with their children and I’d think I want that but then they’d bring their other children...

The words tumbling out passionately are a measure of Lea’s struggles with birth and infancy. So what of this pregnancy? This time no one else is pregnant with her. Friends invite her but she’s exhausted and just wants to be at home.

I feel older this time. I usually glow - don’t feel as nice this time - it may come later. I always enjoy having a belly but it’s awkward telling people. ...This one was pretty much planned. ... but I would have liked just one month later... Most people thought it was unplanned - how could anyone be so stupid to plan to have four children under 5! I think, ‘what’s the difference?’ I’m just praying that it may be a girl and won’t have the same problems... if its another boy it won’t worry me because I think there’s a reason – there’ll be a reason..

At 18 weeks, gender comes up again through a dream. They are trying for a girl.

I dreamt I had an ultrasound and it was a boy - I shouted ‘NO!’ and cried. I must have called out because John woke me and I felt upset. That scares me - this is the last one. I just never imagined going through life without a girl. I had a troubled teenage period and I swore I’d do it differently...I would like to look after grandchildren - (with in-laws) the bond’s not as strong. I’d ring my Mum not my Mother-in-law. I’m going for a scan and will check so I can prepare the family - they’re hoping for a girl. We have a name for both.
She is negotiating for house extensions.

I hate dealing with the bank when I'm pregnant - they worry. I've had experience of a bank manager not taking the woman's wage into account because she can get pregnant and go so I don't like them to know.

Lea loves work but it's stressful. She is very loyal to one work place that has kept her on through three pregnancies and recently offered her a full time management position.

A child's hernia operation confronts her again with the medical system.

I wanted to stay with the baby when he's sick. He's my child. They said 'I'll bring him to you' but by the time they called me I felt not in control - not included.

The second child has started asking questions, which is causing some discomfort for Lea in trying to explain sex and challenging things like

What do we need another baby for? - We've already got three! How do you answer that??

Lea isn't talking to the baby but feels

warm and gooey. There's something about movement at 6 months ... Till then I feel at any stage someone could show a blood test and say 'you're not pregnant.'

Lea's prophetic dream is confirmed, shattering her dreams of a mother-daughter relationship. I feel her pain as she sobs at the news of a 4th boy.

It's a major issue - it upsets me that I'm so upset about having a boy. I don't understand why I'm like this - I don't love this child any less - if someone told me I was going to have a boy I still would have had it. ... The issue is about later - missing out on something - the mother daughter images - sharing. ... There were lots of things I was going to make up for in my own mother's treatment. ... I've talked to John but not to anyone else. I'm usually a talker but the first few days I couldn't talk to anyone - even Mum. I'm usually straight on the phone but friends don't say the right thing - they don't know what to say to me. I asked John to tell friends because I might cry - like now. I don't want others to see me upset. - How will they react? A friend offered to share her child but I tend not to relate to other people's children - I don't like the way they're brought up so I tend to push them aside. If I knew someone in the same boat. Friends are saying they understand but they don't. Reassurance doesn't help. I'm avoiding friends because I don't want them to ask or talk about it. You don't know if fear will eat me for 20 years or will it be all right? I feel like a horrible person being upset about it. Comparing to a friend who lost babies and got one live baby with a defect, I feel so selfish. I should be glad (mine are) happy and healthy ... I worry about a defect in this one. Only time will help.

Grief overshadows her babies' ill health but touches my own story. I too have three boys and lost what I believe to have been a girl, in a miscarriage. Our sharing resonates beyond research.

I'm glad I know now or I'm afraid I'd be upset when the baby arrives. It'll give family and friends time to get used to the idea too. If they're upset, I don't want them to come and see him. I can see it will be more balanced - one girl is likely to be left out or be a tomboy. I don't believe it will make a difference to my relationship with the baby.

John said 'we can have another one' but I'm not interested ... It's too exhausting. He's quite OK about the boy.

I listen to the threads of meaning making and wonder if there is not a little ambivalence.
If we were going to have another, we couldn't have an odd number so we'd have to have six. ...I'm concerned that the boys won't have a girl to grow up with and gain understanding of girls — anatomy and all that.

**By 27 weeks, Lea is accepting but still selective with whom she talks.**

I just sat with it. I feel I have to remind people that we always planned four children — we weren't having an extra to get a girl. I have to justify that I'm happy. I can talk now without crying. ...I'm so conditioned now that if its a girl I'll probably say 'take it away you've ruined everything.' ...We'll never have to mow the lawn and I'll teach them to cook too.

**Her dreams are vivid and perhaps working to help her.**

I had a funny one I wanted to tell you. It's the weirdest dream — I had the baby and everything seemed fine and I was taking the baby in a capsule to show people and they were trying not to laugh and making chicken noises and I was very offended. It (the baby) looked like a chicken carcass and I knew but I felt, "can't you just overlook that?"

**She's panicking that the extensions won't be finished in time, but the biggest issue is work and the pressure around maternity leave plus the attitudes to pregnant working women. She plans to work till 2 weeks before the baby is due.**

You get comments like "it's obvious x is pregnant because she didn't do ..." I jump to the defence. Not everyone who's pregnant is... forgetful, unable to concentrate, not up to usual performance, not participating as well - basically everything (is put down to pregnancy,) I had a ding in my car and people said, "that sort of thing always happens when you're pregnant." WOMEN and their mothers say it!!

**This has led her to play down, and disguise her pregnancy.**

I'm 6 months now and people didn't notice...I wear normal clothes, big jackets, dangling scarves. I'm usually proud to wear maternity clothes. It's a shame because I wanted it to be the last one and wanted to enjoy it. I just don't want to be judged. As a teenager, I replaced a person who was pregnant and the workplace gave her paid maternity leave to get her out. ...I've been conscious when I had the boys to not have any errors..... My hours have been increased - just what I wanted more work!!

**Lea has less discomfort than before but is very tired.**

I need a holiday -- we're both exhausted -John never takes holidays .. just got to get through the next few weeks. I heard about lots of friends breaking up recently. It makes you stop and look at relationships and life. We talk about if we had difficulties - we don't think we would but no one's a saint. ...I think we always get closer when I'm pregnant

**Lea on sexuality.**

I'm more at ease with my body when I'm pregnant than at other times but it's difficult because of lower back pain. ...The first pregnancy John was very concerned about hurting the baby and was willing to try other positions to make it safer but I didn't want to... I'd rather not have it. The first I was wanting more. The second - not very interested. He thought it must be a girl because of the difference. Third - the mind wanted to but the body didn't — a bit frustrating. Now I go to bed to get comfortable. The ends of my bones seem to super glue together when I stop -- I go and go through the day. It doesn't affect the relationship because we talk. At the end of the pregnancy, I'm more interested because it stimulates labour.

**The children, though young, are getting prepared.**
I'm talking to the kids about Alexander as part of the family to prepare them ... The kids are more affectionate and interested. They give me little massages (imitate the chiropractor);

The children love spending time with their Dad

he doesn't respond to the younger ones whereas I love the baby stage, so we compliment each other.

It's 34 weeks. She's proud to be pregnant and has nesting energy.

(W)hen I get pregnant I move everything. I've been known to move pianos, fridges - I just do it. I bought paint and painted.

A chiropractor has helped with lower back pain and a third ultrasound was ordered due to concern about possible growth retardation.

It was scary for one night but it's all fine. Knowing the sex, I'm not in such a rush to have the baby. I'm more content just to be pregnant. ... I'm not as uncomfortable or irritable. I'm usually severely anaemic and need injections. ... BUT I want that final turn off. I want to get uncomfortable, not be able to sleep, get really fat legs et cetera so I wouldn't want to do it again.

The baby is 4 weeks, predictable and Lea' relaxed (Unusual says John). The birth:

YUK - if don't talk about it it'll go away. .. We realized in the last few hours that it was posterior. I've been suffering back pain since - must have a damaged coccyx or something so I'll see my chiropractor. It felt like the first birth again.

Clearly, she felt the staff thought it was her fault that the birth was so long. Though she filled in the survey form, she didn't say what she felt

I was surprised the doctor hadn't picked up that he was posterior. He'd been in the same position for a long time, then the last few days the bulge had shifted to the front. But I had a good pregnancy, so a horrible delivery helped - I wanted something to say 'don't go back and do it again' ....John is happy to stop. I'll wait and make a decision ... later. ...I want help for a couple hours per day but am afraid of becoming dependent or people seeing me - I need to be in control

Though Alexander settles into routine quickly and she feels good, Lea is hesitant to believe all will be well, but it is. Lea attaches strongly to him, having him in bed, which is a first. The family adjusts easily. She enjoys being home but returns happily to work at 3 months. At 4 months, Alexander is bottle-fed as "I lost my milk through stress".

Her relationship is threatened by an attraction between her husband and another woman. It is totally unexpected and shakes her sense of trust and serenity at a deep level. Characteristically she works to make sense of it objectively and compassionately so she can keep communicating. She says the research process helped prevent post-natal depression. Such is the power of interested, empathic listening!

BETWEEN THE LINES: The fourth boy welcomed, despite grief, into an organised world. Where is his place and presence felt?
ROWAN

The first child was conceived overseas after three operations for fibroids despite specialist advice that falling pregnant would be difficult.

I'd been told when I was about 24... "I don't want to see you back in my office in 5 years angry and upset because you had a chance to fall pregnant naturally and (didn't)!" ...I went through a really big 6 months... it really shook me up... one of those life changing events I guess... I was never desperate to have children... we were just living week by week and enjoying ourselves... we thought we'd have a go and fell pregnant first time - which was a miracle... within hours I knew I was pregnant. - (This) Pregnancy is so different... but I'm only 14 or so weeks.

It is our first meeting and the story of the first pregnancy needs to be told. A gastric upset at 5 weeks began a chain of ill health that totally drained Rowan.

I got home and collapsed in bed for a week or two... they came that close to giving me a transfusion. I totally freaked out... My parents-in-law were running the restaurant - we were running the motel. I was completely wrapped in cotton wool (and) spent about 3 months in bed. I was so ill they wouldn't let me do anything... I've always been quite independent... I was very very ill with my pregnancy... but I wasn't like brain dead.

Rowan is a compelling storyteller. Her early life, the first pregnancy and birth filled our first interview. Buzz, the dog, commanded attention while the quiet, serious product of the story moved around us warily, aloof and independent. The story flowed freely unfolding in graphic, fascinating detail a very difficult time but told with laughter and lightness. I was reminded of a stream bubbling and sparkling above a deep, strong, dangerous current.

I couldn't believe I was pregnant - even when I could feel the baby moving!... I never felt an instant bond with Laura... it was just like - here's a baby. I kept expecting someone to come in the door and say 'oh thanks for minding her.' I had no realisation that she really was mine and that I was fully responsible... it took me more than 6 months.

The first birth was long and difficult. I wondered if the process of talking about it so fully was important - debriefing perhaps? Connecting with the reality of this pregnancy? Preparing for the journey? Such clarity of detail also occurs in trauma.

I breast-fed her up until probably... about 14 months... she really didn't like the taste after I fell pregnant... Again, I fell straight away... I guess I've just started feeling more motivated this my 12th week... it's so different because - I've been nauseous the whole time unbelievably nauseous all day... I had literally some days when I couldn't put my head off the pillow.

The family is in the process of opening a restaurant and she does the books while Laura stays with her paternal Grandmother.

I'm lucky I have a choice...Whenever I thought about having children I would be staying at home - I mean why bother having kids if you still want to work?... I can see why people want to go back... it's BORING staying at home... my husband works 7 days per week... Owning your own business - it's 100% 200% commitment. My husband wanted children before we were married... he would love a football team... I don't want to go through a pregnancy (or) birth like that again but all that is softened and like the memories fade. I will be much more aware through this birth of what's happening. I had no idea when I look back... Two of my girlfriends had I guess traumatic births in some ways -like the responsibility was taken away from them...
She spoke about her fears, well grounded in the experience, however, this pregnancy feels all together different.

...I felt this baby move in the last few weeks; and I actually went to see the obstetrician last week and said ‘can I really be feeling this baby?’ But I still can’t believe I felt it - like a fluttery feeling

Rowan shared a picture of her early life - born in Canada of Australian mother and Northern Irish Protestant Father whose father died when he was three

I think I protected myself from a lot of things that happened when I was young with my Dad and Mum. We moved to Australia when I was 8 or 9... I never once saw (Mum & Dad) laughing together - not a chuckle together or even a smile - no niceties like that. I was never harmed or abused so in that respect I had a very happy childhood but emotionally I think I suffered... I can’t remember whole lots of my childhood. ... I was so happy when they finally separated (at 14 or 15 years) ... I just think he hates women that’s basically it... I probably have a better relationship with him now because I don’t let him railroad me. ... My Mum ... was agoraphobic - had a nervous breakdown ... I guess I was 2nd in command and had to take over a lot of times but looking back I can see I hated ..every minute of it but what do you do? I remember at 15 wanting to leave home so badly because then I could be my own boss. I could do what I wanted to do. I wouldn’t have to be there for my brothers ... if I’d had a Dad around ... it wouldn’t have been my responsibility. I’ve been through all that guilt and everything about both my brothers .. (one) was highly allergic to a lot of food and it would make him very angry ...He was beautiful but add the sugar add the preservatives ...and he was a psychopath - extremely bright,- extremely violent.....The youngest lost all his hair when he was about 4 or 5 - went completely bald - all his hair, eyebrows - stress related... became addicted to gambling (but he's fine now).

Tears keep welling up, surprising her, moving me, as she revisits the past. The first interview portrays a life of dual experiences lived at two levels - fun, free, very capable, independent, "very lucky". Simultaneously, full of pain and struggle with coping skills well tested and developed to keep difficulties in their place below the days full of interest, beauty, order and wonderful friendships. The incongruence between the inner world and outer presentation is striking. Throughout the pregnancy, her emotional life is a struggle. At about 20 weeks, I ask about postnatal depression.

Funny, I thought the other day, can you get PND in pregnancy? I don’t know what it feels like – am I a bit depressed? How would one know – everyone has bad days. Normal stress triggers me – pregnancy exaggerates normal reactions. My Mum suffers from depression – she’s been medicated for years and will be for the rest of her life. She hates it.

There are many good reasons for her distress, but she sees hormones as the issue.

Being pregnant, I’m not rational. My emotions are up and down a lot in the last two weeks – before I would get upset once a month – last week, every day I’ve been low...I used to paint or draw but it won’t come out – total block.

At about 5½ months pregnant Rowan feels pregnant and is “thinking a lot more about the baby and the impact on me ... reality hits – I’m more than half way there”. Rowan has only vague images of arms and legs with no features or gender and worries about how to set up the house so the baby doesn’t disturb Laura. This baby
is not passive like Laura – a nightmare child. People say it has to do with the mother or environment but it has also to do with their personality. If it's a high need baby I'd find that very stressful – I'm an independent person – I need a lot of space. It was only last month that Laura came for a cuddle – I had to initiate before.

I think I smell fear and worry about coping.

I feel like a single mother! I can't imagine what it will be like with two. I feel like putting an ad in the paper for single Mums to get together...it's so boring at home all the time.

It is a desperate theme threading through subsequent interviews. She feels alone with such a big responsibility and needs someone to share it. Even in a marriage, isolation can be profound and, worse, invisible. The risk of stating it is that the partner you love and want to protect is implicated/blamed/at fault. Friends and family are vital but too far away for the support Rowan needs. People met through Nursing Mothers give some support that increases her energy and motivation, but with her husband working extremely hard 7 days a week, Rowan's needs cannot be met. The internal battle between need, understanding and guilt explodes out in intense brief sobbing or fury, then recedes to its place just under the surface of her capacity to cope.

At every interview, busyness and the business stress Rowan who is also frustrated by Laura's stubborn refusal to talk.

Thirty-one weeks.

My father in law has cancer and he's had a very big operation. Friday and Saturday I couldn't sleep. It's silly but I saw myself at the funeral... I've known him since I was 13. I got furious instantly – when Jonathan told me I said how long has he had discomfort or pain and done nothing about it. I was furious!

She talks in detail struggling to make sense of it.

Jonathan is terrified of hospitals – he won't go to see his father – he's got terrible memories of his father being in hospital.

Visiting maternity won't be a problem because there's a different smell and feeling.

Apart from that (father-in-law's cancer) I've been pretty down these last few weeks... I was here by myself with the news and I really got the shits – I was upset as well – and had nobody here – just to be here; just to have some company. I was really, really lonely and that sounds stupid. I do have one or two friends here. My phone bill is going to be really huge – ringing (city friends) and overseas to my Dad.

At 31 weeks, the baby is strongly present though the stress takes her attention away.

I keep thinking my waters are breaking now the pressure is so bad. Laura never gave me this much grief. I just don't have the room in there like this belly's just so rock hard all the time. This baby kicks me constantly – I think it's just got the shits. A really active baby like a basket-baller in there... You shouldn't do this to me baby... it moves and moves and moves... there's already a personality in there – I know it'll come out screaming. I never thought about Laura... this is much more real, it feels high and low - spikey... (!) can see a baby blob thing – a being – I didn't have even this with Laura... perhaps I'm thinking more because I can compare... I never felt Laura at night... this one wakes me. It just doesn't seem to stop - I swear it has more than two hands and feet. It rolls around and tumbles - everything is going at the same time.
She doesn't want to be pregnant any longer.

I really want to have this baby!! I never got like this with Laura - part of that was probably denial of the fact that I was pregnant (she laughed). ... Even when my belly was out to here I did not think I was having a baby. ... somewhere deep down I think I was absolutely terrified. I know I’ll have a whole different set of problems when the baby is born but nothing like what I’m feeling now. Work was easier, you had a routine, 2 days off when you could sleep in. It's not the life I lead now! Laura doesn’t want anyone to touch me. I pushed her away – that’s horrible but I just couldn’t stand it – just me and a toddler. I thought I’d be too busy to be lonely but there’s only so much housework you can do. I know its part of the job but I just feel ‘stuff it!’ if Jonathan was at home he could take her.

The repercussions of the cancer continued over the months with more operations, her mother-in-law unable to care for Laura, her partner away. Rowan is trying to protect Jonathan from her feelings but he came home to find her sobbing and upset.

I felt so bad that I did it to him - He’s probably hanging by a thread himself you know. Laura can go 3-4 days and not see him at all. ... there are things he wants (big house, boat et cetera) I’ve got everything I need– I just want him home- just 1 day a week would be nice at the moment.... but I just can’t say that to him at the moment I just can’t. I’ve told him I’ll go in and help. It wouldn’t be really satisfying but at least I’d see him. When the baby’s born, he’ll probably have a couple days off.

Rowan is glad that Jonathan still finds her sexually attractive at 33 weeks.

The first 8 weeks of pregnancy is a strange phenomenon for me – I was out of control having it all the time; then morning sickness takes any sexual thoughts away; near the end it’s impractical and uncomfortable.

Rowan is so sensitive to everybody’s needs that it seems to make it harder for her to stand for herself without lashings of guilt.

On top of the most horrible news we could get (which was the cancer), we got the most fantastic news which is my mother’s getting married. ...in the same Church that Jonathan & I got married in which is really sweet. .. I really needed her when I found out about Jim’s cancer but disappointed that I couldn’t really celebrate her news.

Someone calls telling me that Rowan is in a city hospital. A 1.6kg baby boy was born a month premature. I meet Joe, perfectly formed and tiny at 3 weeks. A very traumatic story unfolds. An ultrasound revealed a very distressed baby. They IMMEDIATELY went to a city hospital for an emergency caesarean.

I got to see the top of his head that was all. I thought I was only there for 1/2 hr but I was in theatre another 2 hours because of the fibroids. ...poor Jonathan ... he was very very stressed out about the whole thing... Inside of the uterus was like a cobbled stone road - there was no viable uterine wall. ... They stole all that blood that Joe should have been getting. ... I didn’t feel like I’d had a baby.... I really wanted to see him so badly.

It was a very stressful time. Rowan struggles to recall little details – exact days, times, as if trying still to get a grasp of the experience and events. She recalls feeling totally overwhelmed by the medical staff though appreciating their helpfulness. Rowan was desperate to go home and frustrated that they thought she shouldn’t. Rowan felt her intuitions were not trusted or respected.
They were so much stronger and sure of themselves – it was easy to doubt oneself and give up. It took a long time to get over the birth with Laura and I felt I never wanted to have more kids; this pregnancy was different – more energy; doing more... but after I had him, I thought, ‘I want another baby’... and then being told I couldn’t.

The intensity of it all shines through her voice and expression. There is anger at the fibroids, at not being able to see him, at her intuitions and desires being ignored by staff. Rowan had wanted to have the baby in the small local hospital with familiar people and surroundings. Her ideal was shattered culminating in a feeling of powerlessness and lack of control. A sense of detachment and unreality is a perpetual undercurrent in these postnatal interviews.

By six weeks, struggles with mastitis, not getting out of the house, a nagging fear that he may have been damaged by the deprivation in utero have not overwhelmed her basic calm and at 4 months, she is coping well.

It’s not as bad as I’d anticipated – the pregnancy was MUCH worse. I’ve not seen Jonathan much at all but it’s not bothering me. I had a bad day the other day... just one of those days when you wake up with the grumps, but apart from that I’ve been fine...I’m doing things differently...not so fussy as with Laura – more laid back...

Many months after the last interview we meet unexpectedly at the Family Support playgroup. She jumps up and gives me a big, lingering hug.

I’ve been thinking to ring you to tell you to put a post-script to my story.

In private she pours it out - deep post natal depression; admission to a mental health unit for 1 month: struggling to stay above the darkness even with medication. The feelings of total rejection to Laura frightened and horrified her.

It takes me by surprise – I can be feeling fine and then suddenly I’m a mess, crying, overwhelmed. I don’t feel ready to be alone but I have to be.

A year later Rowan drops in with some things left over from a collection she and a friend organised in response to the children of East Timor. She continues to battle depression. She reads her story.

I can’t believe how I sounded ... and how I hold the emotions about the family. It’s irrational. Before you become a parent you don’t think about your own parents – they’re just there. Then you become a parent – it’s a big wake up call. Hormones were raging but its NOT just that. I’ve not talked to anyone about what it brings up from childhood.

BETWEEN THE LINES: The fibroids are symbolic of the intense distress, lack of support, pains from the past that intrude in this prenatal relationship. Will attachment be delayed as with her first child?
Chapter 5  RESULTS and DISCUSSION

The extension of memory and learning into the natal and prenatal period of our development awakens us to previously unthinkable possibilities for prenatal communication, stimulation, modeling and bonding. Formal research on prenatal stimulation already confirms the important rewards that are available when the minds of babies and the minds of parents meet before birth or even before conception (Chamberlain, 1988, p 211).

This chapter presents 1) The development of the prenatal relationship, and 2) the supports and stresses that had potential to affect prenatal relating and the prenate.

1. DEVELOPMENT OF THE PRENATAL RELATIONSHIP

From a content analysis of participants' baby-related comments (see appendix G) five themes emerged. As I listed them the continuous nature of each theme became clear. A schema was the easiest way to present and make sense of the complex, fluid and non-linear facets of prenatal relating.

a. THE SCHEMA:

<table>
<thead>
<tr>
<th>AWARENESS</th>
<th>WEAK</th>
<th>MODERATE</th>
<th>STRONG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy ignored; unreal; rarely noticed; infants occur in dreams;</td>
<td>External events, symptoms; movement, ultrasound lead to knowing; awareness has quality of detachment or is intellectual; Not fully experienced</td>
<td>feels presence, movement, heart beat; baby in mind; realization it is, will be a baby; awareness is more personal, closer, deeper</td>
<td></td>
</tr>
<tr>
<td>ASRIPTION</td>
<td>Knows there's something there but no ascription; or vague, generalized ascription</td>
<td>Imagine physical, gender, emotional, or personality characteristics;</td>
<td>Imagine the foetus as a being with separate identity, capacity and intent;</td>
</tr>
<tr>
<td>CONNECTION</td>
<td>Disconnected; may imagine the preborn but no sense of involvement or responsibility</td>
<td>Aware preborn is/will affect own life; knows actions affect foetus. Indications of a link between self, focus or future child. General thinking about names; emotional energy attached to the awareness</td>
<td>Name given; Change behaviour for baby's sake; realization of a being coming into life; act to prepare for birth, for baby, for role of parent. Intense identification as mother - positive or negative</td>
</tr>
<tr>
<td>INTERACTION</td>
<td>No interaction or awareness of preborn as interactive; own life and issues dominate; no space for relationship</td>
<td>Recognize capacity of preborn to communicate, respond, intrude; imagining future interaction with real being; one sided communication occasionally</td>
<td>Interacts often with prenate through thought, talk, touch, song, - positive &amp; negative; Sees responsiveness as 2-way; change behaviour in response to an imagined communication from foetus; accepts/rejects foetus</td>
</tr>
<tr>
<td>SOCIAL PRESENCE</td>
<td>Pregnancy a totally private matter; foetus not acknowledged in wider network</td>
<td>Family or friends recognize &amp; react to the pregnancy; woman sees as propam or mother-to-be; recognition that baby will affect parents' relationships.</td>
<td>Focust has presence in family - part of conversation; direct interactions between it and partner, siblings, extended network; preparations to accommodate the child socially</td>
</tr>
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Following is an explanation and discussion of each continuum illustrated by the data.

i. NON-AWARENESS to AWARENESS

Some level of awareness of the other is a precursor to relationship. The women came to know that the foetus was there initially through physical symptoms (except for Rowan who 'just knew' she was pregnant) or tests. The first months of pregnancy (and falling in

134 Facets are the sides of a many sided body or gem and seemed to be the closest representation of relating.
love) are usually characterized by somatic symptoms, heightened sensitivity, sickness and vulnerability which break the boundaries of self and enable openness to embrace, merge, become attached and bonded to the other. When the women read back over their stories nearly 2 years later, what had been extremely significant then seemed insignificant now. Many couldn’t believe how sensitive and emotional they had been.

WEAK AWARENESS: All the women knew they were pregnant at the first interview, but for some, it was unreal. Dreams, being a more unconscious and temporary phenomenon, are located low on the awareness spectrum. Seven of the women reported dreams of the baby, two at four months or under; five from 5 months on.

MODERATE AWARENESS: Theoretical, general awareness about the foetus and its capacity came from external sources such as books, ultrasounds, being given something for the baby, childbirth classes and through the interest of other children. The foetus, not just the pregnancy, was mentioned.

STRONG AWARENESS: As awareness became stronger, the mother would report thinking about the baby, feeling its presence emotionally or spiritually. Hearing the heart beat and feeling movements were significant markers in moving toward more personalized awareness, though not for all. Sometimes, as the pregnancy progressed, early awareness ebbed and the baby was not mentioned. Kylie became more focussed on herself when stress was high, despite living in a residential setting where her awareness of the realities of birth and parenting increased. Stress inhibits relating (Cranley, 1981a, Stainton, 1990).

Stainton (1990) found four coexisting levels of cognitive and sensory awareness of their foetus in mothers during the third trimester of pregnancy. These emerged in this study and fit into two cells of the schema (figure 5.1). Stainton’s “awareness of the infant as an idea” is in low to moderate awareness; “awareness as a presence”, and “awareness of specific behaviour” fit in strong awareness; “awareness of the infant’s interactive ability” belongs in this schema to strong ascription. Consistent with Stainton’s (1990) findings, quickening triggered increased awareness which increased naming, personalised language. Participants rarely used the word ‘foetus’.

Awareness, like unconscious processes, has power to affect behaviour and indicates that these processes are coming to consciousness (Chamberlain, 1987, 1998; Papousek & Papousek, 1997; Ornish, 1998; See chapters 1 & 2).

ii. NON ASCRIPTION TO ASCRIPTION

Once there is awareness, the mother may begin to imaginatively construct what the baby is like. This is a form of projection, which, according to Dunphy (personal communication 28.9.00) is the process that underlies all identification and relationship.

It is through projective identification that we come to understand others, make sense of their similarities and then differences and thus relate to people.

Ascription described by others (Condon, 1985; Cranley, 1981a & b; Stainton, 1990:) has sub-elements. Gottlieb (cited Carter-Jessop & Keller 1987) found mothers moved from
identifying characteristics to complex descriptions of how the baby would be. Robson & Moss (cited Carter-Jessop & Keller 1987) found mothers became more personal, specific and feeling in their descriptions of the newborn.

WEAK ASCRPTION: Mothers spoke about babies in general or wondered vaguely about this baby, but made no specific ascriptions.

MODERATE ASCRPTION: Early ascriptions seemed to come out of hopes or fears and knowledge about foetal capacities. Kylie wanted her baby to have blue eyes and not look like its father. Several mentioned the capacity to hear. Imaginings are like stronger hypotheses and related specifically to this particular baby. Joanna decided the baby was emotionally strong of necessity, because of the stress she (Joanna) was going through.

STRONG ASCRPTION: The baby is described as a separate being with identity and capacity for intent. Alyson said 'it's trying to get comfortable'. The teen Mums saw the baby as responsible for their discomfort late in the pregnancy. "I vomit because the baby is saying it doesn't like what I've eaten," said Kylie.

Until we know another, and this applies particularly in pregnancy where the 'other' is invisible, we build a bridge starting from our own identity. This is projected onto others - Kylie and Abbey both thought the baby would be like them and made few other ascriptions. When that projection is shown to be 'wrong' (that others stubbornly persist in being themselves) then we begin to see their identity as separate (sometimes likeable and sometimes not). If there are rigid projections held despite contrary feedback, then projection becomes a problem. If projections, ascriptions, representations are adapted with feedback of difference, then healthy relating builds. Karen notes

Slade has found a need for control typical among the anxious mothers she has studied thus far. It has sometimes shown up in rigid ideas about whether they wanted to have a boy or a girl. 'It's another example of how these kids don't have much autonomy, even before they're born. You should be a boy, you should do this, you should do that - the baby doesn't really have a chance to come out and be heard and listened to and be seen. The secure mothers have much more curiously about who the baby's going to be. They bring the past into their expectations, too, but they do it in more flexible ways' (1994, p367).

Lea's grief at the loss of her ideal (girl) baby helped her accept the boy she was to bear.

Internal representation (Zeanah, 1993; Stern, 1995; Bowlby 1979a & b:) is another way of expressing this aspect of the developing relationship.

The conviction that the mother's representations can influence how she acts with her infant is as old as folk psychology ... The represented baby has a long prenatal history. As the fetus grows and develops in the mother's uterus, the represented baby undergoes a parallel development in her mind ... the networks of schemas about the fetus develop under the influence of psychic and social factors as well as biological ones. (Stern, 1995, Pp 20-23)

He notes, with Piantelli (1992) that, at about four months, movement and ultrasound pictures make the baby-to-be more real with a corresponding 'leap in richness and specificity of the maternal representation of her fetus-as-infant.'
In this study, attributions tended to correspond with frequent or intense movement. From strong movements, Beth thought s/he would be more outgoing than her firstborn. However, this is not always the journey. Kate’s negative image of motherhood made her determined not to obsess, preventing her from paying attention to the baby inside even after feeling movement.

It appears harder for first time mothers to imagine a baby. Rebecca, Kate, Kylie and Abbey all pictured an older child and made few ascriptions. Beth, on the other hand, spent a lot of time comparing and contrasting to her previous pregnancy, trying to make sense of the similarities and differences (Cranley, 1981a). Margaret and Joanna were inclined to ‘wait and see’, even late in the pregnancy. They were all secure in and accepting of their identity as ‘mother’ and any ascriptions they did make were tentative. Perhaps this was a way to identify but not project TOO much and thus leave the child free to be itself (Minde, 1993; Tracey, 1994). Lea and Beth accurately dreamed the gender and colouring respectively. Lea, Kate, Rebecca and Charly made almost no ascriptions and appeared less connected.

This continuum describes the process of moving from general, non-specific awareness of the foetus through an understanding of specific characteristics to the realization that she has a separate individual capable of intention inside her.

iii. DISCONNECTED to CONNECTED

As the baby is identified as having particularity, the possibility of a connection arises.

This continuum is difficult to describe. If you take a moment, you will draw on your own experiences of that mysterious sense of connectedness or non-connectedness - those moments in nature or in relationships when non-connectedness slips into connectedness and out again. It is a subjective feeling of being plugged in, independent of tangible interaction. It is like having a computer with Internet access. You are not always connected but you know when you are, because the little world on the screen turns around or your modem makes it’s own distinctive sounds. It is also like the profound experience of oneness with the universe experienced in meditation momentarily (or more continuously by the mystic). This continuum describes the process in which the mother connects with the foetus. The baby’s presence is real and she changes.

There appear to be several aspects indicating connection. Connecting....

* To self as I (personal): the foetus is felt to be part of the self; she realizes her life will be affected and changed; the baby’s presence motivates behaviour change; birth becomes more real and becomes a marker of change – before and after birth.

* To self as mother (role): She realizes that she will be a parent and begins to prepare for birth and parenting. This brings positive, negative or ambivalent feelings about motherhood and herself in the role.

* To infant as separate being (other): She prepares for the presence of the baby in her life; the process of naming begins. Her behaviour changes out of concern for the baby.
I have taken comments from all three as indicators of connection.

LOW CONNECTION: Though aware and perhaps imagining the foetus, the mother can remain emotionally disconnected. Indicators of disconnection include dis-identification as a mother; no action or response to the awareness of pregnancy; focus on existing attachments, lifestyle, stresses so that the baby does not feature. Joanna and Beth both spoke of ‘blocking’ the baby or ‘not wanting to get too attached’ due to current stress or a recent miscarriage – they were aware of the foetus as a separate entity but could not allow themselves to connect. Kate was so afraid of obsessing and becoming like other mothers whose behaviour she didn’t like, that she appeared detached—holding back from connecting with the baby both pre and postnatally.

MODERATE CONNECTION: There is a growing awareness that her life will change, that the baby will have an impact on her, that her behaviour affects the baby, that they are linked in some way, that there will be a relationship between them. It is more than an intellectual understanding—emotional energy attaches to this awareness.

STRONG CONNECTION: Participants who were intellectually aware of pregnancy, birth, parenting operated differently once they connected emotionally to the process—they expressed more feeling, reality and personal responsibility and behaviour changed. Alyson commented at 5 months “Movement brings the realization that I have a baby and am responsible.” Kate read a story about a woman jumping out of a car to escape abduction and suddenly realized that, being seven months pregnant she could not do that now. She began to move with more caution, becoming inward and protective. Beth stopped smoking as soon as she thought she was pregnant. For Abbey and Kylie they knew intellectually that smoking affected the baby early on but it was not until about eight months that, though unsuccessful, they intensified their efforts to give up.

The process of naming the baby indicated that a connection was being made. There are levels to the naming process: thinking about or choosing names generally; choosing a specific name or nickname for this baby. Some people would use the word ‘baby’ as if it were a name. To my knowledge, four people did not choose a name during pregnancy. Three appeared to be less connected. Joanna was sad that, unlike previously, she did not have a nickname for this one. Choosing a name early seemed to be more a name she liked than an indicator of connection.

As with each continuum, there is potentially a positive and negative face to connectedness. The sense of responsibility can be picked up with pride (Alyson) or with resentment (Abbey — I don’t care about the effect on the baby!) Identification as a mother can be embraced (Anna) or rejected (Kate). Current life stresses, the needs of other children, work, strong physical symptoms, held Charly, Joanna and Margaret’s attention. For others, such as Rebecca, anxiety about the birth and her capacity to parent would sometimes push the baby out of mind. Fonagy et al, (1992) found that infants were more likely to be secure at 12 and 18 months postpartum if their mothers were self-
reflective and able to identify psychological states in pregnancy, which demonstrates the power of connecting (Slade, cited Karen, 1994 see below).

iv. NON-INTERACTION to INTERACTION

From a sense of having some connection with a separate other, the potential for interaction may arise. Winnicott concluded (cited in Karen, 1994, p 373) that secure attachment develops out of the child’s confidence that the parent will respond accurately and appropriately to its emotional and mental states. The parent’s projections and attributions give way to the accurate perception of the Being before them. Stern’s description applies prenatally

The interaction is the bridge between the parent’s and the infant’s representations. ...the parent filters and regulates the growing but still limited traffic with the world external to direct parent-infant interactions...pathogenic influences can arise from anywhere, but they will impact on the baby only to the extent that they influence the privileged caregiving dyad or triad (1995, P59 & 60).

In pregnancy what the mother experiences affects the baby through both her physiological response and directly through the baby’s own sensory apparatus. Piantelli’s work (1992) shows that, though apparently subject to the same experience, twins can have differential sensitivity and responsiveness in the womb.

LOW INTERACTION: Non-interaction is indicated when there is no awareness that the foetus is a being capable of interaction; when the mother’s own life and issues dominate leaving no space for actual interaction or relationship with the foetus. She may be detached from the movement or activity of the foetus with no sense that she or the baby can respond to, or moderate each other’s behaviour or feeling. She may feel she just has to suffer symptoms caused by the pregnancy rather than respond or make sense of them from the baby’s perspective. Rowan and Charly, consumed by other issues, paid little attention to the baby directly and rarely reported interaction with it.

MODERATE INTERACTION: includes recognition of the prenat’s capacity to communicate or respond to mother. Some imagined future interactions with a real baby or child. “I’ll love it even if it’s not like me” said Kylie. They may attribute intent, including negative intent, to the baby and have a feeling or behavioural response. Abbey feels the foetus is interfering with her life. She may find herself relating what’s happening in her life to the baby. Rebecca wondered what effect her job would have on the baby. “What does it think of me when I yell at the other children?” wondered Alyson.

STRONG INTERACTION: Here there is actual interaction with the foetus through talk, touch, song, thought. “It responds when I talk to it in my mind” said Joanna. Movement is seen as a specific communication from the baby. Margaret said her baby let her know it was uncomfortable. Some women spent time touching their stomach to soothe the baby. They may recognize a sensitive, reciprocal responsiveness between themselves

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and the foetus. Rebecca: ‘it knows when I need a rest’. They may change their behaviour, not out of a general belief, but specifically in response to a communication attributed to the foetus. Alyson: “It kicks before meals saying ‘feed me’”. Interaction can be rejecting as well as accepting. Abbey interacted by shouting at the preborn. Beth and Alyson, who both identified strongly as mothers, attributed personhood and interaction earlier in the pregnancy. Charly was very ambivalent about being a mother and gave no signs of interacting.

We know that babies learn in the womb. Postnatally, mothers who are excited and love being with the baby are more responsive and their babies are more likely to develop more secure attachments (Beulah Warren, personal communication, November 2000).

This continuum describes the way the mother and foetus interact with intention. It involves an endeavour to make shared meaning. Others recognize this spectrum of behaviour as part of pre and postnatal bonding.136

v. ISOLATION to SOCIAL PRESENCE

The relationship is not just between mother and infant but also has a wider community context indicated by actions such as introducing the baby by showing ultrasound pictures. This appeared to give the preborn a presence in the family and community. The research process gave the participants regular time to focus on and talk about self, the pregnancy, the baby and thus played a part in giving the baby a social presence.

LOW COMMUNITY PRESENCE: Women may be quite private about their ‘state’, especially early in the pregnancy, going on as if not pregnant. Joanna couldn’t share it until her partner had accepted the pregnancy. Charly had few people with whom to share. Lea was disappointed that, though this was to be her last pregnancy, she could not show her pride at work and dressed to hide it. Kate was distressed about looking unattractive at a wedding and was determined to go on as normal with family and friends, though happy to share the pregnancy with her partner. With a lot of distracting stress, (Charly, Rowan and sometimes Margaret), the baby seemed to be there for the ride but not in the action directly.

MODERATE COMMUNITY PRESENCE: Being pregnant can attract interest and sharing (sometimes of the horror story variety) from other women. In contrast, Abbey and Kylie, the teenagers, felt judged and ostracized by complete strangers as it became obvious they were pregnant. Support by family and friends for the pregnancy and a wider welcoming of the baby into the mother’s world were important and had implications for the woman’s changing identity. It took Rebecca some time to speak about her pregnancy. The enthusiasm of relatives and friends enabled her to embrace it. Rebecca (very reluctantly) and Kylie had a baby ritual or shower which acknowledged the baby in their social network.

In most families there were references to 'after (or before) the baby is born thus making the birth a reference point in the family story.

**STRONG COMMUNITY PRESENCE:** As time passes, the baby becomes a presence beyond the confines of the womb and part of the woman's wider social world. Partners and siblings interact directly with the baby. Children's questions and interest in seeing, touching, talking to the baby serve to amplify it's presence in the family. The baby featured frequently in family conversations for Margaret, Alyson, Beth and Lea. Rebecca was amazed at her ability to accept people touching her stomach, which she assumed she would experience as intrusive being, by nature and experience, a very private person. Later in the pregnancy, nine of the eleven women had to make adjustments in what they could do. This forced some, but not all, to ask for, or accept help. Kate and Charly tried to continue working and living as if not pregnant. Does the secure mother allow and encourage siblings, partner and others to relate to the infant directly? Does the insecure mother stop this? Raphael-Leff's (1991, 1993) distinction between facilitating and regulating mothers would support this. (Also Slade, cited Karen, 1994 see below).

This continuum describes how the prenat features in the world beyond the womb. It can be totally internal with the mother living as if not pregnant. It may, through the acknowledgment of mother's and others, become part of her social world. Fathers, siblings, family and friends (even strangers) can interact directly, and thus form their own relationship with the baby.

These then are the working 'definitions' or ideas behind the categories in the schema. Peer review, narrative or content analysis would refine and strengthen the definitions. Though a useful preliminary guide for service provision, the schema will need further validation if used as an assessment or research tool, however, it presents a more encompassing schema than previous work.\(^{137}\) Awareness, ascription, connection, interaction and social presence are continua which reflect the complexity of the development of the prenatal relationship and may contribute to further understanding of the origins of ambivalent and anxious attachments. These aspects of prenatal relating can provide indicators and guiding questions that women and clinicians can ask in order to tailor the supports and skills needed to optimize prenatal relating. I stress they are not discrete or mutually exclusive but attempt to capture the rich, complex process of prenatal relating. Women move back, forward, round through the cells of this schema as the process of attachment waxes and wanes, grows and is refined through a mutually reinforcing system of awareness, ascription, connection and interaction. It does not represent a linear process, (Stainton, 1990) but is, rather, part of the process of projective identification in which attributions are adjusted through reality checking and feedback. Making meaning of life experience is a process involving awareness, assumption (attribution), projective identification (or connection) and interaction in which confirming or disconfirming

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feedback (hopefully) refines the initial assumptions. The terms 'attunement'\textsuperscript{138} and 'good enough' parenting\textsuperscript{139} are general terms for similar processes.

Please note:

1. The themes identified and discussed attempt to go beyond the behavioural to qualities of experience, feelings and attitudes, and are subjectively assessed. (Condon & Corkingdale's Maternal Antenatal Attachment Scale (1998) has a similar intention.)

2. While there may be a logical progression in the relationships, it is NOT a linear process nor have I tried to oversimplify or force data into discrete attributes.

3. Women can potentially occupy each spot. In this sample, it appeared that women did sometimes miss or stay stuck in a position.

4. There are both 'positive' and 'negative' aspects of each element. For example, liking or disliking certain qualities both indicate ascription has taken place; strong acceptance or strong rejection of motherhood both indicate connection; Swearing at or crooning to the foetus both indicate interaction.

5. The schema does not adequately reflect the circular, back and forth movement that is the nature of these findings (Stainton, 1990).

There are many factors influencing this dynamic fluid system of prenatal relating. Outer life events, the women's inner life, the life of the foetus, all play into the forming, dispersing, changing quality of the prenatal relationship.\textsuperscript{140} The women moved rapidly from month to month between the different elements which, at times, co-existed within the one interview. The schema, used over the course of the pregnancy, has a better chance of capturing this movement and the complex nature of the prenatal relationship than single measures or measures at one point in time. This schema should not be relied on too heavily, nor used to judge as healthy or pathological a woman's capacity to form a relationship with the foetus.

No single theory adequately explains women's adjustments during the transition to parenthood. Thus, it is not useful to rely on simple outcome measures collected at one time point to assess women's adjustment (Parr, 1996, p165).

Ultrasound pictures and now videos, must affect the process of prenatal relating.\textsuperscript{141}


\textsuperscript{139} Winnicott, date unknown and also cited Karen, 1994.


\textsuperscript{141} A word about ultrasounds and active imagination: Kent notes that "imaging technology aids diagnosis and has served to identify the foetus as a 'new patient (subject) distinct from its mother" (Her brackets, 2000, p 7) and "extended the techniques of surveillance applied to the mother and therefore the scope of influence and control that obstetricians had over the mother and baby". (P 21). "The foetus could not be taken seriously as long as he (sic) remained a medical recluse in an opaque womb; and it was not until the last half of this century that the prying eye of the ultrasonogram rendered the once opaque womb transparent, stripping the veil of mystery from the
b. LINKS TO ATTACHMENT

Technically, the term 'attachment' refers to the nature of the child's relationship to caregivers, (the child attaches, the parent bonds). In common language, however, attachment refers to affectional ties and was sometimes the best word to describe the relating process. Chapter two presented knowledge of the prenatals capacities and individuality which indicate that prenatal relating is not a one sided process. The part played by the prenatals was outside the scope of this study except as revealed through the mother's perception.

Are there parallel processes of relating in pregnancy, postnatal attachment or falling in love? Bowlby considers attachment of child-to-parent to be

a complex array of relationship seeking patterns like babbling, looking and listening – that are enriched and developed by the responses they receive from the environment...to Bowlby attachment was much closer to the idea of love, if not identical with it (Karen 1994 p90).

Condon and Corkingdale (1998) liken the qualities of parent to infant attachment (or love) to those reflected in adult love. After developing the above schema, I discovered Ainsworth's five stages of postnatal attachment (Karen 1994, p137) which describe aspects of relating that approximate those of my schema, thus lending confirmation of the similarity between pre and post natal relating. The context of postnatal attachment and prenatal relating and the capacity of the child to move in space, are the main differences.

AINSWORTH'S 5 STAGES OF ATTACHMENT and BARTLETT'S SCHEMA

1. Undiscriminating stage in which there is little response from the newborn. This is like the unaware/disconnected spots in the schema.

2. Differential response in which the infant shows preference for the mother. This parallels the pregnant woman's increasing awareness, capacity for attribution and connection to her specific baby not just the pregnancy or babies in general.

3. The infant is able to respond from a distance to the mother's leaving. The foetus has become a separate identity, imagined, named with characteristics attributed to it. The
mother senses the baby as an entity/identity beyond the movement of the moment and is connected to it even when busy about other things.

4. Active initiative in which the baby follows, approaches, greets others. Here the mother is relating and interacting with the foetus that has become a being with the capacity for intent, agency, interaction and relationship.

5. The child shows anxiety with strangers and has become aware of the social context. The other side of selective clinging is a capacity for discrimination and belonging. The foetus becomes part of the extended family in the day to day interactions of mother and others. This can be reflected in the mother's clinging to the pregnancy not wanting it to end, feeling close/attached. "I'll miss my tummy," said Abbey. The wish to have the baby out may indicate a desire to have the baby in the world beyond the womb - part of the family (and/or an end to the strains of pregnancy).

The similarity between the descriptions of these five phases support the possibility that prenatal relating and postnatal attachment are similar processes, and part of a single continuum. For some, though, the jury is still out. The operational definitions of bonding and the available tools are not up to measuring love as it crosses the threshold of birth. Ainsworth notes

Because of the diversity of attachment behaviour and its differential arousal in different situations, there can be no simple criterion of attachment (1969, p1005).

Condon (1985) found that reported relationship feelings did not correlate with relationship behaviours - they appear to be independent variables. He criticises previous work for not separating the mother's attitudes to pregnancy from attitudes to the foetus, which don't correlate and confuse assessment. This is an important point. I have avoided this problem in the development of this schema by analysing comments about the baby specifically. Comments about the pregnancy can indicate that the process of relating (as described in this study) is beginning as awareness and so are included as indicators on the awareness continuum. This schema describes more fully the quality of each phase or aspect that makes up 'relating' on the basis of the women's lived experience - their own feelings and behavioural descriptions. Behaviour is not separated from feelings.

Role identification did emerge as an indicator of and factor in connection. Some women embraced the role and images of motherhood, while others struggled with or rejected them. It seemed to me that, either way, both indicated that a connection to motherhood is developing. I also felt from these women that awareness of and connection to the presence of the foetus was the precursor to facing motherhood. Hence role identification was included as part of the process of prenatal relating. Attitudes to motherhood could also be a source of stress or support to the women during the pregnancy

\(^{142}\) Cranley, 1981a, 1992; Muller, 1996; Fava Vizziello, 1993; Condon, 1985, see chapter 2.

\(^{143}\) Raphael-Leff, 1991, 1993; Fava Vizziello, 1993; Ammaniti, 1992
independent of their feelings to the pregnancy or the baby. Alyson found the pregnancy hard but had strong (positive) attitudes about motherhood.

c. THE SCHEMA IN PRACTICE

Pregnancy can be a very difficult time psychologically for women (Parr, 1996). The schema can assist women and the service providers to understand more about a mother’s prenatal relating and illuminate patterns to aid individual women in making the transition. This is not a diagnostic tool – the definitions are not mutually exclusive or refined; there is inadequate understanding of the implications of the different ways of relating. It may also assist development of policy, allocation of resources, clinical decisions.

Let’s use the schema in relation to two participants (table 5.2 & 5.3) - one with less difficulty and one with more difficulty (see table 5.13 for rank ordering of difficulty).

**Case Study 1 - Beth Relating**

The pregnancy is certainly wanted but a recent miscarriage stops her embracing it until she’s sure she won’t miscarry again. There is no ambivalence. In other ways she has responded to the pregnancy quickly - stopped smoking immediately, went to the doctor at 8 weeks, felt the heart at 14 weeks and is thinking about how her child will react to a new baby. She always wanted to be a parent, preferring to be at home for this baby. She is very aware of the foetus, ascribes personality, physical features and intent, and interacts. The baby quickly becomes part of the family conversation and both her son and partner interact directly with the baby. She references her first pregnancy frequently to understand this one. Physically it is a more difficult pregnancy with some worries about the baby, but she has more confidence generally. Moving house, illness, and partner’s changes of job and unemployment were hard but overall she was very relaxed about the pregnancy and the birth. Money worries were the main stress. She and the family had a strong relationship with the baby despite less time to sit and think about it. She wasn’t depressed at the end but sick of waiting and wanting it out.

**4 months pregnant**: blocking connection until risk of miscarriage passes. Feels a natural parent and actively seeking information.

**5 months**: baby becoming part of the family through her conversation and direct interactions. She feels it’s presence and ascribes personality (more outgoing) and physical features (dark curly hair and big brown eyes) as well as its intent “to let me know its here.” She talks but doesn’t name the baby but definitely feel its there. She likes to share her positive experience to counter the many horror stories about pregnancy and birth. Baby is constantly moving; didn’t find out gender but, as the pregnancy is different, she thinks it may be a girl.

**6 months**: talking to baby more; starting to prepare the house, clothes. Will work until 3 weeks before the baby is due. She feels relaxed despite knowing she’ll have less freedom. Very worried about risk to baby of another child’s illness and her possible kidney infection. Reads about the pregnancy and is quite knowledgeable. Morning sickness is passing - she
feels good being pregnant and that she’s starting to glow. Her intention is to stop work at least until the baby is 10 months old. She’s not worried about the birth and will just go with what happens.

7 months: looking forward to having the baby - just wants it to be healthy. No specific images except different personality to her other child. More focus on preparing for the baby and the labour. Have to move house so hope it doesn’t come early.

8 months: left work with relief but very tired from move. Preparing son for baby’s arrival - he thinks it is a boy. Baby is breach - hopes it turns.

9 months: no time to sit and think about the baby as with the first. Wonder about having two children, about the baby’s personality, no picture in mind beginning to think it’s a boy. Very ready and wishing for the birth.

| Table 5.2: BETH’S PRENATAL RELATING |
|-----------------------|-------------------|-------------------|
|                      | WEAK              | MODERATE          |
| AWARENESS            | 2 mths – visits Doctor; | 5 mths – feels presence |
| ASCRIATION           | 6 mths – few ascriptions | 5 mths – character and intent |
| CONNECTION           | 4 mths – block connection - fear of miscarriage | Stop smoking immediately; strong identification as mother throughout |
| INTERACTION          |                   | 5 mths – direct interaction; it lets me know it’s here |
| SOCIAL PRESENCE      |                   | 5 mths on - Part of family |

**Case Study 2 - Charly Relating**

The pregnancy came just as she had taken a step to get back to her art work and was overshadowed by depression, phobias, relationship stress, inability to find a sense of connection to place, loss of her independence, culture, creative work and support of family and friends. There were only two interviews (Charly went overseas). Awareness of the pregnancy was reduced, detachment and lack of connection were evident. Comments indicated awareness that the baby could be affected and expressing concern for the baby. There was no speculation about the post birth child just a wish that it would be easy. After the first trimester, she indicated that the pregnancy was physically easy.

4 months pregnant: little connection to the baby; tests cause fears for the baby’s wellbeing and a comment that ‘you love them despite their difficulty.’ She is concerned about how her first child will adjust. The first months had been very difficult - no motivation or energy like chronic fatigue. She spoke about not bonding with her first child until the baby made eye contact and responded at several months old.

8 months: lot of movement and ‘sticking out everywhere’ - physically she is fine. She felt happy and well for the three months in her native country. Back in Australia and struggling with great emotional pain and intense vulnerability. She says “I hope it doesn’t affect the pregnancy or baby too much.” Little connection to the pregnancy - “I forget about it except when I can’t lie down” but the movement is new and fascinating and the baby gets hiccups. Not wanting to think about the birth and thinks it’s a myth about all these preparations and needing so much - things will take their course. There is little evidence of awareness,
ascription, connection, interaction or social connection. She seems detached but not rejecting. Charly enters the postnatal relationship from a weak position thus risking repetition of the delayed bonding experienced with her first child.

<table>
<thead>
<tr>
<th>Table 5.3: CHARLY'S PRENATAL RELATING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WEAK</strong></td>
</tr>
<tr>
<td>AWARENESS 8 mths – I forget about it except when can’t lie down,</td>
</tr>
<tr>
<td>ASRIPTION few ascriptions</td>
</tr>
<tr>
<td>CONNECTION Throughout; does little to prepare; identifies self as artist;</td>
</tr>
<tr>
<td>INTERACTION No evidence of direct interaction</td>
</tr>
<tr>
<td>SOCIAL PRESENCE No evidence of anyone else interacting</td>
</tr>
<tr>
<td><strong>MODERATE</strong></td>
</tr>
<tr>
<td>8 mths – Lot of movement and sticking out; fascinated by movement</td>
</tr>
<tr>
<td><strong>STRONG</strong></td>
</tr>
<tr>
<td>8 mths – hope emotions don’t affect baby</td>
</tr>
</tbody>
</table>

In the case studies I have walked through the process. Following I place the other women on the schema, without the detail, to demonstrate the variety of processes involved in prenatal relating. The first three, plus Beth, comprise the low risk group (see table 5.13) and with the exception of Kate, relate most strongly.

**Alyson’s Relating:**

Alyson related strongly on all facets of the schema. She had support and relatively few stresses until later in the pregnancy. She strongly identified as a mother and had a well developed ability to make meaning of her life, placing her in the low stress, strong relating group.

<table>
<thead>
<tr>
<th>Table 5.4: ALYSON’S PRENATAL RELATING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WEAK</strong></td>
</tr>
<tr>
<td>AWARENESS Strong identification with pregnancy and desire for child from beginning</td>
</tr>
<tr>
<td>ASRIPTION 7 mths – it responds; separate identity &amp; agency; 9 mths pregnant will be active in its own birth;</td>
</tr>
<tr>
<td>CONNECTION Positive identification as mother; 5 mths – feels responsibility; 7 mths – special bond; preparations begin; 9mths totally prepared;</td>
</tr>
<tr>
<td>INTERACTION 7 mths interacts directly and frequently.</td>
</tr>
<tr>
<td>SOCIAL PRESENCE Partner and Children interact directly; part of family.</td>
</tr>
</tbody>
</table>

**Kate’s Relating:**

Kate has least stress, a totally supportive partner and network (though not locally) and a capacity to make meaning. Though happily pregnant for the first time, ambivalence about motherhood keeps her detached, which reflects in an awareness that, though strong, involves low ascription, interaction, social presence and moderate connection. Uniquely she is in the low risk, low relating group.
### Table 5.5: Kate’s Prenatal Relating

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Weak</th>
<th>Moderate</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td>Pregnancy played down</td>
<td>4 mths gift raised awareness; excited</td>
<td>7 mths aware pregnancy limits her; Focus on birth and parenting</td>
</tr>
<tr>
<td>Ascription</td>
<td>Will be a “perfect child”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connection</td>
<td>Generally seemed detached and</td>
<td>Start preparing 5 months; imagines future connection; Planning how to</td>
<td>7 mths: little more inward &amp; protective to focus; negative identification to motherhood</td>
</tr>
<tr>
<td></td>
<td>determined not to obsess or let baby</td>
<td>prevent baby affecting friendships;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>interfere</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interaction</td>
<td>Little interaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Presence</td>
<td>Pregnancy is very private; avoids</td>
<td>Shared with partner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>acknowledging foetus in wider network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Lea’s Relating:**

Lea is strongly aware and moderately connected. She is low on ascription and interaction, and split on social presence – strong within the family but low outside it. Work, three small children, inadequate support, a history of postnatal depression and distress about the loss of a future daughter distract her. Acceptance of motherhood, her own personal strength and a good relationship support her. Risk and relationship are moderate.

### Table 5.6: Lea’s Prenatal Relating

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Weak</th>
<th>Moderate</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td></td>
<td></td>
<td>experience as mother prompts strong awareness of pregnancy and foetus;</td>
</tr>
<tr>
<td>Ascription</td>
<td>Few ascriptions but at 3 mths</td>
<td>5 mths; Ultrasound confirms gender; boys are easy;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>expects she’ll get to know baby;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connection</td>
<td>3 mths – not connected but expects it</td>
<td>3 mths: Names for boy or girl;</td>
<td>6 mths Name chosen; prepares; Positive identification as mother; grief re gender;</td>
</tr>
<tr>
<td></td>
<td>to come;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interaction</td>
<td>Little direct interaction reported;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>busy; preoccupied with work and other</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>children;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Presence</td>
<td>Dresses to hide pregnancy; grief re</td>
<td></td>
<td>4 mths on: Part of family conversation; siblings interact directly;</td>
</tr>
<tr>
<td></td>
<td>gender blocks social presence; no</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>pregnant friends;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Margaret’s Relating:**

Margaret has a strong and early awareness and connection, with moderate ascription, interaction and social presence. Severe financial stress and only moderate support affect her emotionally despite an accepting adaptable attitude. She is low risk, moderate relating.

### Table 5.7: Margaret’s Prenatal Relating

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Weak</th>
<th>Moderate</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td></td>
<td></td>
<td>4 mths Feels movement; imagine it as a person; tuned into baby not just pregnancy</td>
</tr>
<tr>
<td>Ascription</td>
<td>Few ascriptions overall; wait and see</td>
<td>4 mths person like its brother; recognised a separate individual with</td>
<td></td>
</tr>
<tr>
<td></td>
<td>what its like</td>
<td>general capacities;</td>
<td>6 mths – responds to music;</td>
</tr>
<tr>
<td>Connection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interaction</td>
<td>Financial stress and needs of other</td>
<td>Recognize capacity of newborn but doesn’t interact directly very much</td>
<td>Positive identification as mother; correctly intuits a girl; despite distractions seems quite connected with</td>
</tr>
<tr>
<td></td>
<td>child occupy her</td>
<td></td>
<td>pronate, parenting &amp; motherhood</td>
</tr>
<tr>
<td>Social Presence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shared with partner and sibling &amp;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>friends in NMAA;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Rebecca’s Relating:
For Rebecca (first time mother) awareness was moderate but connection and social presence steadily grew strong. Ascription was low. She interacted moderately but without a sense of mutuality. She struggled intellectually with images of motherhood but showed strong warmth and commitment to it. Childhood and current family issues and stresses (especially work) placed her in the moderate risk and relating group.

<table>
<thead>
<tr>
<th>Table 5.8: REBECCA’S PREGNATAL RELATING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WEAK</strong></td>
</tr>
<tr>
<td>AWARENESS</td>
</tr>
<tr>
<td>ASCRIPTION</td>
</tr>
<tr>
<td>CONNECTION</td>
</tr>
<tr>
<td>INTERACTION</td>
</tr>
<tr>
<td>SOCIAL PRESENCE</td>
</tr>
</tbody>
</table>

Joanna’s Relating:
Strong awareness, sibling interest and positive identification as a mother are important for her prenatal relating which is blocked by intense early distress, relationship difficulties and continuous busy-ness. This is reflected in few ascriptions, and weak interaction and connection until the very end of the pregnancy when they suddenly strengthen. Social presence is moderate (strong with the children, weak elsewhere). Moderate risk with low relating until right at the end of the pregnancy when it becomes strong.

<table>
<thead>
<tr>
<th>Table 5.9: JOANNA’S PREGNATAL RELATING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WEAK</strong></td>
</tr>
<tr>
<td>AWARENESS</td>
</tr>
<tr>
<td>ASCRIPITION</td>
</tr>
<tr>
<td>CONNECTION</td>
</tr>
<tr>
<td>INTERACTION</td>
</tr>
<tr>
<td>SOCIAL PRESENCE</td>
</tr>
</tbody>
</table>

Kylie’s Relating: In ways Kylie’s awareness and connection were strong but with a fantacised, unreal quality thus moderating them. Interaction and social presence were weak. Ascription was generally weak moving to moderate. Her very difficult history, situation and emotional state limited her ability to relate despite a very strong desire to be a good mother. She lacked support and was part of the high stress group with fluctuating but overall moderate relating.
### Table 5.10: KYLIE’S PRENATAL RELATING

<table>
<thead>
<tr>
<th></th>
<th>WEAK</th>
<th>MODERATE</th>
<th>STRONG</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWARENESS</td>
<td>There is an air of idealised fantasy tempering awareness</td>
<td>3 mths: aware of foetus and its potential; seems very aware of the pregnancy;</td>
<td></td>
</tr>
<tr>
<td>ASCRIPTION</td>
<td>5 mths – general attributions; generally few ascriptions</td>
<td>3 mths imagine older child; 7 mths emotional &amp; physical characteristics attributed</td>
<td>6 mths – one comment attributes agency to foetus;</td>
</tr>
<tr>
<td>CONNECTION</td>
<td>Ambivalent re motherhood; wants to be a good mother; 5 mths worries re capacity to parent &amp; affect on her life;</td>
<td></td>
<td>5 mths Name given; 6 mths – it feels what I feel; 8 mths begins to try to stop smoking; eat better</td>
</tr>
<tr>
<td>INTERACTION</td>
<td>3 mths aware of possibility of interaction; Fears and emotional distress re lack of mother’s support dominate as pregnancy progresses; Early interaction fades</td>
<td>5 mths – talks to preborn; 6 mths – aware of pregant’s capacity &amp; that her behaviour can soothe the preborn but little interaction for most of the pregnancy.</td>
<td></td>
</tr>
<tr>
<td>SOCIAL PRESENCE</td>
<td>Lack of mother’s support and isolation limit social presence.</td>
<td>Shared in residential House; Negative social judgement</td>
<td></td>
</tr>
</tbody>
</table>

**Rowan’s Relating:**
Rowan had early and strong awareness, generally weak ascription, interaction and social presence with moderate connection. Though happy about the unplanned pregnancy, she is ambivalent about motherhood, worried about the effect of the fibroids and wants an end to the pregnancy. Great emotional distress, lack of felt support, past painful history leave little space for prenatal relating placing her in the high stress, low relating group.

### Table 5.11: ROWAN’S PRENATAL RELATING

<table>
<thead>
<tr>
<th></th>
<th>WEAK</th>
<th>MODERATE</th>
<th>STRONG</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWARENESS</td>
<td></td>
<td>4mths: just ‘knew’ that pregnant; strong awareness throughout</td>
<td></td>
</tr>
<tr>
<td>ASCRIPTION</td>
<td>6mths Vague arms &amp; legs but no features; few ascriptions made</td>
<td>6 mths: a nightmare child; 7mths- strong personality in there</td>
<td></td>
</tr>
<tr>
<td>CONNECTION</td>
<td>5 mths: enough to be pregnant; don’t want to get too close to it.</td>
<td>Though anticipate difficulties wants baby out &amp; pregnancy to end</td>
<td>4mths on worry re health of foetus; 8mths: pack bag.</td>
</tr>
<tr>
<td>INTERACTION</td>
<td>own life and issues dominate; no space for relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOCIAL PRESENCE</td>
<td>few indications of wider social presence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Abbey’s Relating:** In ways Abbey seemed strongly aware of the prenate but made few ascriptions, or concessions to its presence. She was rejecting, interacting to express her frustration rather than to connect or relate, though the strength of her negative reactions indicate moderate connection and interaction. Social presence was weak. Her severe depression, isolation and ambivalence were very high risk. Relating varied: weak but moderate at times.
Table 5.12: ABBEY’S PRENATAL RELATING

<table>
<thead>
<tr>
<th></th>
<th>WEAK</th>
<th>MODERATE</th>
<th>STRONG</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWARENESS</td>
<td>5 mths - Pregnancy is unreal</td>
<td>3 mths Awareness through symptoms and effect of pregnancy on her life; many mixed feelings; 7 mths wants birth over and her life back;</td>
<td>Awareness of pregnancy and foetus</td>
</tr>
<tr>
<td>ASRIPTION</td>
<td>Generalized ascriptions; Attitude like me;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONNECTION</td>
<td>Mixed sense of responsibility; grief &amp; depression limit connection to prenate; spoke of a name she liked;</td>
<td>Spoke re parenting older child; afraid of effect on life; 5 mths knows re need to stop smoking, reduce caffeine; ambivalent re wanting the baby; ambivalent re motherhood</td>
<td>9 mths tried to stop smoking</td>
</tr>
<tr>
<td>INTERACTION</td>
<td>Little interaction</td>
<td>Recognize capacity of preborn; often swears at prenate &amp; hits stomach; 9 mths aware baby moves more if she drinks coffee.</td>
<td></td>
</tr>
<tr>
<td>SOCIAL PRESENCE</td>
<td>Mother &amp; some friends involved in pregnancy but no direct interaction; negative social judgement; rejection by father of baby; shares with few people</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There are marked individual differences in prenatal relating and the schema is one tool to assist women and clinicians develop understanding of the processes involved. As the trend for an inverse relationship between stress and prenatal relating is supported, it may be helpful to identify women’s strengths and challenges. Reducing stress and increasing support during pregnancy is in the best interests of child, family and society.

2. SUPPORT, STRESS AND PRENATAL RELATING

This section presents these women’s experiences of support and stress. I collated the responses to questions 1 - 6 from the final interview administered 4 months post partum (see appendix F). In addition, I reviewed the stress events and supports raised in prenatal interviews. I had to draw on my own observations and subjective understanding of the broad stories to penetrate apparent inconsistencies (van Manen, 1990; Putnam et al, 1995). For example, seven women acknowledged the support of partners throughout the pregnancy but only Lea, Margaret and Alyson mentioned partners retrospectively as supports. Please recall that this study aims to retain complex descriptions which future work may explore (see appendices H, I, J for overview of what these women found helpful, unhelpful and what was desired). I ranked each family according to my subjective, global understanding of their situation, then independently on specific key indicators. The rank order altered slightly but the women remained in the high, medium and low stress groups (see table 5.13). While adequate as a guide for this preliminary work stronger measures and independent raters are necessary to take it further. Trends support the link between stress or support and prenatal relating. Alyson, Beth and Margaret (low stress group) related most to their prenate. Charly, Abbey and Rowan (high stress group) related least.
Table 5.13: ESTIMATE OF THE BALANCE BETWEEN STRESS AND SUPPORT

<table>
<thead>
<tr>
<th></th>
<th>Work*</th>
<th>Anxiety+</th>
<th>emotion</th>
<th>#Stress a, b</th>
<th>#Prime relationship</th>
<th>Identity as mother</th>
<th>support</th>
<th>score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth</td>
<td>1</td>
<td>2</td>
<td>1 Low</td>
<td>3 (1)</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Alyson</td>
<td>4</td>
<td>3</td>
<td>1 Low</td>
<td>4 (5)</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Kate</td>
<td>2</td>
<td>4</td>
<td>1 Low</td>
<td>1 (2)</td>
<td>1</td>
<td>4 amb</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Margaret</td>
<td>3</td>
<td>3</td>
<td>1 Low</td>
<td>5 (4)</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Lea</td>
<td>3</td>
<td>4</td>
<td>2 Low</td>
<td>4 (3)</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Rebecca</td>
<td>6</td>
<td>5</td>
<td>2 Low</td>
<td>3 na</td>
<td>2</td>
<td>5 amb</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Joanna</td>
<td>6</td>
<td>3</td>
<td>3 med</td>
<td>6 (6)</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>Charly</td>
<td>6</td>
<td>5</td>
<td>4 med</td>
<td>5 (3)</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>36</td>
</tr>
<tr>
<td>Kylie</td>
<td>2</td>
<td>6</td>
<td>6 high</td>
<td>6 (6)</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>37</td>
</tr>
<tr>
<td>Rowan</td>
<td>5</td>
<td>4</td>
<td>6 High</td>
<td>6 (6)</td>
<td>6</td>
<td>5 amb</td>
<td>6</td>
<td>38</td>
</tr>
<tr>
<td>Abbey</td>
<td>5</td>
<td>6</td>
<td>6 High</td>
<td>6 (4)</td>
<td>6</td>
<td>6 amb</td>
<td>6</td>
<td>41</td>
</tr>
</tbody>
</table>

* Study, paid work.
+ Emotion is split into anxiety (worried, phobia, expressed anxiety) and depression (down, overwhelm, distress, despair) – used PND scale (see table 5.20); narratives: observation of distress or happiness.
^ Stress level: assessed from narrative; ratings that were completed; events reported; checked against postnatal rating of pregnancy stress. a = researcher's assessment; b = retrospective assessment by participant at 4 months.
# Quality of relationship assessed from narratives re relationship difficulty & question re feeling single.

The impact of stress and importance of social support for people’s physical and emotional health is well documented.\(^{144}\) The mother’s emotional well being impacts directly on the foetus’s development and will influence her capacity to form a relationship pre and postnatally.\(^{145}\) The capacity for attunement facilitates secure infant attachment.\(^{146}\) Beckwith and Belsky (cited, Beckwith, 1990) describe a dynamic between parental support and parenting applicable to the prenatal relationship.\(^{147}\)

The determinants of parenting can be examined within three domains:
1. The parent’s own history and personal psychological resources
2. Contextual sources of stress and support
3. The child’s characteristics...

Belsky argues that parental history and personality are the most influential determinants because they not only affect parenting directly but they indirectly determine the quality of support the parent receives through... the selection of a spouse, the maintenance of stable friends, work and its satisfaction, and the quality of the relationships with others (Beckwith, 1990, p 55).

The stories (chapter 4) present the history and personality of these mothers. Following is a summary of factors that influenced their capacity to attune to their prenate. Primarily

\(^{144}\) Ornish, 1998; Seligman, 1990; Parr, 1996; Oakley et al, 1990; Cochran & Woolever, 1988
I will focus on sources of stress and support that emerged from the experiences of these women and is supported by the literature.

3. FACTORS INFLUENCING STRESS AND SUPPORT

This section will discuss key factors that affected the mother's capacity to relate to the prenate:

- Whether the pregnancy was planned or wanted (Raphael-Leff, 1993)
- The mother's childhood and relationship with her own mother
- Support from key sources - partner, extended family, friends
- Community resources including practical, information and medical services
- Current emotional state and significant life stresses including work, finances, home and mobility, other events
- Emotional well being including depression and anxiety which could be cause or consequence
- The impact of the research process itself

a. MOTHER'S CHILDHOOD AND ATTACHMENT

This study supports Fraiberg's notion that 'ghosts in the nursery' (1974) can block a parent's capacity to be aware of and responsive to their infant and foetus. From the initial data and the time lines, I was able to identify a range of specific events that potentially influenced participant's relating: Adoption; Indigenous heritage (a mother in one family and a father in another); Non English Speaking Background; separation and divorce; drug and alcohol addictions; trauma including fatal fire, abuse and sexual assault; domestic violence; severe family dysfunction or stress that resulted in symptoms in the research participant or their siblings; homelessness; major physical ill health; life threatening accidents; near death experience; depression in self or family; self harm; eating disorder.

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149 Parr, 1996; Oakley et al, 1990; Cranley, 1981a & b; Gau, 1996
151 Field, 1995; Parker, 1995; Egeland & Erickson, 1990
154 Raphael-Leff, 1993; Piontelli, 1992; Condon, 1997; Earnshaw, 1987; Biringen, 1994
The mother's security of attachment predicts fairly reliably the attachment status of the infant. Slade found that despite the usual difficulties, secure mothers are more open to the pregnancy and able to remain balanced and positive. Also the secure women had already begun a relationship with their unborn babies, had nicknames for them, and felt pleasure and fulfillment in imagining what their babies were like (Karen, 1994, p 367).

While I did not assess the security of attachment of the mothers, and could not correlate backgrounds, levels of anxiety, and ways of relating to their unborn child, there were clear differences. No doubt, attachment status is a contributing factor, (Main & Hesse, 1990; Main et al 1985) but current life circumstances were critical. For example, Joanna had nicknames and "happy hormones" in her first two pregnancies and believed that having a nickname related to the process of bonding. This time however, she did not have 'enough emotional space to be caught up with names - a shame really.' Her own attachment status would not account for this differential response between pregnancies. It was the stress of her current situation not her attachment pattern that blocked her relating. Kylie and Abbey had the most disturbed relationship with their mothers and were in the high stress group.

b. PREGNANCY PLANNED OR ACCEPTED

Table 5.14 summarizes both parents attitudes to the pregnancy - whether it was planned, wanted or at least accepted and issues raised around the conception. Charly, Kylie, Rowan and Abbey (high stress group) had unplanned or unwanted pregnancies - strong correlation. Joanna wanted the pregnancy but her partner took time to accept it and she was top of the medium stress group.

Joanna considered a termination if there were congenital abnormalities. Kylie let me know when she had finally decided against termination. Abbey said she and her mother didn't believe in terminations but she considered surrendering her baby. All others said they had not considered a termination even fleetingly.

Abbey and Kylie, the teenage Mums, did not plan pregnancy, were doing it tough and were very ambivalent about being pregnant and becoming mothers. Rebecca and Kate, (first timers) though happy to be pregnant struggled with and were ambivalent about motherhood. Beth wanted the pregnancy but a recent miscarriage 'blocked' her from embracing it until she was reassured by the doctor that she was unlikely to miscarry again. Charly had just gained an agreement that she could recommence her work when she found she was pregnant. She accepted the situation but struggled with relationship difficulties, the conflict between motherhood and work, and her isolation from family and friends. She had no sense of place in Australia - being a migrant was a major issue limiting her capacity to delight in the pregnancy. There is a correlation between those who did not plan the

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pregnancy (Charly, Kylie, Rowan and Abbey), high stress and reduced prenatal relating (Condon, 1997; Chamberlain, 1998).  

Beth, Alyson, Kate, Margaret, Lea and their partners planned and wanted the pregnancy and rank, in that order in the low difficulty group. Alyson, Beth and Margaret related most strongly to their preborn. Abbey, Rowan, Kylie and Charly, the high stress group, did not plan the pregnancy. Charly and Abbey related less to the prenate as did Joanna whose partner did not want the pregnancy. Kylie at times idealized the pregnancy though not always wanting it and did relate moderately as did Rowan who was happily surprised to be pregnant. This study supports the link between wanting the pregnancy and prenatal relating.

<table>
<thead>
<tr>
<th>Table 5.14: WISH FOR AND ACCEPTANCE OF CONCEPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned</td>
</tr>
<tr>
<td>Mo</td>
</tr>
<tr>
<td>Beth</td>
</tr>
<tr>
<td>Alyson</td>
</tr>
<tr>
<td>Kate</td>
</tr>
<tr>
<td>Margaret</td>
</tr>
<tr>
<td>Lea</td>
</tr>
<tr>
<td>Rebecca</td>
</tr>
<tr>
<td>Joanna</td>
</tr>
<tr>
<td>Charly</td>
</tr>
<tr>
<td>Kylie</td>
</tr>
<tr>
<td>Rowan</td>
</tr>
<tr>
<td>Abbey</td>
</tr>
</tbody>
</table>

C. SUPPORT

Love and intimacy are at a root of what makes us sick and what makes us well, what causes sadness and what brings happiness, what makes us suffer and what leads to healing. If a new drug had the same impact, virtually every doctor in the country would be recommending it for their patient. It would be malpractice not to prescribe it. (Olmish, 1998 p3)

Lack of social support is a critical issue for women and men (Parr, 1996), affecting the transition to parenthood and the social construction of the baby.  

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156 Condon (1997 p169) found a correlation between attachment and planning as did Chamberlain: "Planned infants showed higher levels of cognitive capacity and attachment to their mothers than did the unplanned infants, as shown by vocal responses to mothers (versus a female stranger) ... (s)tatistics for the 8000 women revealed that babies of unwanted pregnancies had two and a half times the risk of death in the first twenty-eight days of life compared to the babies from wanted pregnancies" (1998, p209-210).
Participants mentioned support at most interviews. Each woman said what would help her through the pregnancy. These ideas indicate what makes for a more child and family friendly community and thus facilitative of strong parent–foetal relating (see p190).

Social and practical support from partner, extended family (especially mother or father), friends (especially those pregnant or parenting) were important. All saw support as helpful even those who were unsupported. Charly, anticipating little support in Australia, was glad she was self-reliant. Her severe anxiety and depression disappeared when she was in her homeland with family and friends. Her mother’s rejection frequently distressed Kylie, and Abbey felt alone with her situation. Work and family illness robbed Rowan of much needed support. Joanna was relieved, happier and felt supported when her partner accepted the pregnancy. Sachs et al (1999) found that depression was more likely with higher everyday stress and low social support and recommended social and practical support (e.g. childcare) which is consistent with what women wanted in this study.

The significance of external events depends on the subjective experience and meaning for the participants (Condon and Corkingdale, 1998; Young–Eisendrath, 1996; Bass & Davis, 1990). The objective, medical criteria used to assess maternity care and birth outcomes are often very different to the subjective experiences of women159 and confirmed in this work (see medical section below). Consistent with other literature,160 perceived or felt support is more useful than assessing the number of supports. Condon (1997) notes that the level of perceived social support from the partner and others is correlated with quality and intensity of attachment. Parr’s (1996, p45) distinction between ‘emotionally sustaining behaviour’ such as listening, intimacy, concern, and ‘support aimed at problem solving’ helps illuminate these findings and the experiences of women in this study.

Results from this study support Carter–Jessop & Keller, (1987) finding of a correlation between support and increased interaction with, and attachment to the foetus. Those with less support related less (Charly, Rowan, Abbey, Kylie). Kate (invested in being detached) related less. She reported being very well supported but was often left alone because her partner worked, and friends and family lived out of area. Alyson, Beth & Margaret related

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158 “Lack of emotional support constitutes perhaps the most significant factor in a woman’s vulnerability to the stresses of pregnancy and motherhood” (Raphael-Leff, 1993, p204). Hodnett (2000) concluded from his review of fourteen studies that support had no impact on medical birth outcomes, despite acknowledging that “studies consistently show a relationship between social disadvantage and low birth weight ... Some improvements in immediate psychosocial outcomes were found in individual trials.” “The link between poverty and low birth weight babies, Oakley argues is ignored by policy makers who “consistently define the problem in biological rather than social terms” (Kent, 2000, p25).

159 Oakley, 1993 Kent, 2000; Roberts, 1992; Parr, 1996.

strongly and were supported most. Rebecca felt supported but struggled with ambivalence, work stress and anxiety, which enable moderate relating.

I support Parr's (1996) criticism that some of the literature ignores family as the prime source of support and tends to pathologize the need for it, thus making women feel guilty about, or undeserving of, support indicated clearly by Lea and Alyson's stories.

i. Partners

Tom's the only thing that's helped me keep my sanity. It would have been a total nightmare if he was a womanizer or not communicating (Margaret).

Practical assistance, the quality of communication and the emotional relationship were important elements in partner support. Charly, Kylie, Abbey and Rowan who did not have partner support ranked most distressed and struggled to cope. There was an inverse relationship between strong partner support and stress level (see table 5.13). Cranley (1981a) reports that marital relationship correlates highly with foetal attachment. Charly, Abbey, Rowan and Joanna had relationship stress and (except Joanna) were in the low relating group. Joanna's distress was very high until her partner got work. The relationship to partner and prenatal improved. Alyson, Kate and Margaret related strongly to partner and prenatal.

Difficulties in the prime relationship dominated interviews even in the face of other stresses and were accompanied by emotion. Her father in law's cancer was a major stress for Rowan but lack of support to cope brought strong emotional expression. With great feeling she said

I feel like a single Mum!

Where there was stability in the prime relationship, specific stresses came into sharper relief. Lea surprised herself at the depth of tears on finding out she was having a boy but the support of her partner helped her to resolution.

ii. Extended Family

Extended family, especially mothers (or fathers if there was conflict with the mother) were important in assisting practically and emotionally. All the women spoke about their mothers through the pregnancy even if ambivalently.

Rebecca was surprised to find herself early in the pregnancy longing to be near her mother, though difficulty made her prefer her sister as birth supporter. She did discover different sides of her mother and father through being pregnant. Alyson felt supported by her father more than her mother. Charly was happy, energetic without anxiety or depression when she went home to country, family and friends.

For Kylie and Abbey, who had no partner, the longing for their mother's support was intense. Kylie was "over the moon" that her mother attended the birth, temporarily forgetting the intense hurt and despair at her mother's disinterest through the pregnancy and long, painful history of rejection. Kylie got support from her sister and brother in law
and the youth workers. She travelled a couple hours by train to visit the workers at the refuge until it became too difficult. Abbey spoke frequently about what Mum thought or said despite being unable to share feelings and left to do a lot of the housework and meals.

For those separated from parents, in-laws were important though more for practical help. It upset Lea and Margaret that in-laws would not assist with childcare. Rowan unfortunately lost this support when her father in law had cancer.

iii. Friends featured strongly, again either because they were there and valued or because they were painfully lacking. It was the enthusiasm and excitement of friends that helped Rebecca own and begin to embrace the pregnancy. Support was critical in changing Kylie’s ideas about a termination. Being with young pregnant women at the House, though difficult at times, helped her prepare. The young mums were isolated and felt judged. Other young people were forbidden to associate with Abbey, increasing isolation - a key to her’s and Charly’s sadness. Though visitors were stressful (sometimes rated 4/5) for Rowan, she longed for more contact with friends. Hence “I have a huge telephone bill,“ and her suggestion to other mothers to “meet other mums and have a good old whinge.”

All the women, except Joanna and Charly expressed need for contact with pregnant women which prenatal classes facilitated for those lacking pregnant family or friends. Friends and work colleagues without children were more difficult (Parr, 1996) especially for first time mothers whose support networks are often childless. Kate was particularly concerned about the impact of a baby on her friendship network and was determined to keep the pregnancy and the baby in the background. Lea, sadly, could not be proud about her pregnancy at work.

Why does social support work? Social support enables the processing of events and feelings: increases capacity or confidence to assertively go for what one needs; creates opportunity to reality check with others (eg Lea, Beth comparing experiences); gets people out and involved; enables distraction, fun, fulfilment; affirms and validates

Oakley says that it works because women acquire ‘a heightened assertiveness’ and are able to secure the help they feel they need and the most appropriate care (Cited in Kent, 2000, p 26).

Kent doubts that women are free from the social view of what they need, thus socially constructing their wants.

iv. Community Resources

Informal networks seem more essential for the mother’s emotional well being than formal ones (Parr, 1996) but community facilities were helpful.

The best source of support is Mums at Playgroup (Beth).

Rowan was depressed and in retrospect knew she needed to go out more. Nursing Mothers was a good support for Rowan and Margaret: Abbey valued the Young Mums group and Kylie the weekly prenatal classes at the House. Aqua-aerobics was good but hard for parents to access at 5.30pm. Community facilities were not always child friendly and Kate
became passionately aware of access issues for mothers and people with disabilities after trying to get around with a pram. Lea added

you just imagine that I've got these three and I'm doing the grocery shopping and one of them needs to go to the toilet all of a sudden - there's no toilets in Coles - so what do you do? Ask someone to watch the baby while you run the toddler down?... need child sized basins - you can't lift a toddler when you're pregnant. ... Breast feeding facilities are NOT GOOD...I'm NOT going to the mothers' room. It's a glorified toilet - smells of nappies and urine, ... stressful trying to find somewhere to feed - car is hot and dangerous....I'd like to open a mother friendly coffee shop.

Physical changes made ordinary activities more difficult for many of the women.
Joanna: the floor is further away to pick up toys
Alyson: it takes an hour to vacuum!!

Most participants spoke passionately of practical help, especially childcare, housework, shopping and transport, with some passion. Similarly most expressed a wish for nurturing, pampering, massage, and, by majority vote, rest! (especially as the pregnancy progressed and for those with children and working) plus time alone!

I'm an independent person - I need a lot of space (Rowan).

However, Charly built window screens and a stone wall just before going into labour.

Live in housekeepers with massage skills could be overworked (and under paid) if these eleven women are any guide to the market. This child and family unfriendly society significantly stressed these eleven women.

d. INFORMATION:

Participants sought information from various sources. Parr's (1996) participants favoured written material over that from health professionals or prenatal classes. Cranley (1981b) found women sought information from Doctors or other women. Participants in this study favoured other mothers, especially other pregnant women but there were significant individual differences indicating the need for multi-marketing strategies if pregnant people are to be well informed. Beth relied on written material though wanting information from the medical profession. She was sensitive to long waits at the doctor's so felt there wasn't time to talk. She recommended a helpline staffed by people who had counselling skills and medical knowledge.

The prenatal and refresher classes, especially videos, had an impact on the first time parents. Kylie found the weekly Young Mums class and talking about all kinds of issues such as domestic violence very helpful. Seeing other mothers in the House increased her awareness of what she was in for as a mother. Alyson and Joanna both expressed concern about new mothers in prenatal classes hearing 'horror stories'. The young parents would not attend the regular classes - they felt odd having no partner and stared at for being young. Reassurance, linked to information, was important for first timers but also those who had fears about miscarriage or foetal health. They could draw on past experience and compare pregnancies and in utero behaviour. This contributed to increased confidence.
Improvements suggested: Information oriented to fathers; a clear training manual; special classes for single and young mothers; greater focus on the emotional/mental side of pregnancy and parenting (Parr, 1996).

e. MEDICAL SERVICES

were the most accessible but mentioned by nine participants as unhelpful (see appendix J). Perhaps this confirms Parr’s findings that support from health professionals was generally less important than from other sources.

Support from health professionals was rated as more available and helpful after childbirth than was the case in pregnancy (1996, p 159).

This group of people reflected issues in the literature\textsuperscript{161} including lack of communication and time, feeling stupid, not understood, unheard or a lack of power.

My GP was not understanding of my need to be sure that the baby was alright ...not supportive of me having tests (Joanna).

Six people felt the doctors did not listen to, empathize with or communicate well with them. Abbey refused to go back. She was upset by

having a doctor touch you like that ... he didn’t explain

I observed this silence and lack of communication at her birth. Doctors who were approachable, gave information and reassurance were valued over those who were uncommunicative. Joanna and Rebecca both wanted a midwife clinic and a less medical approach.

The midwife does the basic check but you do your own urine sample and records. I like that – it’s a less medical approach (Rebecca).

Rebecca travelled out of area to a birth centre and midwifery care to avoid going to a doctor. Joanna considered a home birth but was too isolated geographically.

Some women accessed resources discriminately. Kate chose a female General Practitioner who was non-interventionist. Four of the five who had severe back problems used alternative practitioners – chiropractor, osteopath, naturopath, yoga. Joanna and Charly were very worried about the health of their babies and struggled with the decision (Phoenix at al 1991) to have an amniocentesis. Joanna got more information from her Doctor; Charly from a playgroup mother. Joanna and Kate (both nurses) were able to use their knowledge to advocate for themselves and access information not generally available. Joanna (third time Mum) was more critical of the system and more selective than Kate (first timer).

Those experienced in the Health system assessed the service more broadly. Kate felt the anaesthetist was a critical player and was upset that she couldn’t meet him/her.

Knowing that the booking in procedure included a “psychosocial assessment” intended to screen for post natal depression, Joanna said the depersonalized approach was inappropriate and suggested options. Several women wanted more flexibility such as alternative booking in times because waiting for forty minutes during a thirty-minute lunch break is difficult. Beth wanted access to people with counselling and medical knowledge.

For several of the women, the doctor’s word was their unquestioning guide. At times I had to restrain myself from suggesting other options or trying to encourage more assertiveness. Beth could not embrace the pregnancy until the doctor said the risk of a miscarriage was past.

f. CURRENT LIFE STRESSES

Each month I left a record sheet (see appendix D) for both mother and father to complete. Completions were irregular - mothers were often too busy. The interviews thus became the primary source of data but records gave additional validation. Following is an overview of the types of situations that affected these pregnant women. It is important to reiterate that some of the women, on reading their stories, could not believe how vulnerable and sensitive they had been. I read this as an important warning that pregnancy is a highly vulnerable time making ordinary events harder to manage (Brown et al, 1994; Parr, 1996). Sixty percent of Parr's low risk sample reported stressful events in pregnancy causing anxiety and isolation in the transition to parenthood. This raises questions about the expectations of society (and women themselves) that women should keep functioning as if they were not pregnant, more vulnerable or emotional (discussed in chapter 1). The debate (difficult to raise) gets caught up with issues such as a woman's rights to work, the low social value of motherhood, the fear of going back to the kitchen bare foot and pregnant. Being such emotive and difficult social issues, society medicalises and medicates the individual and enshrines an unhelpful split between sociological and psychological analysis in a medical model.

Awareness of social causes of dis-ease (social work theory) is growing (Mustard 1998c, 2000) but colonised by the medical system. For example, specialists in psychosocial assessments (4 year trained Social Workers) are being replaced by Nurses, (briefly ‘trained’ to do ‘psycho-social screening’) so they can refer for medical intervention. Joanna found this process most unsatisfactory. Perhaps the difference in my social assessment and the results of the depression screening instrument (EPDS) reflects this. Medication is the predominant treatment of choice for postnatal depression in practice despite Brown et al’s (1994) finding that 96% of the women with postpartum depression improved because of non-medical interventions (increased support, return to work and the baby settling). Only 4% improved through medical intervention. There needs to be a courageous debate so that fundamental social change supports the reality of pregnant women and families. One comment stands out and encapsulates both the personal and the political. Alyson, talking about asking her parents for help with Lachlan:
I have to fib – it's not enough for me just to need a rest. They (meaning society generally not her parents) insist on a stress free pregnancy, but I feel that they imply he's my responsibility.

She wants another day to be available at preschool so she can rest; a taxi service, peace, a long shower without the children; time to talk with other pregnant mothers; housekeeping done. But there is ambivalence – she should cope alone.

Factors affecting these 11 women include: the degree to which they accept their struggle to cope or judge it as a failure; their willingness to ask for help and the availability of help; acceptance of motherhood; their own emotional and physical resources; the degree to which they feel supported especially by partners, mothers and friends; the nature of the pregnancy; life stresses – financial; relationship; isolation; health (theirs or those close to them); other children; neighbourhood quality.

All are embedded in the social constructions of pregnancy, motherhood, women, families and children. This includes prescriptions of what is normal and acceptable; the way society is (or is not) set up to accommodate the realities of this part of life. Hence, many personal psychological problems are consequences not causes, yet individuals, not communities, are pathologized.162

i. Work and Finances

Work was a dominant theme through the pregnancy with important financial and relationship implications, but not mentioned much at four months postpartum as most mothers reported being still happy to be on maternity leave. Lea had only three months maternity leave and was ready to be back at work.

Table 5.15: Type of Paid Work Done during the Pregnancy

<table>
<thead>
<tr>
<th>Professions</th>
<th>Business</th>
<th>manual; unskilled</th>
<th>*unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>#Mother</td>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>Health/educ</td>
<td>4</td>
<td>Office -4</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>-2</td>
<td>Farm; garden -2</td>
<td></td>
</tr>
<tr>
<td>Artist</td>
<td>-1</td>
<td>Service -2</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farm; garden</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# 2 mothers assisted with the business books at home but were not directly paid
*1 left work early in pregnancy; 2 mothers did not work at all – one of these was part time at TAFE;

1 father was briefly unemployed twice; 2 significantly

Work was a significant stress for seven participants, with study affecting two others. The pull between pregnancy, family and work was hard for working mothers and they looked forward to being home. Lea, Rebecca, Joanna and Beth would have liked to leave work earlier than they did. Career lost its importance for Rebecca though, like Lea, she liked her work. Rebecca decided to go back to work after six months and use her year’s maternity leave to work part time (instead of working full time) because she wanted to be with her baby and feared she wouldn't manage full time work. Kate loved her previous work but rarely mentioned her 'brain dead' job during the pregnancy. Work was demanding for

Joanna and stressed her non-traditional relationship (partner was at home), because he wanted to be back at work away from parenting. When my partner struggled with similar anxiety and self-doubt experienced by many women after a stint of home duties, I realized that this might be a role rather than a gender issue. It was hard for all the working women to cope physically toward the end of pregnancy. Beth gave herself permission to do nothing the first week off work.

Being unable to work was desperate for Charly, giving her a unique position in this sample. Work was her ‘life blood’ and “paintings are my babies.” This highlights the importance of supporting genuine choice around parenting and work and avoiding philosophical ‘shoulds’. Families were less stressed where fathers had regular work or the lifestyle was simple and supported. Rowan and Margaret helped in family businesses which were under pressure (one was opening and one faced foreclosure) and stress was intense for both partners.

All I can remember about the pregnancy is what was going on with the business (Margaret).

The stay at home option was more complex for women who were primary or significant income earners.

I would rather stay home with the children but one income is not enough (Beth).

Lea values part time work, a family friendly work place, the provision of three months paid maternity leave and describes the difficulties as a pregnant working woman coping with the pregnancy, sick children, unreliable child care and social attitudes.

Pregnant people in the work place are usually frowned upon ... “It’s obvious x is pregnant because she didn’t do x y z” ... I jump to the defence - not everyone who’s pregnant is like that – forgetful, .. not up to usual performance ... I had a ding in my car and people said, “that sort of thing always happens when you’re pregnant. WOMEN ... say it!!! I fight it by playing down the pregnancy .... a shame because I ... wanted to enjoy (this last one) ... Two of the three women have children but one doesn’t and she’s always being seen to be staying back, so if I rush off at the tick of the clock then it doesn’t look good. They’ve increased my hours ... just what I wanted! More work!! .. I’m the only one with three kids but the easiest to get hold of and willing to come in.

On the other hand, she is sympathetic to the difficulty for small employers when they hold jobs open for women who don’t return after maternity leave.

If I were an employer I wouldn’t employ pregnant women – it’s not worth the trouble.

It was interesting that the two young Mums, both on Youth Allowance, spoke little about financial pressures seeming to just accept their situation and restricted lifestyle. They were in the high stress group. Abbey’s mother received a carer’s pension for her daughter and felt the strain of supporting her postnatally. Margaret (on a farm) and Beth indicated greatest financial strain. Joanna, Rebecca (primary breadwinners), Beth, Lea, Alyson worried about the future while on maternity leave without their income. There is not a clear correlation between low income and high stress.
Table 5.16: PAID EMPLOYMENT AND FINANCIAL PRESSURE IN PREGNANCY

<table>
<thead>
<tr>
<th>Financial stress</th>
<th>Full time</th>
<th>P/T</th>
<th>Irregular or little work</th>
<th>Family business</th>
<th>Unemployed during study*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alyson</td>
<td>No</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rebecca</td>
<td>some</td>
<td>yes</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Abbey</td>
<td>Yes - benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rowan</td>
<td>Yes - start business</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes N/A</td>
</tr>
<tr>
<td>Charly</td>
<td>Some - simple life</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Kate</td>
<td>No</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lea</td>
<td>No</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Margaret</td>
<td>Yes - intense</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Joanna</td>
<td>some</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Beth</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kylie</td>
<td>Yes - benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>yes N/A</td>
</tr>
</tbody>
</table>

* not including maternity leave of less than one month

ii. Home Base:

Over half the participants were involved in altering their home base during pregnancy - moving house, extensions, rearranging it to accommodate the baby. Table 5.17 indicates the participants’ living arrangements during the pregnancy. For Kylie (homeless and in the high stress group) having a home was critical, but there are no clear overall trends.

Table 5.17: LIVING ARRANGEMENTS DURING PREGNANCY

<table>
<thead>
<tr>
<th>No home – refuge or welfare home</th>
<th>In parental home</th>
<th>In house on In Laws property</th>
<th>Rented</th>
<th>Own home</th>
<th>Moves</th>
<th>Alterations building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kylie</td>
<td>Abbey</td>
<td>Margaret</td>
<td>Beth</td>
<td>Alyson</td>
<td>Beth</td>
<td>Lea, Rowan, Rebecca</td>
</tr>
<tr>
<td></td>
<td>Rebecca was living with in laws initially</td>
<td>Charly</td>
<td></td>
<td>Rowan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rebecca (later in pregnancy)</td>
<td></td>
<td>Lea, Kate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Joanna</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mobility can be a risk factor (Field, 1984) so table 5.18 indicates the number of schools attended, my impression of their sense of stability from the interviews, the length of time in the district and recent history of moves. Stress reduced for Rowan, Alyson and Lea when extensions were finished before birth. A bigger house compensated Beth for moving at the end of her pregnancy. Kylie, homeless and in a refuge, transferred with great stress out of area to supported accommodation at the House. She settled in slowly and in the end was very relieved that she would be able to stay there for six weeks post birth but longed for her own place. Rebecca lived with her in-laws until she, like Margaret and Charly, lived separately on the in-laws property. This had moments of support and increased stress.

Both young parents had house fires within the first year postpartum. Mobility (Rowan) and lack of a sense of place (Charly, Kylie, Rebecca) are factors in the high stress group but also occur in other groups. Thus it lacks correlation with stress and relating.
### Table 5.18: Mobility in Childhood and Pregnancy

<table>
<thead>
<tr>
<th></th>
<th>schools</th>
<th>Stable sense of place as child?</th>
<th>In this house</th>
<th>In district</th>
<th>Moves past 5 yr</th>
<th>Moves in research</th>
<th>Post birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alyson</td>
<td>7 plus trips</td>
<td>Likes change so not a problem to move</td>
<td>1 yr</td>
<td>1 yr</td>
<td>3</td>
<td>0 - renovating</td>
<td>settled</td>
</tr>
<tr>
<td>Rebecca</td>
<td>7</td>
<td>No - lot of moves not always positive</td>
<td>1yr</td>
<td>1 yr</td>
<td>6</td>
<td>1 - renovating wants own place</td>
<td>moved out of district 1st yr</td>
</tr>
<tr>
<td>Abbey</td>
<td>unknown</td>
<td>unknown</td>
<td>unknown</td>
<td>unknown</td>
<td>unknown</td>
<td>2 - to a refuge; back home; house burnt down; 1st yr 2 moves</td>
<td>Build &amp; move by 2 yrs</td>
</tr>
<tr>
<td>Rowan</td>
<td>7</td>
<td>Moved lot including living internationally</td>
<td>10 mths</td>
<td>3 years</td>
<td>3</td>
<td>0 - plans to build</td>
<td></td>
</tr>
<tr>
<td>Charly</td>
<td>2</td>
<td>Born overseas - NESB settled</td>
<td>2 yr</td>
<td>2 yr</td>
<td>several</td>
<td>Travel over seas for 3 months</td>
<td>Moved 1st yr No Sense of place in Australia</td>
</tr>
<tr>
<td>Kate</td>
<td>3</td>
<td>settled</td>
<td>5 mths</td>
<td>5 mths</td>
<td>4 (last yr)</td>
<td>0 - renovating</td>
<td>settled</td>
</tr>
<tr>
<td>Lea</td>
<td>3</td>
<td>settled</td>
<td>5½ yrs</td>
<td>0</td>
<td>0 - renovating</td>
<td>settled</td>
<td></td>
</tr>
<tr>
<td>Margaret</td>
<td>7</td>
<td>Moved lot as child</td>
<td>Move 1st yr</td>
<td>0 - unsettled</td>
<td>Move 1st yr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joanna</td>
<td>3</td>
<td>settled</td>
<td>5 yrs</td>
<td>5 yrs</td>
<td>0</td>
<td>0</td>
<td>commutes</td>
</tr>
<tr>
<td>Beth</td>
<td>2</td>
<td>Moved due to separation - stressful</td>
<td>18 mths</td>
<td>11 years</td>
<td>4</td>
<td>Week before birth</td>
<td>Renting -3 moves by 18 months</td>
</tr>
<tr>
<td>Kylie</td>
<td>unknown</td>
<td>Homeless, stay with people or refuge from 11 yrs</td>
<td>5 mths</td>
<td>On and off for several years</td>
<td>Lot - unknown</td>
<td>5 by 5 months</td>
<td>Fire in flat; lost contact</td>
</tr>
</tbody>
</table>

### iii. Emotional Well-being

HORMONES! said Kylie, when asked what had been stressful. All the women experienced heightened sensitivity and emotionalism, which wasn’t always easy to read from self-report or observation. I often relied on clinical skills. After reading her story, Margaret said she sounded more competent than she felt.

Perhaps I didn’t tell you I often cried (Margaret).

Is the heightened emotionalism experienced by all these women simply a matter of hormones? Do the hormones create the stress or heightened sensitivity to internal and external events? Reaction to ‘objective’ stress events such as cancer, unknown illness, threatened bankruptcy, moves, relationship difficulties, exams and assignments, social rejection is affected by perceived support, temperamental factors such as extroversion or introversion, past, especially early childhood, experiences, resolution of trauma, concurrent and cumulative stresses.

Dependency became an issue for some (Parr, 1996). Charly feared being dependent on her partner while Rowan needed someone to just be there, to sometimes take over the responsibility and decide for her.

I want someone to take the responsibility off my shoulders – just tell me what to do. I want a housekeeper but don’t deserve one. It’s my job. I used to work in stockings, high heels a suit - this is not really a job (Rowan).

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166 Main & Hesse, 1990; Terr, 1991; Herman, 1992; Egeland & Erickson, 1990.
Alyson speaks about being supported but somehow I don't feel she's supported. She admits that it's hard to ask for and receive help; that deep down she links support with loss of independence - perhaps loss of her Self? It is as if there is an inner constraint - a need to be in control, self reliant, independent, thoughtful and caring of others - preventing support from nurturing her.

iv. Depression and Anxiety:

Postnatal depression significantly affects infant development.\(^{168}\)

Table 5.19 gives the results of the EPDS administered as a qualitative measure of emotional functioning at the second prenatal and six week postnatal interviews. Some scores did not correlate with my clinical assessment or the women's self-reflection at 4 months. Lower numbers indicate better mood. Over 10 is worrying. Abbey's scores are extreme.

<table>
<thead>
<tr>
<th></th>
<th>In PREGNANCY</th>
<th>POSTNATAL</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alyson</td>
<td>3</td>
<td>Missed assessment</td>
<td>Seemed fine</td>
</tr>
<tr>
<td>Rebecca</td>
<td>5</td>
<td>4</td>
<td>Low Confidence, Karitane admission</td>
</tr>
<tr>
<td>Abbey</td>
<td>21</td>
<td>22</td>
<td>Unstable situation - lot of difficulty and low mood</td>
</tr>
<tr>
<td>Rowan *</td>
<td>8 (I would say inaccurate)</td>
<td>6 (I would say inaccurate)</td>
<td>High distress, depression prenatal. Severe PND - hospitalization postnatal</td>
</tr>
<tr>
<td>Charly</td>
<td>She felt EPDS inappropriate as depression situational</td>
<td>Had phobic reactions, and high distress</td>
<td></td>
</tr>
<tr>
<td>Kate *</td>
<td>4</td>
<td>4</td>
<td>History of PND; she said research process helped prevent it this time; I think a well baby was also significant</td>
</tr>
<tr>
<td>Lea</td>
<td>6</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Margaret</td>
<td>6</td>
<td>12</td>
<td>Stress through pregnancy but seemed to manage. Baby was very demanding and took months to settle</td>
</tr>
<tr>
<td>Joanna *</td>
<td>4</td>
<td>6</td>
<td>High distress early in pregnancy</td>
</tr>
<tr>
<td>Beth</td>
<td>7</td>
<td>9</td>
<td>Baby born with heart problem</td>
</tr>
<tr>
<td>Kylie *</td>
<td>7</td>
<td>10</td>
<td>Depressed in pregnancy. Unstable situation; Luke for some time in care of paternal grandmother</td>
</tr>
</tbody>
</table>

*Not consistent with my clinical assessment

The EPDS was limited in its capacity to differentiate low mood and distress.\(^{169}\) Following are some examples of the misfit between interview and score. Charly was very upset, suffered high anxiety, phobia and presented as quite depressed but did not complete the Edinburgh scale as she felt it was irrelevant - she knew why she was legitimately upset and it was unrelated to pregnancy. Rowan asked if it was possible to have prenatal depression and suffered a lot of distress, however her scores did not reflect this.


In fact, the second assessment occurred within a short time of her admission to hospital for severe depression. Kylie and Beth's scores were similar but they did not present similarly in terms of their distress. Kylie was very down, emotional and at times withdrawn prenatally. Beth tended to be reserved but quite matter of fact and philosophical about issues that affected her. Joanna was very distressed early in the pregnancy but scored quite low. As a health professional she knew the scale and understood depression. Lea suffered postnatal depression after the previous three pregnancies and felt the research process helped prevent its recurrence this time despite disappointment at not having a girl and some significant relationship stress in the first 4 months postpartum. I believe a healthy baby contributed. Abbey’s scores and her presentation were consistent and extremely worrying. She and Kylie rejected the foetus sometimes, demonstrating Condon’s assertion that

the depressed pregnant woman may experience the foetus as a source of irritation or guilt, and feel overwhelmed, or even invaded, by the foetal presence (Condon 1997, p360).

This study supports Condon’s (1997 p 360 & 365) conclusion: depression, anger and anxiety affect the quality of prenatal attachment (ie pleasure, closeness, tenderness), and Carter-Jessop & Keller’s (1987) finding: those with less support reported less detailed and frequent foetal interaction. External factors (like children, busyness, relationship problems, work) affected the mother’s intensity of preoccupation, strength of feelings and time spent thinking about or interacting with the foetus.

v. Research as Support

All women either valued or wished for open communication to process and share the experience of pregnancy. Partners, other pregnant women, friends, mothers were favoured contenders but I was overwhelmed at the retrospective positive valuing of the research process. Two men expressed appreciation after their interviews. Rebecca, Margaret and Joanna heard their partners talking to mates very positively about their interviews. Other research findings support this.170 The process of deeply listening to people’s stories is basic to therapy. Depression reduces with empathic listening.

The overwhelming view from women who had been depressed was that talking about it helped. Depression after childbirth is a very common experience; listening to what women say about their lives as mothers and acknowledging the validity of these feelings – believing women – may make an enormous difference to women currently dealing with the sorts of difficulties experience by the women in this study (Brown, et al 1994, p262).

The spinning of stories was in and of itself valued, supportive. It assisted them in their process of making meaning of their experiences and effected their transformations, perhaps even healing. Lea talked and cried about having a boy, which helped her accept and resolve the gender issues. Kylie and Abbey both struggled through the pregnancy and found the sharing valuable. No one dropped out and cancelled interviews were easily

rescheduled with all but Kylie. Much later, someone told me just how important meeting with me had been for Kylie. I was touched because at times she had refused to talk to me on the telephone. At the end, she did say briefly.

You’ve been part of my support; I get to talk to you about everything. It was good. Very good (kylie).

Abbey invited me to attend the birth. She was very depressed and had no one else she really talked to about how she felt. Five participants indicated during the research that it was a supportive process. All responses at the last interview were positive about the research experience.

There were no down sides (to the research) (Lea).
Good. Definitely not a hindrance (Joanna).
You were very unobtrusive — a very positive experience (Kate).
Great. At least someone came — I could talk, exchange with. It distracts me from routine (Charly).
When asked what helped in the pregnancy, five people mentioned the research.
Talking to you (Joanna, Lea).
You helped us think about things we’d not thought about (Rebecca).
You listened to how we feel (Kate, Jack).

The only comment with an edge to it was,

I worried about what kind of weirdo I’d get hooked up with when I picked up the brochure! A few times I thought, ‘Oh boy – am I in the mood?’ (Lea).

What was valued about the research process?

1. Being able to talk about feelings and express them.
   The talking (Margaret).
   Me talking led to another process — to think about things (Joanna).
   Not surprised if its part of why I didn’t have any depression or stress this time (Lea).

2. Being listened to with neutrality and objectivity
   It was more constructive than having a group (Lea).
   It was like having access to a counsellor … someone objective (Margaret).
   You’re a neutral party. A good sounding board. You listened to how we felt (Kate).

3. Questions extended their thinking and reflection
   Good because it got me talking — to think and look at things I wouldn’t have talked about. I could think about what I can do (Lea).
   Good. It’s been helpful to process things in myself; to normalise. You made comments that other’s felt similar — it was a gentle thing. It helped me look inwards and think about things (Joanna).
   The questions make me think … express, talk about things in a completely objective way (Margaret).

4. Facilitated communication between couples
   A couple times you spoke with Phillip which was enlightening for me. It was good for him to verbalise (Joanna).
   It made us talk and bring up things. You asked us to talk about feelings. Or asked about things we’d never thought about before which led to us talking about it (Kate).

   The research process provided the participants with a chance to ‘be’ pregnant in a more reflective, conscious way which was perceived as positive. They also regularly had
focused time to share all aspects of the journey (not just the physical or problematic parts) with someone outside the family in a very personal, intimate way.

Pregnancy is a complex journey for the mother and the child. Clearly relating to the foetus is part of the process though many factors affect the nature of that relationship. Condron (1997) notes an inverse relationship between how busy a woman is and the degree of preoccupation with the baby. This study supports this trend.

Stressful and distracting events did interfere with the mother's ability to relate to her preborn, but support, acceptance of motherhood, processing experiences (being listened to in research) can moderate these effects and facilitate prenatal relating.

Efforts have been made to understand and increase prenatal bonding through movement and dream work (Kestenberg, 1987), yoga (Olkin, 1987), guided imagery (Kim, 1990), teaching mothers to interact with the foetus (Carter-Jessop, cited Freud, 1987). Results are promising, though mixed. My schema highlights the complexity of prenatal relating and isolates aspects of relating that could be enhanced for a particular woman. It may help illuminate the importance for later attachment of particular aspects of prenatal relating. It can enhance and refine clinical interventions and the capacity of women to understand, make choices and act in the interests of their preborn.

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Chapter 6

CONCLUSIONS

In 1956 when this work was begun I had no conception of what I was undertaking (Bowlby 1971 p11).

The beginning of love is interviewing people. The end of love is writing it up (Francine in despair 1999).

So, we near the end of the journey. In this thesis I have journeyed through the literature on the postnatal impact of resilience and risk factors, stress and trauma, relationship (attachment) on children's development (see chapter one). This confirmed that stress and trauma can directly result in childhood attentional and behavioural problems, that earliest experiences are potent because they build neurological connections and physiological patterns that act as a blueprint for living. Attachment theory, particularly, described the critical role of early relationship and caregiving in this process. It is through relationship that the infant develops tendencies for empathy, vulnerability and/or resiliency, patterns of expectation and responsiveness which also tend to be continuous. Where patterns are changed, supportive or loving relationship plays an important part (van IJzendoorn et al, 1995). However, a personal psychological approach must take into account the power of the sociological context to influence the quality of the developing parent-child relationship. Social support is critical.

Attachment theory, though considering the quality of the relationship between parent and child, primarily describes the way the young child relates and thus neglects the prenatal period. Similarly, much of the literature in chapter 1 addresses post birth factors ignoring prebirth experience. This has left a significant gap addressed by this study.

So I ventured behind the veil of birth to find how these factors, mediated by the mother's experience, affect prenatal life (see chapter 2). The neurological literature explored a totally new and exciting view of early childhood and prenatal development. Work into the capacities of the newborn and foetus supports the thesis that the prenatal period is continuous with postnatal development. Research supporting the link between stress in pregnancy and attentional/behavioural problems has accumulated dramatically in recent years. There is a strong theoretical foundation for the idea that maternal stress and support in pregnancy affects child development.

On this foundation I have built rich, detailed descriptions of the process of prenatal relating. I accompanied the journey of eleven women through pregnancy by listening each month to their experiences (phenomenological study). The stories of these women has given rich text-ure and detail to compliment data from neurological and sociological studies of the importance (I suggest primary importance) of the prenatal period in human development. My data confirms that love and relating begin prenatally, though the foetus is invisible and its responsiveness (primarily movement) less differentiated.\footnote{Verny, 1987; Verny & Kelly, 1981; Chamberlain, 1987; 1998; Condon, 1997; Raphael-Leff, 1993; Piontelli, 1992; Cranley, 1981a & b, 1992; Lumley, 1980; Muller, 1992, 1996.}
From the themes of the stories I have proposed a more complex schema of prenatal relating than I have found elsewhere. The schema attempts to reflect the complex, circular dance between mother and preborn. Five facets to prenatal relating emerged - awareness, attribution, connection, interaction and social presence in the community. The process of attribution and projective identification is preparing the parent to be responsive to the infant. Fantasy lays the foundation for postnatal life and relationship (Condon, 1997, Raphael-Leff, 1993). From the analysis of the women's experiences, I propose specific feelings and behaviours that indicate the presence, strength or weakness of each component of prenatal relating. The schema illuminates some of the landmarks a particular mother and child is likely to pass on their journey from conception to birth. It reveals different patterns of prenatal relating which may eventually add to our knowledge about the continuity and postnatal consequences of particular qualities of pre and postnatal relationships for attachment, parenting and child development. I stress, this schema has potential for clinical work and parent understanding, but is not a diagnostic tool and requires further refinement, testing and research to see how well it can reflect the many ways in which women begin their prenatal relationship with their preborn. It may assist in specifying what supports and what inhibits that relationship developing, what short and long term consequence there may be, especially for the child, of the emergent patterns.

The stories herein, reveal just how stressful some of the ordinary events of pregnancy can be and indicate what supported and hindered these women's ability to focus on and relate to their preborn. Social factors are powerful in post birth and pre-birth health and well being. The participants' ideas are vital for those wishing to create child and family friendly communities and can be used to advocate for society's role in supporting families in this critical transition (see appendix I and J). Support, support and more support was wanted - practical support around child care, transport, housework especially late or when there were difficulties in pregnancy. Supportive relationships with partner, family and friends and contact with other mothers and pregnant women were critical, but also helpful was some time alone, space and nurturing for the woman herself. Family friendly work places and appropriate physical community facilities are needed plus accepting attitudes toward young parents.

The research models a non-pathologizing way of supporting families in the transition to parenthood through the power of genuinely interested listening (Oakley et al 1990; Oakley, 1981, 1992, 1993). Lack of this in the medical system was problematic for these women. The project managed to get close to the lived experience of the participants - demonstrated by 100% retention in the study and very positive reactions.

LIMITATIONS

There are significant limits to this study – it’s small, self-selected sample, though broad, does not allow cross-cultural application or generalisations. The phenomenological analysis would benefit from corroboration and quantifiable measures. The volume of data generated required me to narrow my focus to the mother’s developing relationship but I am sad that I was unable to incorporate the men’s views here despite my belief that fathering is critical for healthy child development. There were not enough fathers participating regularly to gather the data needed. I am also disappointed that I could not process the video material and thus explore the relationship between pre-birth relating and post birth outcomes. My resources could not stretch to pay for video analysis – a future project.

I intended greater collaboration\textsuperscript{174} with participants who were given their stories for review near the end. Monthly interviews required an extensive commitment of time for me and the participants making group meetings and feedback sessions difficult. I kept participants in mind as I worked with the material and considered how they would feel about what I wrote. Thus I tried to remain faithful and respectful to the trust they gave me by letting me into their lives and sharing this vulnerable, intimate journey.

The interviews generated a large data base from which I selected as an essential focus the developing relationship between mother and foetus. I hope I have listened closely enough and been successful in drawing out the key facets of this relationship but it is difficult to approach the world of the pregnant woman and child with confidence. Future research could work with one pregnant woman, repeat the same journey and develop an even more in depth understanding through collaborative discourse or narrative analysis. Assessment of the videos would give insight into the continuity and impact of prenatal relating on postnatal life. Exploring how the prenate participates in relationship is an important future step. Using the tool with a large number of women would provide insight into the applicability of the schema, the range and persistence of prenatal relationship patterns

Despite these limitations, this work adds weight to the importance of the prenatal period and the power of support at this time to improve the possibility of resilience and healthy outcomes for children. However, this is a very delicate issue at risk of being framed as a competition between the rights of women and the rights of children. It is clear that women’s emotions and experiences in pregnancy affect the preborn. While keen to find ways to promote a safe inter-uterine environment for the preborn, like Cranley (1992) and Muller (1992) I would not want to see women being assessed and made to operate as controlled environments incubating babies. Advocating for the needs of preborns will only be successful if the interests of women are also advocated. Adequately supporting pregnant women financially, emotionally and practically will increase the

likelihood that they can make choices that are beneficial to themselves and the baby they bear.

It is seven years since beginning this thesis - a long journey for me but one that has validated my clinical observations that a child’s well-being and relationship capacity begins in pregnancy and that society must prioritize the well being of children for the future health of individuals and society. Supporting the transition to parenthood can reduce stress and increase the chance that parents can welcome and respond lovingly to their offspring from pregnancy.

When we compare the pragmatic consequences of behavioural social science with phenomenological human science we note that traditional behavioural research leads to instrumental knowledge principles: useful techniques, managerial policies and rules-for-acting. In contrast, phenomenological research gives us tactful thoughtfulness: situational perceptiveness, discernment and depthful understanding (van Manen, 1990, p156).

I will be happy if this work contributes to society's greater perceptiveness and 'depthful understanding' about the beginnings of a mother's love for the baby inside her and the capacity for the preborn to experience that love and ultimately reciprocate, not only in the family but in the way they live lovingly in community.

I fantasize that we will have a truly effective antiterrorist campaign when money is put into creating loving communities within which children and families can grow without terror from conception - a real beginning in, and of, love.

Thank you for being my witness and listening as I gathered the threads and wove them together into this story about the beginnings of love.
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APPENDIX A

PARTICIPANT INFORMATION AND CONSENT

I am inviting you to be a participant in the Pregnant to Three community research project. I am a local mother, experienced social worker and masters degree student who is researching pregnancy and birth experiences with the aim of understanding how to prevent family problems.

I want to find out
what is it like for you and your family in pregnancy, birth and the first months;
what would support you and your children most at this time;
what helps people, especially those in difficult circumstances, in becoming parents?

I am asking your permission to:
1. interview you individually as soon as possible
2. contact you monthly throughout the pregnancy to hear the important events and feelings you want to share. You can talk to me by phone, with others in a small group or by yourself.
3. talk with you three times after the birth, and video you and your baby at these times.
You will receive a copy of the video at the end of the study.
If it can be arranged and I receive funding I may ask you later if I can
a) look at the hospital and early childhood records covering the pregnancy, birth and first 4 months,
b) have the video looked at by an expert in parent-infant relationships. If you want, you can receive suggestions to assist you.

It is important you know that:
1. You will not be identified at any stage of the study and everyone’s ideas will be presented together. Your privacy will be respected at all times.
2. You are free to withdraw at any time.
3. whether you agree to participate or not won’t affect your relationship with, nor ability to use any health or community service. It will not affect any current or future treatment you receive.
4. I will be checking with you to ensure you agree that I’ve got your point of view correctly.
5. You can contact me and/or I will refer you to a counsellor, if our conversation raises distressing issues with which you need some help.
6. If at any time you have questions about the study, you can contact Debbie Horsfall, supervisor and lecturer at University of Western Sydney, Hawkesbury, on (02) 45 701 301. The Manager, Research and consultancy Unit, U.W.S. Hawkesbury, Richmond, 2753.
Tel. (02) 45 701259 can also be contacted formally or informally about any concerns or complaints you may have as a participant and these will be dealt with confidentially.

CONSENT
I________________________ have read/had explained and understood the Information sheet and consent form. I understand that my decision whether or not to participate in, or subsequently withdraw from this study, will not affect any current or future treatment, or my relationship with any organization or person co-operating in this study, including the South Western Sydney Area Health Service. I understand the purpose of the study, what is asked of me and that I can refuse to participate in any part of the study or withdraw completely at any time. With this understanding I
agree to take part in this research.

NAME ___________________________ SIGNATURE __________________

WITNESS ________________________ SIGNATURE __________________

DATE __________________________

Thank you for agreeing to participate. I look forward to sharing this time together. 
You can contact me on 48 722440 if needed at any time. Francine Bartlett.

CONSENT FORM - RESEARCHER'S COPY

NAME: __________________________

ADDRESS: ________________________

PHONE: __________________________

PARTNERS NAME: __________________

CHILDREN’S NAMES: __________________

I am generally available:

<table>
<thead>
<tr>
<th>MON</th>
<th>TUES</th>
<th>WED</th>
<th>THURS</th>
<th>FRI</th>
<th>SAT</th>
<th>SUN</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

Put N/A in any spaces that you are definitely NOT available. 
I would like to participate in a group: yes...... no........
What I would like to get out of participating in this project is:

I ___________________________ have read/had explained and understood the Information sheet and consent form. I understand that my decision whether or not to participate in or subsequently withdraw from this study will not affect any current or future treatment, or my relationship with any organization or person co-operating in this study, including the South Western Sydney Area Health Service. I understand the purpose of the study, what is asked of me and that I can refuse to participate in any part of the study or withdraw completely at any time. With this understanding I agree to take part in this research. DATE __________________

NAME ___________________________ SIGNATURE __________________

WITNESS ________________________ SIGNATURE __________________
APPENDIX B

INTERVIEW PLAN

INTRODUCTION INTERVIEW
* explain process and sign consent
* what do you want to get out of this process? - enjoy the journey; talk and share the experience; get information; access resources; contact me if you need to; hear other people’s experiences; contribute to local improvements.
* give base data form and monthly record - arrange method that suits best.
* individual or group participation?
* make appointments

SECOND INTERVIEW
* look at data form and discuss.
* personal history - life-line
* current situation
* this pregnancy
* use of resources and what want
* issues/ questions/ ideas that have arisen so far.
* draw uterus and what is in it now?

MONTHLY INTERVIEW:
Briefly tell me what has been happening this month (use record as a guide)
Check that the ratings have been done on each of the incidents recorded.
Administer EPDS in third interview and second post partum interview
Each trimester have participant draw what they imagine is inside the uterus.
APPENDIX C

BACKGROUND INFORMATION

We will talk about some of these issues over the next months, but I want to be sure I have your
details accurately. So, please fill this in as best you can. Feel free to question or comment on
anything here. If there are questions you prefer at this stage not to answer, please leave them.
Only I will know who fills in this form.

Name: ____________________________

address .................................................................................................................................

date of birth: ___________ age in years ______ place of birth ___________
cultural heritage

FAMILY:
single........married.......defacto........separated.......divorced.......widow/widower........
Do you ever feel like a single parent?

no. of pregnancies ______ miscarriages ______ terminations ______

children: name _______ DOB & age ______ sex ______ planned/unplanned ______ step/live elsewhere/other ______

THIS PREGNANCY:
Was it a) planned/unplanned

b) pleasant surprise/an unwelcome shock/other

Was there anything distinctive about the conception?

When and how did you know you were pregnant?

What were your first thoughts and feelings?

How do you think and feel about it now?

Have you thought, even briefly, of a termination?

YOUR EDUCATION

age left school ______ Number of schools attended as child ______

Have you studied since? ______ If yes, what and where? ______

WORK:
current work ____________________________________________

work history ____________________________________________

rough income level ____________________________________________

Any comments re your educational, work and financial situation? eg happy/unhappy

MOBILITY:
How long have you lived a) at current address ______ b) in Wingecarribee?

How many moves of house a) last year? ______ b) in the last 5 years?

How has this been for you?

Did you move a lot as a child? How was that for you?
SUPPORTS: family/friend network
Put a number between 0 - 5 for each. 0 = totally unsupported - 5 = totally supported
Do you feel supported by
your partner
your mother
mother-in-law
siblings
1-2 friends
other
Whose support matters most? (You don't have to be getting what you need from them)
What do people do that makes you feel supported?
What do people do that makes you feel unsupported?
What needs to happen ideally to give you the support you need?

RELATIONSHIP:
How long have you and the father of this baby been together?
Genogram:
PREGNANCY: Experience so far:
HOW IMAGINE: the baby; the pregnancy; the birth; being a paren; the future
RELATIONSHIP: (current and past) with partner: with mother and father and siblings
OWN HISTORY: of parenting; of loss; of trauma; of stress; of emotional or physical ill-health

APPENDIX D
MONTHLY EVENT RECORD
WHAT'S HAPPENING THIS MONTH FOR YOU

NAME: ___________________________ MONTH
rating: 1 (very mild) 2 (mild) 3 (neutral) 4 (intense) 5 (very intense)
DATE TELL THE STORY ___________________________ RATING
APPENDIX E

EDINBURGH POSTNATAL DEPRESSION SCALE
(Cox et al, 1987)

I would like to know how you are feeling now, after you baby's birth. Please underline the answer which comes closest to how you have felt IN THE PAST WEEK, not just how you feel today. It has been found that responses are more accurate when not discussed with other people, so it is advisable to fill this in on your own when you have a few spare minutes. Please complete ALL items.

Here is an example already completed.

I have felt happy: Yes, all the time
Yes, most of the time
No, not very often
No, not at all

This would mean "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:
   As much as I always could
   Not quite as much now
   Definitely not so much now
   Not at all

2. I have looked forward with enjoyment to things
   As much as I ever did
   Rather less than I used to
   Definitely less that I used to
   Hardly at all

3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time
   Yes, some of the time
   Not very often
   No, never

4. I have been anxious or worried for no good reason:
   No, not at all
   Hardly ever
   Yes. Sometimes
   Yes, very often

5. I have felt scared or panicky for no very good reason:
   Yes, quite a lot
   Yes, sometimes
   No. not much
   No. not at all

6. Things have been getting on top of me:
   Yes, most of the time I haven't been able to cope at all
   Yes, sometimes I haven't been coping as well as usual
   Not most of the time I have coped quite well
No, I haven't been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all

8. I have felt sad or miserable:
   Yes, most of the time
   Yes, quite often
   Not very often
   No, not at all

9. I have been so unhappy that I have been crying:
   Yes, most of the time
   Sometimes
   Only occasionally
   No, never

10. The thought of harming myself has occurred to me:
    Yes, quite often
    Sometimes
    Hardly ever
    Never
APPENDIX F

FINAL INTERVIEW SCHEDULE

<table>
<thead>
<tr>
<th>NAME</th>
<th>BABY'S AGE</th>
<th>DATE</th>
</tr>
</thead>
</table>

**A. PREGNANCY:** When you think back over the pregnancy
1. How stressful was it overall - rate 0 (no stress) - 5 (extremely stressful) 0 1 2 3 4 5
2. List the things that made it stressful and if possible rate each one.
3. What would you have changed or done differently?
4. What was helpful in getting you through?
5. What was unhelpful?
6. What do you wish could have been available that wasn't?
7. What would you suggest to other pregnant women/men?

**B. BIRTH:** Thinking back over the birth: 1. How difficult was it? 0 1 2 3 4 5
2. What made it difficult?
3. What was helpful in getting you through?
4. What was unhelpful?
5. How close was the birth to what you had expected or planned for?
6. What do you wish could have been available that wasn't?
7. What would you suggest to other birthing women/men?

**C. POSTPARTUM:**
1. Describe your experience of becoming/of being a mother/father so far.
2. Is there anything that you would have changed? anything you would do differently?
3. What was most helpful in getting you through?
4. What was most unhelpful?
5. What do you wish could have been available that wasn't?
6. What would you suggest to other new mothers/fathers?
7. How does it feel to be a mother/father? DO EPDS
8. What do you think others think of you as a mother/father - especially your own mother.
9. How do you feel toward your baby at this time. What types of feelings have you had. (Remember normal women can feel very negatively to their babies at times.) Draw a circle divided to represent how much of the time you feel each type of feeling.
10. What support have you had and has it been what you need?
11. Describe your baby. sex; personality; temperament (easy, difficult, slow to warm up), like anyone in the family; just as you imagined/different;
12. How has the baby's arrival/becoming a parent affected -
   - you - your feelings and behaviour to yourself, others, life, work
   - your relationships with your partner,
   - children,
   - family, friends, work, neighbours etc
   - your position in the world.
   - How has it affected your partner and children
13. If you were to create a child and family friendly community what would it be like? What needs to happen?
14. How has the research process been for you?
APPENDIX G

DATA: SCHEMA CATEGORIES – SAMPLE COMMENTS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Who</th>
<th>when</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNAWARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t feel pregnant;</td>
<td>Lea</td>
<td>3</td>
</tr>
<tr>
<td>Hard to tell I’m pregnant; reality not hit</td>
<td>Rebecca</td>
<td>3; 5</td>
</tr>
<tr>
<td>Pregnancy feels unreal</td>
<td>Kylie</td>
<td>6</td>
</tr>
<tr>
<td>Little mention; Only notice pregnancy when can’t lie down</td>
<td>Charly</td>
<td>4; 8</td>
</tr>
<tr>
<td>determined not to obsess or focus on it too much</td>
<td>Kate</td>
<td>4; 5; 6</td>
</tr>
<tr>
<td>2 kg of miracle in tummy; don’t see myself as pregnant</td>
<td>Abbey</td>
<td>5; 6; 7</td>
</tr>
<tr>
<td><strong>Dream re baby</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rebecca</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Lea</td>
<td>4; 6</td>
</tr>
<tr>
<td></td>
<td>Beth</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Abbey</td>
<td>5; 6; 9</td>
</tr>
<tr>
<td></td>
<td>Kylie</td>
<td>5; 7</td>
</tr>
<tr>
<td></td>
<td>Margaret</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Joanna</td>
<td>6</td>
</tr>
<tr>
<td><strong>Awareness of foetus</strong></td>
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</tr>
<tr>
<td>• Due to physical symptoms</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>• Raised through external event eg gift of baby clothes; reactions of others; sharing with others; classes; another’s birth</td>
<td>Rebecca</td>
<td>3; 5; 7</td>
</tr>
<tr>
<td>• Feel movement without ascription</td>
<td>Kate</td>
<td>4</td>
</tr>
<tr>
<td>(Month of interview not listed if movement not mentioned)</td>
<td>Kylie</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Beth</td>
<td>4; 5; 6; 7</td>
</tr>
<tr>
<td></td>
<td>Margaret</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Kate</td>
<td>from 4</td>
</tr>
<tr>
<td></td>
<td>Lea</td>
<td>4; 5; 6; 8</td>
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<td></td>
<td>Kylie</td>
<td>5</td>
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<tr>
<td></td>
<td>Abbey</td>
<td>5; 7</td>
</tr>
<tr>
<td></td>
<td>Joanna</td>
<td>5; 6; 7</td>
</tr>
<tr>
<td></td>
<td>Rebecca</td>
<td>7</td>
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<tr>
<td></td>
<td>Charly</td>
<td>8</td>
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<tr>
<td></td>
<td>Beth</td>
<td>4 on</td>
</tr>
<tr>
<td></td>
<td>Kylie</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Rebecca</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Margaret</td>
<td>4</td>
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<tr>
<td></td>
<td>Joanna</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Alyson</td>
<td>5; 7</td>
</tr>
<tr>
<td></td>
<td>Beth</td>
<td>all through</td>
</tr>
<tr>
<td></td>
<td>Kate</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Rebecca</td>
<td>7; 8</td>
</tr>
<tr>
<td></td>
<td>Alyson</td>
<td>7</td>
</tr>
</tbody>
</table>

| Awareness of baby as older child |  |  |
| Set limits when its older; school age; teenager. | Kylie | 3; 5; 7 |
| Loss of mother-daughter relationship | Abbey | 5; |
| Past birth only | Lea | 5; |
| Hope it’s quiet | Kate | throughout |
| Let it make informed choices | Charly | 8 |
| Wonder about its future | Rebecca | 8 |
| Not mentioned | Alyson | 9 |
| | Joanna |  |
| | Beth Rowan |  |
| | Margaret |  |

<p>| Reduced awareness after initially attained |  |  |
| Other stresses; | Margaret (farm) | 6 |
| Talk less to baby; too busy to talk to it | Kylie | 5; 6; 7; 8 |
| Baby barely mentioned in interview | Joanna | 7 |
| Aware that behaviour will affect foetus | Joanna | 3 on |
| Eg smoking; emotions; medication; worry re deformity due to smoking/medication; | Kylie | 3 |
| Aware emotions affect baby | Abbey | 5; 7; |
| Stop smoking because of physical aversion | Rebecca | 8 |
| Says don’t care about effect on baby | Rowan | immediate |
| Hope emotions don’t affect baby | Abbey | 7 |
| Think a lot re baby; moves when I’m quiet; when stress baby kicks more than normal &amp; makes me feel sick | Charly | 8 |
| Begin to change behaviour for baby’s good eg reduce smoking/caffeine; eat better; exercise | Alyson | 7; 8 |
| No discussion | Beth | immediate |
| No ascription | Abbey | 5; 9 |
| Wait and see; | Kylie | 8 |
| No ascription throughout | Kate; Margaret | 8 |
| No ascription | Margaret | 6 |
| Minimal ascription | Lea | |
| Curious what baby like, No picture in mind (after previous minimal ascription) | Kate | |
| Ascribe generally not specifically | Charly | |
| All babies are different | Rebecca | |
| speculating re prenatal patterns continuing postnatal wonder if can hear eg responds to music | Joanna | |
| Aware of abilities of babies generally eg see light; hear music | Beth | 8, 9 |
| Ascribe physical characteristics | Kylie | 5 |
| Eg hair, eye colour; | Joanna | 6 |
| like me; handsome, energetic | Lea | |
| Dr says – low birth weight | Margaret | |
| Ascribe character/individuality/specific ability | Kate | |
| Will have an attitude like me; won’t scream but squeal like a dolphin; | Charly | 3 |
| A shit; attitude like me; hope like me | Rebecca | 6 |
| Emotionally strong – has to be more outgoing than sibling | Joanna | 7 |
| known when I need a rest | Beth | 8 |
| feels what I feel – tired when I’m tired; calm when I’m calm | Rebecca | 8 |
| Communicates; has attitude; | Kylie | 8, 9 |
| I vomit because baby saying doesn’t like what eaten, | Alyson | 3 |
| Ascribe meaning to movement via frequency or intensity | Abbey | 8 |
| Busy, active; emotionally strong – has to be a protest; | Beth | 4; 5 |
| I’m uncomfortable/ it’s being a shit | Kylie | 3; 5; 7 |
| Movement causes me pain – it’s having a good time | Joey | 8 |
| Feed me or else; if I stress it kicks more than normal and I feel sick; kicks and goes quiet like tantrum | Margaret | 5 |
| DISCONNECTION TO CONNECTION | Joanna | 6 |
| part of me blocking the baby - (Due to recent miscarriage) | Kylie | 7, 9 |
| don’t want to get too attached to it ‘feel different – no happy hormone so much going on | Alyson | 7; 8; 9 |
| feel little connection | Beth | 4 |
| Joanna | 3 |
| Charlotte | 3; 5; 8 |</p>
<table>
<thead>
<tr>
<th>Name baby</th>
<th>Joanna</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begin to think of naming (but don’t)</td>
<td>Margaret</td>
<td>4</td>
</tr>
<tr>
<td>Think of names generally</td>
<td>Lea</td>
<td>4</td>
</tr>
<tr>
<td>Choose names for both genders</td>
<td>Kylie</td>
<td>5</td>
</tr>
<tr>
<td>Choose name or nickname for this baby</td>
<td>Alyson</td>
<td>7; 8</td>
</tr>
<tr>
<td>Name not chosen to researcher’s knowledge</td>
<td>Abbey</td>
<td>9</td>
</tr>
<tr>
<td>Lea</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Joanna</td>
<td>Kate</td>
<td>5</td>
</tr>
<tr>
<td>Charly</td>
<td>Beth</td>
<td></td>
</tr>
</tbody>
</table>

| Love the connection when it kicks; feel a special bond                    | Alyson  | 7; 8; 9 |
| Connecting more; more real like baby not fetus; tuning in                |         |      |

| Prepare for parenting or the post birth baby                              | Alyson  | 5; 7; 8; 9 |
| Movement brings realization I have baby and am responsible; I’ll have a new baby to get to know; think re baby’s future; excited about the birth | Kylie   | 6      |
| I’ll love it even if it doesn’t look like me                              | Rebecca | 3; 5; 7; 8 |
| Thinking re kind of parent I’ll be; worried re lack of sleep              | Kylie   |         |
| Strong views re parenting; determined not to obsess                       | Kate    | throughout |
| Minimal – clothes and bigger cupboard                                      | Abbey   | 8      |

| Awareness of birth triggered by external event eg reactions of others; birth videos | Rebecca | 3; 7 |
| judgement                                                                  | Abbey   | 5; 5; 8 |
| another birth; classes;                                                    | Kylie   | 5      |

| I’m next; hospital stay                                                   | Abbey   | 7; 9 |
| Birth as a marker – end/change/beginning                                  | Kylie   | 7; 8 |
| Want it out, gloomy view postbirth; feel like a child, don’t want to but will have to grow up | Joanna  | 6    |
| Plans for her life post birth                                             | Alyson  | 7; 9 |
| Ominous till born (defect)                                                | Kate    | 7    |
| Will baby’s sleep cycle be same pattern after birth; know things will change but looking forward to the birth. |         |      |
| Won’t be so free after the birth; isolated                               |         |      |

| Preparation for birth                                                     | Joanna  | 9    |
| setting up and acquiring things; Birth plans; Birth becoming more real or a focus | Abbey   | 9    |
| Alyson                                                                     | 7; 9    |
| Kylie                                                                      | 5; 6    |
| Lea                                                                        | 5       |
| Kate                                                                       | 5; 6; 7 |
| Beth                                                                       | 5 on    |
| Rebecca                                                                    | 5 on    |
### Non-Interaction to Interaction

<table>
<thead>
<tr>
<th>Ascribe intent/communication/interaction</th>
<th>Margaret</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Movement - baby saying 'I'm uncomfortable'</td>
<td>Alyson</td>
<td>9</td>
</tr>
<tr>
<td>Letting me know its there;</td>
<td>Beth</td>
<td>5</td>
</tr>
<tr>
<td>Responds to music and voices</td>
<td>Joanna</td>
<td>6</td>
</tr>
<tr>
<td>feels what I feel</td>
<td>Alyson</td>
<td>7</td>
</tr>
<tr>
<td>Birth a struggle for both of us</td>
<td>Kylie</td>
<td>3;</td>
</tr>
<tr>
<td>Indicate relationship between; it responds when I talk in my mind to it</td>
<td>Kylie</td>
<td>6</td>
</tr>
<tr>
<td>Cuddle it</td>
<td>Joanna</td>
<td>7</td>
</tr>
<tr>
<td>Kicks before meals saying feed me; responsive; soothed by rubbing stomach; what does it think of me?</td>
<td>Joanna</td>
<td>9</td>
</tr>
<tr>
<td>Talk to baby</td>
<td>Abbey</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Alyson</td>
<td>7</td>
</tr>
<tr>
<td>Don't talk but think about it often; Sing loud and it responds; feel a special bond</td>
<td>Kylie</td>
<td>5</td>
</tr>
<tr>
<td>Swear at baby</td>
<td>Joanna</td>
<td>9</td>
</tr>
<tr>
<td>you’re big enough to push yourself out – get cracking. It’s not all that hard.</td>
<td>Alyson</td>
<td>7; 8; 9</td>
</tr>
<tr>
<td></td>
<td>Abbey</td>
<td>7; 9</td>
</tr>
<tr>
<td></td>
<td>Alyson</td>
<td>9</td>
</tr>
</tbody>
</table>

### Isolated to Social Inclusion

<table>
<thead>
<tr>
<th>Little indication of social connection achieved</th>
<th>Abbey</th>
<th>4; 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Mum can’t feel it move;</td>
<td>Kylie</td>
<td>5</td>
</tr>
<tr>
<td>Mother unsupportive; no-one to relate to baby with her</td>
<td>Charly</td>
<td>all but 3 mths</td>
</tr>
<tr>
<td>Isolated</td>
<td>Rebecca</td>
<td>all through</td>
</tr>
<tr>
<td>First pregnant in group; partner can’t feel from outside</td>
<td>Kylie</td>
<td>all through</td>
</tr>
<tr>
<td>Socially judged</td>
<td>Abbey</td>
<td>all through</td>
</tr>
<tr>
<td>pregnancy supported but no evidence of others interacting with the baby directly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified in family or social network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spoken about with partner/mother; strong partner support</td>
<td>Kate</td>
<td>4; 5; 6; 7; 8</td>
</tr>
<tr>
<td></td>
<td>Beth</td>
<td>4 on</td>
</tr>
<tr>
<td></td>
<td>Rebecca</td>
<td>3 on</td>
</tr>
<tr>
<td></td>
<td>Abbey</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Alyson</td>
<td>5; 6; 8</td>
</tr>
<tr>
<td></td>
<td>Lea</td>
<td>5 on</td>
</tr>
<tr>
<td></td>
<td>Beth</td>
<td>7; 8; 9</td>
</tr>
<tr>
<td></td>
<td>Alyson</td>
<td>4; 5; 6; 8</td>
</tr>
<tr>
<td></td>
<td>Beth</td>
<td>4; 5; 6; 8</td>
</tr>
<tr>
<td></td>
<td>Lea</td>
<td>3; 5;</td>
</tr>
<tr>
<td></td>
<td>Rebecca</td>
<td>5 – 7 mths</td>
</tr>
<tr>
<td></td>
<td>Charly</td>
<td></td>
</tr>
<tr>
<td>Baby spoken about as part of family;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children or partner relates to baby directly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended family excited; supportive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for 3 months with family overseas and felt connected (rest of time isolated from family/friends/country)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambivalence re pregnancy or motherhood that is characteristic not just occasional.</td>
<td>Kylie</td>
<td>5; 6; 7; 8</td>
</tr>
<tr>
<td>says I’ll be a good mother, but lot of fear re coping &amp; responsibility; judgement; depression, thoughts of giving baby up; idealise/reject</td>
<td>Abbey</td>
<td>5; 6; 7; 9;</td>
</tr>
<tr>
<td>expresses regret re pregnancy right through but excited at beginning; depression;</td>
<td>Charly</td>
<td>4; 8</td>
</tr>
<tr>
<td>Punches self in stomach; calls baby shithed; wants her life back; very easy to kill the baby; hates movement;</td>
<td>Kate</td>
<td>6; 7</td>
</tr>
<tr>
<td>Was about to resume art work; depression; don’t identify as mother</td>
<td>Rebecca</td>
<td>3; 5; 8; 9</td>
</tr>
<tr>
<td>Negative image of mothers; fear re isolation; loss of carer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Struggle between image of feminist and mother; fear and anxiety re birth and parenting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased sensitivity/ vulnerability (for post natal depression scores see table 5.20)</td>
<td>Kylie</td>
<td>3; 5; 6; 7; 8</td>
</tr>
<tr>
<td></td>
<td>Abbey</td>
<td>5; 6; 7; 9</td>
</tr>
<tr>
<td></td>
<td>Margaret</td>
<td>1st trim; 8</td>
</tr>
<tr>
<td></td>
<td>Charly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rebecca</td>
<td>3; 5;</td>
</tr>
<tr>
<td>Identity as mother - negative</td>
<td>Kylie</td>
<td>3; 5;</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Fear re coping; thinks about being a mother and how will she survive; if hear baby scream “anxious to kill the thing” don’t want to be by myself; see her washing all day; tired all the time</td>
<td>Abbey</td>
<td>5; 6; 7; 9</td>
</tr>
<tr>
<td>No freedom; hard; afraid of cot death; want to throttle the crap out of it; no mothering crap;</td>
<td>Kate</td>
<td>4; 5; 6; 7</td>
</tr>
<tr>
<td>See mothers obsessing, unable to talk about anything else; doing nothing; not respected</td>
<td>Alyson</td>
<td>7;</td>
</tr>
<tr>
<td>worry re coping with 3;</td>
<td>Lea</td>
<td>3; 5;</td>
</tr>
<tr>
<td>fear re ill child and PND again</td>
<td>Charly</td>
<td>4; 8</td>
</tr>
<tr>
<td>identity through work; not parenting; don’t identify as a mother</td>
<td>Rebecca</td>
<td>3; 8; 9</td>
</tr>
<tr>
<td>terrified of PND; worried re coping with lack of sleep; judge self as horrible parent;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>anxious re self as parent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identify as mother - positive</th>
<th>Both</th>
<th>4 on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likes being mother;</td>
<td>Joanna</td>
<td>3; 9</td>
</tr>
<tr>
<td>Can’t get enough of the children; really want this baby</td>
<td>Alyson</td>
<td>5 on</td>
</tr>
<tr>
<td>Primary role is mother; Reflect – this is what being mother about</td>
<td>Lea</td>
<td>3 on</td>
</tr>
<tr>
<td></td>
<td>Rebecca</td>
<td>3</td>
</tr>
<tr>
<td>Think we’ll be good parents; others think so too</td>
<td>Kylie</td>
<td>5; 7</td>
</tr>
<tr>
<td>thinks be a good mother; Want to cherish, spoil it</td>
<td>Abbey</td>
<td>7; 9</td>
</tr>
<tr>
<td>I suppose I’ll have mothering instinct; Mum thinks I’ll be good mother</td>
<td>Kate</td>
<td>5; 6;</td>
</tr>
<tr>
<td>DiscIdentify as mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>work is most important</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’m a mother not by choice; don’t want to be mother</td>
<td>Charly</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Abbey</td>
<td>5; 6; 7; 9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attachment to the state of pregnancy</th>
<th>Joanna</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief re end of last pregnancy</td>
<td>Alyson</td>
<td>9</td>
</tr>
<tr>
<td>Will miss the connection</td>
<td>Abbey</td>
<td>9</td>
</tr>
<tr>
<td>(both are last pregnancies)</td>
<td>Lea</td>
<td>8</td>
</tr>
<tr>
<td>will miss my little tummy; getting used to movement</td>
<td>Rebecca</td>
<td>3; 8; 9</td>
</tr>
<tr>
<td>really enjoying pregnancy; wants that final turn off so don’t do it again.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looking forward to 9 months to prepare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear and anxiety re birth and parenting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Want baby out;                                                                                  | Abbey  | 7; 9                     |
| Hate pregnancy – want baby born; not scared now                                               | Joanna | 9                        |
| reduced fear re birth; want labour                                                             | Alyson | 9; 9                     |
| looking forward to birth – excited; forgot what pregnancy was like; so painful, glad when its out | Kylie  | 8                        |
| wish it’d hurry up and come                                                                     | Bath   | 9                        |
### APPENDIX H

#### DATA: EVENTS AND STRESSES

<table>
<thead>
<tr>
<th>Category</th>
<th>111</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREGNANCY</strong></td>
<td></td>
</tr>
<tr>
<td>Normal things harder to handle – travel – 5/5; wedding; children; housework; relationships</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td><strong>PHYSICAL SYMPTOMS – SEVERE</strong></td>
<td></td>
</tr>
<tr>
<td>carpal tunnels; fibroids; severe back and hip needing treatment; brace; varicose veins; morning sickness</td>
<td></td>
</tr>
<tr>
<td><strong>EMOTIONAL</strong></td>
<td></td>
</tr>
<tr>
<td>Depression, like chronic fatigue; highly emotional; Struggling to accept bodily changes</td>
<td></td>
</tr>
<tr>
<td>Fear re baby’s health or wellbeing</td>
<td></td>
</tr>
<tr>
<td>Partner not wanting pregnancy</td>
<td></td>
</tr>
<tr>
<td>Anxiety re labour</td>
<td></td>
</tr>
<tr>
<td>Needy but hard to ask/accept help; fear of dependancy</td>
<td></td>
</tr>
<tr>
<td><strong>SUPPORT and RELATIONSHIPS</strong></td>
<td></td>
</tr>
<tr>
<td>Lack of support, isolation; family not close by</td>
<td></td>
</tr>
<tr>
<td>partner stressed/ill/unavailable/not helping problems in primary relationship</td>
<td></td>
</tr>
<tr>
<td>no primary relationship</td>
<td></td>
</tr>
<tr>
<td>problems in relationship with her own mother community judgment</td>
<td></td>
</tr>
<tr>
<td>stress in other relationships (including work)</td>
<td></td>
</tr>
<tr>
<td><strong>CHILDREN</strong></td>
<td></td>
</tr>
<tr>
<td>More irritated with them; they more demanding or difficult; pregnancy makes it harder to manage* can’t get rest or space</td>
<td></td>
</tr>
<tr>
<td>health problems and appointments</td>
<td></td>
</tr>
<tr>
<td>health risk to child and nowhere to find out about it; PARENTING</td>
<td></td>
</tr>
<tr>
<td>fear of obsessing; capacity to parent (first timers) how cope</td>
<td></td>
</tr>
<tr>
<td><strong>EXTENDED FAMILY ISSUES</strong></td>
<td></td>
</tr>
<tr>
<td>Cancer; operations; hospitalisations; death; father leaving overseas; mother in law won’t mind children; Visits of family or friends (mostly welcome but rated 2 - 5)</td>
<td></td>
</tr>
<tr>
<td><strong>WORK OR STUDY</strong></td>
<td></td>
</tr>
<tr>
<td>could do with less; have to hide pregnancy; push self harder to counter attitudes to preg women</td>
<td></td>
</tr>
<tr>
<td>Want to be working; work is my life blood</td>
<td></td>
</tr>
<tr>
<td>Loved my career – now brain dead job Partner unemployed (even briefly)</td>
<td></td>
</tr>
<tr>
<td>work ok but need practical support study – stress of assignments etc</td>
<td></td>
</tr>
<tr>
<td>fear and anxiety re being the prime breadwinner – implications; pressure of work</td>
<td></td>
</tr>
<tr>
<td><strong>BUSINESS</strong> – bankruptcy threatened – (stress rated 3/5; 5/5); opening new business</td>
<td></td>
</tr>
<tr>
<td><strong>FINANCIAL 4/5</strong></td>
<td></td>
</tr>
<tr>
<td>having to go to bank manager when pregnant worry re economy</td>
<td></td>
</tr>
<tr>
<td>worry re loss of mother’s wage post birth INTERESTING - teenagers didn’t mention money much at all;</td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAL SYSTEM</strong></td>
<td></td>
</tr>
<tr>
<td>visit to doctor; ultrasound 3/5; medical system</td>
<td></td>
</tr>
<tr>
<td><strong>HOME</strong></td>
<td></td>
</tr>
<tr>
<td>building; reorganising; moving; homeless; moving out of area to the House; sharing;</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Numbers indicate the stress level, with 5 being the highest.*
In pregnancy

Partner at home more
- Partner's acceptance of pregnancy
- A partner
- partner to massage, bring flowers
- pamper me

friends, family close

So hard to get the housework done a
- cleaner; shopping; housekeeping;
- a housekeeper

peace
- a long shower without the children
- time without interruptions

more time to talk with other
- pregnant mothers - group
- sessions
- Other mothers to chat to,
- watch TV with,
- time with people with the same
- problem - makes me feel

CHILD CARE
- occasional and respite;
- Quality;
- accessible - location &
- cost; in extended family;
- another day available at preschool

transport to the clinic

better baby shop locally so don't have to go our of area
The clinic open more then 1/2 day fortnightly
a help line staffed by people with medical knowledge and
counselling skills

transport

to work less

to work more
<table>
<thead>
<tr>
<th></th>
<th>HELPFUL</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>APPENDIX J</strong></td>
<td></td>
<td><strong>WISHED FOR</strong></td>
<td><strong>UNHELPFUL</strong></td>
<td></td>
</tr>
<tr>
<td><strong>FAMILY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents and extended</td>
<td>7</td>
<td>My family</td>
<td>4</td>
<td>Trouble Mum gave me</td>
</tr>
<tr>
<td>father</td>
<td></td>
<td>Grandmother: support</td>
<td></td>
<td>Not doing child care</td>
</tr>
<tr>
<td>mother’s visit</td>
<td></td>
<td>of meeting of</td>
<td></td>
<td>Family overseas</td>
</tr>
<tr>
<td>support</td>
<td></td>
<td>mothers of pregnant</td>
<td></td>
<td>Mother staying out</td>
</tr>
<tr>
<td>mum</td>
<td></td>
<td>teenagers</td>
<td></td>
<td></td>
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<tr>
<td><strong>PARTNER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEFINITELY; feel very</td>
<td>7</td>
<td>Support of partner</td>
<td>3</td>
<td>Partner’s lack of help;</td>
</tr>
<tr>
<td>lucky he’s so</td>
<td></td>
<td>A partner</td>
<td></td>
<td>stresses; illness;</td>
</tr>
<tr>
<td>helpful; Talk</td>
<td></td>
<td>communication</td>
<td></td>
<td>unwillingness to talk</td>
</tr>
<tr>
<td>together a lot</td>
<td></td>
<td></td>
<td></td>
<td>No partner</td>
</tr>
<tr>
<td>helps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FRIENDS &amp; neighbours</strong></td>
<td>9</td>
<td>Family and friends</td>
<td>4</td>
<td>None here</td>
</tr>
<tr>
<td>Support of friends</td>
<td></td>
<td>closer</td>
<td></td>
<td>Worried re how friends</td>
</tr>
<tr>
<td>Excitement and</td>
<td></td>
<td></td>
<td></td>
<td>reactions eg fuss or act</td>
</tr>
<tr>
<td>interest celebration</td>
<td></td>
<td></td>
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<td>as if I’m still single;</td>
</tr>
<tr>
<td>Friend visited</td>
<td></td>
<td></td>
<td></td>
<td>none pregnant</td>
</tr>
<tr>
<td>Talk to friends with</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>children Social</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>contact important</td>
<td></td>
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<tr>
<td><strong>Other pregnant</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>women - sharing,</td>
<td>7</td>
<td>Pregnant friends</td>
<td>4</td>
<td>Friends obsessing re their</td>
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<tr>
<td>talk to</td>
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<td></td>
<td>babies</td>
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<tr>
<td><strong>CHILDREN</strong></td>
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</tr>
<tr>
<td>Neighbour’s child</td>
<td>5</td>
<td>Reliable child care</td>
<td>6</td>
<td>mother in law won’t care for</td>
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<td>takes child to</td>
<td></td>
<td>More child care –</td>
<td></td>
<td>children</td>
</tr>
<tr>
<td>bus</td>
<td></td>
<td>family and centre</td>
<td></td>
<td>mother in law’s inability to</td>
</tr>
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<td></td>
<td></td>
<td>based</td>
<td></td>
<td>take child suddenly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Break from children</td>
<td></td>
<td>increased difficulty of</td>
</tr>
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<td></td>
<td></td>
<td>Manage child better</td>
<td></td>
<td>and irritation with child</td>
</tr>
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<td></td>
<td></td>
<td>Someone to take kids</td>
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<td></td>
<td></td>
<td>to school some days</td>
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<td></td>
<td></td>
<td>People to entertain</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>the kids</td>
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<tr>
<td><strong>PHYSICAL</strong></td>
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</tr>
<tr>
<td>Sleep, rest</td>
<td>7</td>
<td>Sleep, rest, lie in</td>
<td>7</td>
<td>Morning sickness</td>
</tr>
<tr>
<td>Smoking</td>
<td>2</td>
<td>bed</td>
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<td></td>
</tr>
<tr>
<td>Exercise eg yoga,</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>walking</td>
<td></td>
<td></td>
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<tr>
<td><strong>EMOTIONAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>support</td>
<td>11</td>
<td>Someone phone up and</td>
<td>5</td>
<td>People saying they understand</td>
</tr>
<tr>
<td>Reassurance</td>
<td></td>
<td>encourage me to get</td>
<td></td>
<td>Worrying re getting PND</td>
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<tr>
<td>Knowing gender in</td>
<td></td>
<td>out someone to take</td>
<td></td>
<td>Panic attacks</td>
</tr>
<tr>
<td>advance so can adjust</td>
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<td>reponsibility off my</td>
<td></td>
<td>Fear re baby’s health</td>
</tr>
<tr>
<td>Knowing what’s in</td>
<td></td>
<td>shoulders</td>
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<td>Worrying re labour</td>
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<td>store and that done</td>
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<td>want people to share</td>
<td></td>
<td></td>
</tr>
<tr>
<td>it before</td>
<td></td>
<td>and talk with, know</td>
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</tr>
<tr>
<td>Relying on myself</td>
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<td>someone in same</td>
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<td>because know there’ll</td>
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<td>situations. Talk to</td>
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<td>be no support</td>
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<td>someone objective</td>
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<td>Know the process,</td>
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<td>To be free to have</td>
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<td>don’t need</td>
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<td>fun – roller blading,</td>
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<td>information</td>
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<td>dancing, drinking</td>
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<td>Like being pregnant</td>
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<td><strong>HOME</strong></td>
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<td>Being at the House</td>
<td>5</td>
<td>My own place</td>
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<td>House flooding</td>
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<td>– talk to staff;</td>
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<td>Verandah finished;</td>
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<td>Extensions finished</td>
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<td>Building not as</td>
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<td>stressful as thought</td>
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<td>Moving - own/bigger</td>
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<td>house</td>
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<td><strong>Information: other</strong></td>
<td>8</td>
<td>breast feeding,</td>
<td>4</td>
<td>Horror stories especially</td>
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<td>women books, Pregnancy</td>
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<td>Parenting info</td>
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<td>for first time and young</td>
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<td>magazine</td>
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<td>Good book re parenting</td>
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<td>parents</td>
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<td>professionals</td>
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<td>from men’s perspective</td>
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<td><strong>PRENATAL CLASS</strong></td>
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<td>Young mums every</td>
<td>7</td>
<td>More info oriented</td>
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<td>classes geared to ladies</td>
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<td>Friday Social</td>
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<td>to men</td>
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<td>with partners; people glaring</td>
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<td>contact; other</td>
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<td>Like a clear training</td>
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<td>because single;</td>
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<td>pregnant teens;</td>
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<td>manual Classes for</td>
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<td>preparation for</td>
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<td>single and young mums,</td>
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<td>birth topics eg DV,</td>
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<td>$10 back cos didn’t</td>
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<td>relationship; Video</td>
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<td>go to classes</td>
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<td>Refresher course</td>
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<td>more mental emotional</td>
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<td>Time alone</td>
<td>Massage - nurtured; pampered</td>
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<td>nonsexual touch; massage</td>
<td>Home massage</td>
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<td>gave self permission to rest</td>
<td>Go back to being a teenager</td>
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<td>mum buying special food for me</td>
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<td>my own determined vision that it'll be OK; confidence - not swayed by partner's negativity</td>
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<td>CIRCUMSTANCES</td>
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<td>Bigger car</td>
<td>away from own country</td>
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<td>Work</td>
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<td>3 month paid maternity leave; leave work</td>
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<td>support and attitudes of work mates</td>
<td>New boss; fight for maternity leave;</td>
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<td>work is life; being active</td>
<td>Unable to work</td>
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<td>Greater financial security</td>
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<td>PRACTICAL HELP</td>
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<td>Building a network who've offered help; neighbours</td>
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<td>Partner helps</td>
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<td>Mother ironed everything down the undies</td>
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<td>Reliable baby sitter</td>
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<td>Someone here to help me</td>
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<td>2 days off to sleep</td>
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<td>Housekeeper</td>
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<td>Gardening; transport; taxi service;</td>
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<td>Total shopping service</td>
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<td>COMMUNITY</td>
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<td>NMAA - definitely; social outlet</td>
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<td>Refuge; the House</td>
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<td>Support of workers</td>
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<td>Aqua aerobics</td>
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<td>Didn't have to rely on services</td>
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<td>Playgroup</td>
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<td>Hypnasia</td>
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<td>Young mums group</td>
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<td>Preschool; child care; family day care</td>
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<td>Family friendly shops eg pram access; toilets INSIDE supermarket with child size basins - can't lift when pregnant</td>
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<td>Aquarobics more accessible</td>
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<td>Pregnancy exercise classes (not gym)</td>
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<td>Good local baby shop</td>
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<td>Accessible relationship counselling</td>
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<td>MEDICAL</td>
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<td>Obstetrician/doctor - supportive; reassurance; information</td>
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<td>Chiropractor; osteopath</td>
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<td>Naturopath; physio</td>
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<td>Ultrasound; knowing gender via</td>
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<td>sure I'm pregnant; beating heart beat</td>
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<td>Less interventionist GP; midwife clinic - not having to see Dr.</td>
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<td>high tech diagnostic option</td>
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<td>Helpline staffed with counsellors with medical knowledge</td>
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<td>More time to talk re worries - happy to talk to a midwife</td>
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<td>To meet anaesthetist</td>
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<td>More flexible system</td>
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<td>Choice of booking in time due to work</td>
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<td>Midwife clinic - too isolated for home birth; less medical more women's input</td>
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<td>Prefer maternity to say 'here's computer - work your way through or do it verbally then type up.</td>
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<td>Dr prescribing antidepressants</td>
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<td>Op and paediatrician made me feel really stupid</td>
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<td>Hospital when trying to find out re child's health risk;</td>
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<td>A &amp; E, Waiting 1 hr for Dr</td>
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<td>Dr not understanding need to know baby ok</td>
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<td>Fear re baby disabled &amp; relationship affected</td>
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<td>Meeting someone who miscarried after amniocentesis</td>
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<td>Obstetrician's manner. More interest, didn't explain; silence; don't like being touched like that by Dr; didn't like him</td>
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<td>Booking in process - personal question while looking at computer - depersonalized; not successful way to screen for PND; need interaction;</td>
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<td>had to wait 40 min in 30min lunch; Lack of encouragement to breastfeed</td>
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<td>Medical model of care</td>
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The Beginnings of Love: Development of the Prenatal Relationship

Francine Bartlett BSW(Hons)
Sociology and Justice Studies
University of Western Sydney Hawkesbury

Thesis
Submitted to fulfil requirements for

M.Sci.(Hons)
January 2002
WITH GRATITUDE

To my sons, Tim, Chris and Jarrad
- living with paper everywhere and a distracted mother
- who awakened me in real life to the issues this thesis explores
- with whom I experienced the beginnings of love

To Dexter, my companion
- wise mentor and loving friend,
- insisting that I have a life beyond the masters
- being with me through it all - the excitement and despair

To Debbie Horsfall, my supervisor
- patient, persistent, en-couraging and brilliant
- holding the thread all this time even when I lost it
- wondering, I suspect, “will she ever finish?” but making me feel that I could

To Beulah Warren,
- unofficial expert consultant
- warm and willing clinical supervisor and discussant

To my friends
- for reaching through my hermitage
- being patient with the refrain, ‘when I finish my thesis’
- bearing with this long gestation and difficult birth

To the Social Ecology Student fund
- for $600 contribution toward gathering the data
- and enabling me to present the spirit of this thesis to a conference

and most of all

To the participants
- for letting a stranger enter the inner sanctum of home and pregnancy
- giving so much of themselves and waiting so patiently for their videos
- who have enriched my life personally, emotionally, intellectually and spiritually

To the preborns
- the silent presences and witnesses
- the foci of inspiration and attention
- the symbol of all future generations who deserve to live in love

thank you!!
SUMMARY

This thesis weaves together disparate sources of theoretical knowledge with the lived experience of eleven women to illuminate the mysterious world of prenatal relating - the foundation for postnatal life and the beginnings of the capacity to love.

Love and supportive relationships can ameliorate stress and trauma post birth, but do they operate prenatally, and if so how? This research clearly shows that mothers relate to their preborns and from the rich detail of their stories, I propose a schema that captures the complexity and changing nature of the process of prenatal relating. The thesis

- indicates what is traumatic for children
- demonstrates the critical role of social conditions in chronic stress and child development
- presents evidence for the relationship between stress/trauma in children and attentional and behavioural problems
- highlights the role of love and support for adequate parenting and for children's resilience despite adversity
- establishes the theoretical foundation for parallel processes between pre and postnatal life, and that the mother's relationship with the preborn mediates the effects of stress and support, thus influencing the form and functioning of the developing foetus.
- proposes a model that describes facets of the prenatal relationship developing between the mother and preborn.

The basic physiological and neurological structures are formed from conception making the preborn vulnerable to the effects of direct and maternal experience. Preborns have extensive capacities that include the potential for interaction. These capacities and experiences affect infant development post birth. This evidence supports my initial hypothesis that prenatal stress is a significant factor in the attentional and behavioural problems of childhood, and challenges purely genetic explanations.

'Normal' life events have greater potency during pregnancy, making the transition to parenthood stressful even for many women in low risk situations. Feeling supported is essential for the health and well-being of the mother and preborn. The balance between stress and support facilitates or disempowers the mothers' post and prenatal relating.

With this theoretical foundation, the thesis reports a phenomenological, prospective study of eleven pregnant women as they lived the prenatal journey. From the interviews I am able to describe the development of the prenatal relationship and the range of stressful and supportive factors that should be considered in the creation of child and family friendly communities.
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ABBREVIATIONS

ADHD  Attention Deficit Hyperactivity Disorder
EPDS  Edinburgh Postnatal Depression Scale
NMAA  Nursing Mother's Association of Australia
PTSD  Post Traumatic Stress Disorder
DSMIV  Diagnostic and Statistical Manual (4th ed.)

Please note:

- I have written this thesis in a more personal way than is traditional because it seemed incongruent to be objective and impersonal when writing about love and relating. Also, I have asked the participants to be personal and open - it would be dishonouring for me to be otherwise myself.

- Unless specified, this work has an Anglo-European cultural context and may not have cross cultural relevance.

- In the interests of the environment, I have used single spacing.

- Where lists of references are long or interrupt the flow of text I have used footnotes.
The period between conception and birth is the time of the most rapid growth of the organism, a time in which each day witnesses changes so significant that at no time later on will so much happen to a human being within so short a space of time. If, as seems to be the case, the earlier an experience occurs in human life the more it may influence what will happen as the person develops, then the subjective experiences of the period immediately following conception should not be over looked. A warning is necessary here. No matter how profound such an early experience may be, there is always the likelihood that its effects can be moderated later on. The human organism has the magnificent capacity to transform itself over and over again every day of its life, to adapt to changing conditions, to repair injury, to heal itself, to re-vision and to revise concepts, to learn and to incorporate learning, and to make out of what to some would appear a catastrophe an opportunity for development. ... re-forming is always taking place, whether we plan it or not, so it seems essential that we apply as much consciousness to the transformative processes in which we are engaged as we are able to do. (Singer, 2000, p199)
Introduction: THE BEGINNINGS OF LOVE

For Euripides, Love is all we have, the only way that we can help each other.¹
All, everything that I understand, I understand only because I love, claims Tolstoy.

Clearly, love is a powerful and important force, mysterious despite being the theme of much contemplation. Where does love begin?

When watching a parent obsessed and wholly engaged with an infant - both merged, dancing in harmony with the other through their soft, locked eyes, it is obvious love begins early - or can. Watching a parent lost in their own deep sorrow, childhood longings, anger or despair with an infant desperately searching, in vain, to find the mirror and confirmation of their beauty and Being - the parent's adoring gaze - it is apparent love does not always begin - or begins but in different forms.

Is it, in heav'n, a crime to love too well? asks Alexander Pope

Society answers 'yes' to Pope when young infants are seen to be manipulative and parents feel guilty about responding from their heart to their baby's cry. Whatever the quality, early relationships live through a person's life, giving the tone, theme, underground shape, backdrop to all the passing events in the action of the life (see chapter 1). Like the signature key to a piece of music, the theme of a relationship can be changed but usually isn't. The health and well being of children (and the person they will become) is strongly influenced by, perhaps dependent on, the quality of first relationships.²

This study does three things. 1) It explores literature that relates to the prenatal period as the basis for later child development and the role of trauma and support in the aetiology of subsequent disorders. 2) It proposes a schema describing the development of a pregnant woman's relating to her preborn. 3) It indicates what helps or hinders the beginnings of loving prenatal relating. My original intention was to accompany families through the pregnancy to 4 months postpartum, tracking stress events and support, to see if there was any relationship between these factors, the quality of the post natal relationship and infant outcomes. Unfortunately, I was unable to process the data collected on the postnatal period or fathers due to lack of resources.

IMAGINE³

A 3 year old out of control at home but not preschool - screaming, hitting, spitting, little sleep, labelled ADHD and medicated but noticeably worse when there is parental conflict or stress; when parents walk on egg-shells and

³ These composite vignettes come from my social work practice.
do anything to avoid confrontation for the sake of peace. During her gestation, there were enormous pressures on the mother due to a car accident, the death of her mother and intense marital disharmony.

A 9-year-old, sullen, angry and prone to explosive aggressive outbursts who, from birth has been called "the turd" or any one of a number of other derogatory, insulting names by his parents who are similarly prone to violent outbursts. They didn’t want to get pregnant till he had a job and they were established. They wanted to be able to do better for their kids than was available to them. They decided on an abortion but couldn’t afford it.

Born to a 17-year-old girl who hoped for the ideal family with her 19-year-old boyfriend. During the pregnancy, he went into a remand home. Her parents were angry and she was very stressed and unsupported. The baby was born prematurely the day after her boyfriend was released. For the first two years of her life the baby was bathed in a tumultuous sea of violence, threat and aggression in which the mother struggled to stay afloat. For ten years now, since she was four, this girl has seen a procession of professionals for help with her uncontrollable, violent behaviour in the family.

Miners used to take canaries down the mine with them because they couldn’t smell the noxious gases until it was too late to survive. Canaries, being more sensitive, would get distressed and die early enough to warn the miners to escape in time. This image flashed into my mind one day as I was pondering the numbers of distressed children overwhelming the Child and Family Service in which I worked, and increasingly labelled Attention Deficit Hyperactivity Disorder (ADHD). Could their distressed behaviour be a sign of more than brain pattern abnormality, family dysfunction, ineffective management strategies, family genetics, problematic personal psychologies?

Thus began my quest to understand more about the origin of these painful scenarios so that I could be more effective in treating and preventing them. I realised that ADHD and post traumatic stress disorder share many characteristics. Could lack of loving attention be experienced as traumatic in early life?

INFLUENCES

Certain values act like the warp that, though invisible, gives shape and form to the ideas weaving through this thesis. Revealing them helps you know what influences my work.

a. SPIRITUAL

As the daughter of a Protestant minister, Christianity was a formative force in my life. By exploring a range of spiritual traditions I have come to believe that at the core, all are one. The following two spiritual traditions encapsulate potent practices or ideas that inform this project and my way of thinking.

i. The oral teachings and practice of Buddhism give the threads of interconnectedness: of co-arising, mutual causality; of the nature, cause and way out of unsatisfactoriness or suffering; of compassionate action; of deep ecology.

ii. Rudolf Steiner and anthroposophy give threads of the four fold nature of humanity—body, life force, emotion/intellect, and spirit; child development as a microcosmic reflection of the great historical eras of humanity (Bittleston, 1975); pedagogy (zur Linden, 1980; Glas, 1983) and ways of being with children as parent and therapist.
b. THERAPEUTIC

i. Social work provides threads of psychology, sociology and the interface of the individual with society; the social construction of personal psychology; social-political action and change; analyses of institutionalized disadvantage, power, inequity and oppression; systems theory; child and family therapy.

ii. Process oriented psychology reinforces the threads of power; systems theory, interconnection, personal and global change. Weaves in deep democracy, Taoism, shamanism, Jung and the 'shadow', new physics, chaos theory and the embracing of diversity. It notices the consistent manifestation of the 'spirit' of things through diverse aspects of the individual, material and social world (Mindell, 1982).

Overall, experiences as a mother and therapist helped me weave these together into an holistic understanding of the co-arising nature of psyche-soma-social forces and that symptoms are a key to healing, resolution and wisdom, needing understanding not repression (Ornish, 1998).

SO, BACK TO THE QUEST.

This thesis is the end of a long and winding road, starting with wanting to test the link between attention deficit disorder (ADHD) and post traumatic stress disorder (PTSD). Children presenting in my practice with a range of attentional, behavioural, anxiety problems usually have some form of trauma in their history. If it is recent or the child is older, the connection between the trauma and the behaviour is clear and can be treated therapeutically (Buntain, 1994). However, for very young children or those for whom the trauma is more distant, the connection is not so apparent and often unacknowledged by caregivers or therapists. Perry et al note the ultimate irony that at the time when the human is most vulnerable to the effects of trauma - during infancy and childhood - adults generally presume the most resilience (1995, p272).

SOURCES OF STRESS:

So, I asked myself, what is stressful for children?

The extensive literature on risk factors contributing to child behaviour problems4 gives insight into the range of events that can adversely affect children - poverty; abuse/neglect; experiences of loss, death, separations; prematurity or low birth weight; isolation and lack of supportive networks; the emotional states of parents due to current or past experiences (see chapter 1). Though some events are expected as natural occurrences in many families, they are associated with psychiatric disturbances in adulthood (Holman et al, 2000).

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Separation and divorce, like marital conflict, is a source of stress, if not trauma for many children. Marital conflict, even in pregnancy, is a major factor implicated in the aetiology of child problems.  

Leonore Terr (1991) describes how trauma, especially repeated, on-going events like neglect, physical or sexual abuse, can affect children. Children have come to me for therapy who have similar symptoms but without apparently having suffered traumatic experiences. Interaction patterns in dysfunctional families are characterised by coercion and aversion (Patterson, 1982) but similar patterns are familiar in many average parent-child, teacher-child, sibling and playground interactions. I find myself wondering: since symptoms can occur without classical traumas, are 'low-level', chronic and pervasive coercive-aversive patterns of relationship traumatic to children and damaging to development?

Patterson et al (1992) studied pre-school boys and found that on average they were aversive (ie whine, disobey, argue) once every 3 minutes - 10 year olds, once every 10 minutes. He estimates that the average American preschooler is told 'no' 55 times per day. Imagine being told no so many times in a day - very unpleasant and hard on the self-esteem if not traumatic. For the parent (usually mother) SAYING 'no' 55 times per day may not be too easy either - probably exceedingly stressful! When you consider (or remember) being part of '3-minute-no' days, the link between childhood and trauma emerges - how you tried so hard to be patient while he emptied the spice rack for the 6th time this week (and it's only Wednesday!) - this time into the marinating tofu! Somewhere 'Get Down Off the Bench' sounded more like Attila the Hun than you intended. Oh... the guilt when the face of angelic innocence freezes in a look of indignant horror and then collapses into reproachful tears. For many children, the consequences are much more severe. As I write, the train passes a sign in a station: "FOR SOME KIDS EVERY DAY IS BOXING DAY" plus the picture of the sad face of a young child with a bruised face and black eye.

Many adults in therapy with me have recalled with anger and sadness their childhood experiences at home and school, describing reactions that resemble the symptom picture of post-traumatic stress (Diagnostic and Statistical Manual IV, 1994). For example: While recounting being beaten, mercilessly teased, intimidated or put down, some people  
• respond with what appears to be denial or numbing, eg, they shrug it off "I probably deserved it."
• diminish it's effects "Oh it wasn't that bad." "I turned out all right."
• have childhood amnesia with no memory of parts, or all of their childhood.
• dismiss the importance of family and have lost contact altogether with family or maintain a dutiful, superficial contact.

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5 Patterson et al, 1992; Beckwith, 1990; Lyons-Ruth and Zeana 1993; Seifer and Dickstein 1993.  
• express rage and hostility to their parents while relating with intellectual aloofness and distance to their own partner and children.

The trans-generational transmission literature 7 shows that we learn to parent primarily at our parents' knees. I have observed from my clinical work that people tend to polarise in their response to difficult childhoods - tending to either repeat the patterns of relationship with only minor variations to the theme or to go to the opposite extreme trying hard not to treat their child as they were treated. This later reaction could account for the people who manage to break the cycle and confound research predictions by being the statistical exceptions. Lyons-Ruth and Zeanah (1993) concluded that an ability to reflect on the past is helpful in breaking the cycle. Supportive relationships (past or present) and therapy may enable this capacity to develop (Egeland, Jacobvitz & Sroufe, 1988).

Issues of social injustice, classism, racism, sexism contribute to the conditions of high-risk for families.8 Poverty and race are factors in childhood problems, but rather than frame these merely as personal psychological problems, analyzing the social and institutionalized oppression behind much personal suffering will give a more accurate though complex understanding. However, much research and therapy is based on the psychological rather than social view. This could account for the inability of many services to be effective in situations where social injustice, not personal psychology, is the cause of personal symptoms.

THE EFFECTS ON CHILDREN

*How do children express their distress, especially in the preverbal stage?*

Thomas (1995) describes very specifically the behaviours that can occur in young children who are frequently misdiagnosed as attention or conduct disordered. Based on clinical experience and comparing descriptions of Post Traumatic Stress Disorder and ADHD in the DSM IV (1994), I independently came to the same conclusion. Two alternative classification systems for trauma in children have been developed9 in an effort to articulate the different sources and manifestations of stress/trauma for adults, children and infants. Some work explores the effects of risk factors in infancy and pregnancy, the durability of these effects, the long-term consequences for later functioning, the necessity and effectiveness of intervention.10

*But, I thought, many children survive despite experiencing stress and trauma.*

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Certainly, the intensity, frequency and coexistence of risk events have a bearing on the likelihood of positive or negative outcomes for a particular child. The child’s vulnerability, resilience, temperament, genetic origins, environmental experiences contribute to the picture.  

Support is critical for resilience.  

What shapes and influences the creation of loving, effective relationships and resilience in children faced with environmental or biological adversity?

Clinicians and researchers in the fields of infant mental health, psychotherapy and attachment explore the normal development of emotions, sense of self, capacity for relationship.  

(We) hope that studies of the developing child will expand to include all the 'other than mother' factors, as we continue to search for the key to optimal child rearing in a rapidly changing society. ...research on mothers' experience, as well as supportive services should enhance maternal experience, child development and family well being (Bims & Hay, 1988, p70).

New, exciting players are those studying neurology and how experience and sensitive responsiveness create the physiological templates for emotion and relationship. Then there is Love - that elusive phenomenon (known in the literature as object relations, attachment, bonding) - a vital ingredient for healthy childhood development.

Since beginning this journey (late 1980’s), others have supported the link between post traumatic stress in children and the symptoms of attentional and behavioural symptoms. But, what of children described by their parents as difficult from birth?

PRENATAL

In 1985 I began noticing in my work with children and families, that traumatic experiences in pregnancy, birth and the first months of life occurred in the history of

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12 Kohler, 1987; Werner, 1994; 1990; Moriarty, 1987; Murphy, 1987; Butler, 1997; Young-Eisendrath, 1996; Ornish, 1998; Oakley et al, 1990; see resilience section chapter 1 this thesis.  
13 The term 'attachment' is used in the literature to refer to the child's relationship style. In this work I have used the term 'relating' to refer to the mother's developing relationship with the preborn except where the word attachment conveys the meaning more accurately.  
15 Perry et al, 1995; Perry, 2000a, b; LeDoux 1996; Schiller, 2000; Shore, 1997; Duffy & Als, 1983; Schore, 1997; Greenspan, 1997; Greenspan & Weider, 1993; see normal development section chapter 1.  
16 See love and relating section, chapter 1 this thesis.  
many children referred to me. The idea that trauma experienced by the pregnant mother could cause later problems in the child in utero was like an 'old wives tale' to mainstream medicine and psychology. However, unknown to me, others were exploring this path.\textsuperscript{18}

In 1992/3, when the similarity between symptoms of Attention Deficit Disorder, Conduct Disorder and Post Traumatic Stress Disorder crystallized in my mind, I did a quick retrospective scan of 57 client files in which the mother's response to questions about experiences in pregnancy, birth and the first months of life had been recorded. I found that 87\% of mothers did report one or more stressful events in this period, (eg deaths, domestic violence, marital stress, traumatic birth, postnatal depression). Though inadequate to prove a causal connection, I was encouraged to delve deeper. Perhaps children with clinical problems have experienced early perinatal stress.

Pregnancy and birth are potent times for the mother, infant and the development of their relationship.\textsuperscript{19} What outer events (and internal meanings attributed to these events), affect the foetus and the relationship between infant and mother? Clinicians and researchers have attempted to isolate parent, child or environmental factors. The limited value of single factor studies stimulated growing interest in multifactorial, interactional studies. (Garbarino, 1990 has an ecological model).

Thus my journey brought me to this qualitative study of the prenatal period.

\textbf{METHODOLOGY}

Knowledge uncovered depends on the tools used - archaeologists cannot extricate the delicate strands of a single gold amulet from 3000 years of dust by using a spade let alone a front-end loader. Similarly, to extract the nuances of lived experience requires deep and open listening, not the often blunt tools of quantitative measures. This is not to discredit any method - one doesn't get to the gold amulet in the first place without using the spade. However, struggling with the research process itself has been a powerful part of the journey for me. I wanted to enter the early life of pregnancy to test my intuitions that

- trauma was a key factor in the behavioural and emotional dis-stress playing out day after day in my work with children and families,

- attention deficit disorder was not just some genetic inheritance that distorted the neurology and could be corrected with doses of amphetamine,

- stress in pregnancy affects the infant - love can begin in pregnancy through the quality of mother-infant relating.

I also wanted to know what mothers found stressful or supportive as this may illuminate trauma and resilience and may help guide my own clinical practice.

\textsuperscript{18} Montague, 1962; Verny, 1987; Chamberlain, 1987. See chapter 2

\textsuperscript{19} Kumar, 1997; Piontelli, 1992; Garbarino, 1990; Moss, 1987; Brannen & Moss, 1991
However these 'intuitions' challenged the established psychological and medical mores and met with great resistance from doctors, psychologists and some parents. (Interestingly I have a wealth of individual stories about how difficulties experienced in pregnancy affected their children.)

My intention to use qualitative methods met with even stronger resistance because it challenged the positivist approach to knowledge held by mainstream psychology and medicine. I found myself drawn into the debate between quantitative and qualitative methodology, but do not want to discredit either - both have a place (Higgs and McAllister, 2001). Throughout the course of this work, I have wrestled with the positivist research voice within me and in society, that holds the randomized controlled trial, experimental methods, large sample sizes, statistical analyses as THE ways to true knowledge. I have still not made a very comfortable peace with the part of myself that has been trained to accept this. However, I wanted to understand in detail the experience of women as they lived the prenatal journey. For the depth of understanding I sought, the positivist voice had to give way to the phenomenological.

The native hunter, in effect, must apprentice himself to those animals that he would kill. Through long and careful observation ... the hunter gradually develops an instinctive knowledge of the habits of his prey, of its fears and its pleasures, its preferred foods and favoured haunts (Abram, 1997, p.140).

While my intention was not to kill the participants, this phrase captures something of the quality of empathic identification (perhaps attachment?) I needed to comprehend the process of pregnancy, to approach the dark inner world of the foetus through the mother's experiences, feelings, and meaning making. To begin to enter, as fully as possible, into the beginnings of relationship between mother and infant required a position of connectedness and attunement that the detached researcher of the positivist approach cannot provide. Killing my Self and then resurrecting it to study and reflect was not an easy task.

I sought a way to reveal how stress and trauma feature in the child's development in pregnancy. I decided to listen closely, openly, uncritically to the stories told me by the women and men as they lived through the pregnancy, birth and first 4 months of parenthood.

Phenomenology and grounded research indicate that the way the researcher can best understand social phenomena is to stay close to people's lived experience - the storyteller knows the story. This fits with my approach to therapy. Listening deeply can enable the golden threads of subjective meaning to be identified by the researcher. By hearing the story as fully as possible its wholeness and meaning become clear. It is always difficult for the social scientist to be free of their own phenomenology and to really hear the story of another. Thus, it is important for the researcher to stay as close as possible to the other for the individual context and meaning to be revealed.

My well-tutored belief about research is that I should know clearly what I am doing, then execute a well-formed plan in order to complete a valid piece of research. This has not been my experience. The well thought out method shifted, changed, distorted, fell off track, didn’t quite happen, while the living, pulsing realities of life stubbornly pushed their way into a methodology co-created between me, my work and life, the participants and their lives, the university and the political processes of governmental policies.21

It was Husserl’s genius to realize that the assumptions of objectivity had led to an almost total eclipse of the life-world in the modern era, to a nearly complete forgetting of this living dimension in which all of our endeavours are rooted. ... The true task of phenomenology as Husserl saw it at the end of his career, lay in the careful demonstration of the manner in which every theoretical and scientific practice grew out of and remains supported by the forgotten ground of our directly felt and lived experience and has value and meaning only in reference to this primordial and complex realm (Abram, 1997 p41 and p 43).

While I generally agree, I think meaning develops, at least initially, through the socialization process. A child references the caregiver’s reaction in order to learn how to interpret, assess and value their experience. Acquisition of language is a case in point - a process of gathering meaning through the imitation of sounds AND the caregiver’s emotive response - fear, delight, rejection - and preference. Thus, we learn to give more weight and value to certain things and judge or reject others. The subjective meaning placed on any event has more impact than the event itself.

... global risk factors such as poverty actually tell us little of what we really want to know about a particular baby and family. What look like similar situations or events to an investigator may have vastly different meanings for each poor child and family; this requires us to appreciate as best we can the subjective experience of infants and their caregivers (Zeanah, 1993, P 71).

Thus, the women’s stories contained in this thesis (chapter 4), will give a glimpse of the uniqueness of each experience.

Kabat-Zinn, founder and director of the Stress Reduction Clinic, University of Massachusetts Medical Centre (cited in Ornish, 1998, p175), speaks about a new kind of science needed to get to the bottom of how thoughts, feelings, meaning and connectedness affect the operation, and hence understanding, of the material world including health and dis-ease. He speaks of the Heisenberg Uncertainty Principle, chaos and complexity theory, neural nets and emergent phenomena.

There needs to be a new vocabulary developed that would make sense of all this. We have to be willing to introduce poetic imagination into science ... Einstein’s physics doesn’t contradict Newtonian physics – but, rather, expands it (Kabat-Zinn, cited in Ornish, 1998, p183).

Remen adds

Anything that is not intellectual is seen as a weakness in this culture – the intuition, the spirit, the soul, the heart. Up until very recently, people devalued these things. It still opens one up to the pointing finger of touchy-feely ... Love is more powerful than ideas (Remen, cited in Ornish, 1998, p 206).

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My method of intention differed from my method in reality (see chapter 3).

BACK TO THE QUEST

My quest to understand the link between prenatal stress and postnatal distress has unintentionally developed in tandem with the work of others that has independently produced strong support for my thesis from other fields. Brain research and neurology has taken some exciting strides. Chapter 1 tracks the importance of childhood - what is stressful, what creates resilience, how these contribute to child development and the capacity for love and relating. Having established the theoretical base for the power of relationship in child development, I turn in chapter 2 to review the literature on the prenatal world and the relatively small body of work on the formation of prenatal attachment, the prime focus of this thesis. These two chapters give the theoretical foundation for the continuity of pre and postnatal influences and processes, including the role of stress, support and parent to child relationship.

Abram touches the nature of prenatal experience when he talks about the phenomenological view of language

We do not, as children, first enter into language by consciously studying the formalities of syntax and grammar or by memorizing the dictionary definitions of words, but rather by actively making sounds - crying in pain and laughing in joy, by squealing and babbling and playfully mimicking the surrounding sound-scape, gradually entering through such mimicry into the specific melodies of the local language, our resonant bodies slowly coming to echo the inflections and accents common to our locale and community. We thus learn our native language not mentally but bodily (italics his. 1997, p 75).

Sensations, perception, cognition have a sensory-grounded nature, especially evident for the foetus who, to our best guess is primarily sensuous, perceiving self and womb-world through the constant flow of inter-subjective experience - literally.22

Merleau-Ponty, „spent much of his life demonstrating that the event of perception unfolds as a reciprocal exchange between the living body and the animate world that surrounds it. He showed, as well, that this exchange, for all its openness and indeterminacy, is nevertheless highly articulate. (Although it confounds the causal logic that we attempt to impose upon it, perceptual experience has its own coherent structure…). The disclosure that preverbal perception is already an exchange, and the recognition that this exchange has its own coherence and articulation, together suggested that perception, this ongoing reciprocity, is the very soil and support of that more conscious exchange we call language (Abram, 1997, p 73-4).

... Moreover, not only language, but also relationship to the world encountered by the preborn and newborn.

This journey through relationship to Self occurs in a social context that reflects the developing relationship. It is necessary to be aware of the sociological factors that support or inhibit the mother’s capacity to form a relationship with the foetus and newborn. Ann Oakley (1981, 1992, 1993) and Mary Daly (1990) highlight the consequences and processes of the oppression of women, which seem true for any oppressed group. Children are in a

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22 Chamberlain, 1998; Stern, 1985, 1990; Verry, 1987; Piantelli, 1992; Raphael-Leff, 1993
particularly vulnerable position due to their own lack of power and their dependence primarily on women (also lacking power) for their access to and socialization into the world. The foetus is even more vulnerable. Children of oppressed races or other non-dominant groups (the term minority doesn’t seem right, as often such groups are numerically majorities), carry an extra load. The literature on child and adult health, welfare and education, swims in the knowledge that the disadvantaged suffer more than their share of social problems. However, the focus in much child and family related literature is on individual psychology, thus avoiding the leap to social, political and economic analysis. I attempt to keep both a sociological and psychological view throughout.

Chapter 3 presents the why and how of my own research, while chapter 4 introduces you to the eleven participants who speak directly through story of their prenatal journey.

I have attempted to understand theoretically, and through my research, the process of prenatal relating as a contribution to our knowledge of the powerful beginnings of loving relatedness which assists the child to come to its Self and relate inter-dependently and healthfully. Chapter 5 presents the results of this work which concludes, in chapter 6, with the importance of creating child and family friendly communities in which the prenatal journey is supported socially and emotionally.

One day, I think it was on the ABC’s Science Show, I heard someone talking about the Hubble telescope and presenting a scientific view of the world corresponding to the view of many mystics. I can not now look at the stars and be unaware of what lies behind and beyond them - complex, vast universes expanding at enormous pace since the first collision. This is very like the cells expanding rapidly within the relatively vast body of a pregnant woman. From the moment those cells collide and interpenetrate, a drama comparable to the beginnings of the universe is enacted.

This thesis weaves together disparate sources of theoretical knowledge with the lived experience of eleven women to illuminate the mysterious world of prenatal relating - the foundation for postnatal life and the beginnings of the capacity to love.

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24 Participants were given the choice of name to be used in this thesis and most chose to use other than their real name. As I had lost touch with one participant I chose a substitute name for her.