Mothers' experiences of feeling maternal ambivalence

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Abstract

Feelings related to our experiences of motherhood are often complex. One such feeling is maternal ambivalence, the intertwinement of deep love and dislike of motherhood. Yet, the freedom to share these feelings remains subjugated within our patriarchal neoliberal society. Dominant cultural narratives such as the motherhood mandate prime us to naturally enjoy mothering, while we are also required to maintain the demanding care standards of the 'good mother'. Feelings of maternal ambivalence have frequently been theorised as a negative and harmful psychopathology of motherhood. However, there has been a dearth of research understanding mothers' feelings of maternal ambivalence within their day-to-day mothering experience. During conversational teller-led interviews, ten mothers shared their experiences of having mixed feelings of motherhood for the current study. Feminist phenomenology epistemology and methodology was employed to enable an understanding of how we traverse feelings of both enjoying and disliking motherhood as socially contextualised, embodied mothers. Analysis tells how feeling maternal ambivalence began at differing stages within motherhood; before or during pregnancy, at birth, or once we had a baby in our arms. It arose within day-to-day mothering experiences such as sleep deprivation, loneliness or boredom. Our experiences of mothering events which moved us outside the gendered cultural motherhood narratives we had been told to expect, also opened up mixed feelings of motherhood. How our bodies were treated within our biomedical health system influenced our feelings towards motherhood. Feelings of maternal ambivalence ebb and flow through our lives changing shape and form as we grow, change and transition through our mothering experience. As we experience our mothering transformations within societies culturally embedded beliefs and norms, we are able to understand how our lived environment is influential to how we make sense of, and live our experiences of feeling maternal ambivalence.

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Introduction

I am writing this thesis as a secret wild woman learning to break patriarchal rules which have attempted to diminish how I live life in a female body. I have two children who I love deeply and fiercely. Mothering was always a quiet whisper inside my soul, I knew at age five the name I would call my son. However, after training as a registered nurse I realised mothering was not as easy as I had been led to believe. I nursed babies who did not settle, who cried for hours, whose mothers were exhausted. I cuddled babies in the wee small hours of the night so their mothers could sleep for just a couple of hours. But while I saw this for 'other' women I never truly believed mothering would be so hard for me, let alone filled with so many contradictory feelings. I assumed I would be a mother like my own mother who loved children and appeared, to me, to love every aspect of mothering. My mother died when I was thirteen, so I was never able to understand her experience of mothering. In some ways this project has been a cathartic process of allowing my own mother to be understood as a real woman who, most likely, had feelings of maternal ambivalence. I imagine for her it may well have started in her pregnancies as I did hear her stories of having horrendous hyperemesis gravidarum.

Much like my own mother, I found pregnancy gruelling, people continued to tell me the nausea and vomiting would settle 'next week' but this never seemed to happen. The 'pregnancy glow' never arrived, rather I fell out of all the mothering and pregnancy narratives I had been taught to expect. People would say being so unwell was worth it, but at one o'clock in the morning as I would roll over in bed and vomit again I would wish the pregnancy to stop, just so that I could have my body back and not feel sick. These thoughts felt terrible as I wanted to be a mother, but I also wanted to feel well. I understand now how common these thoughts are, but it was an incredibly lonely time, similar to the experiences shared in Tsalkitzi et al. (2020). I had two very different early mothering experiences with my children, particularly their births. My second birth was filled with anxiety and my son being taken to the neonatal intensive care unit. I know their births have impacted the way I parent, the anxiety of having a sick child infiltrated every aspect of my life, I worried and stressed about every decision I made. I blamed my body for making him unwell and this blame became a pervasive visitor within my own everyday experience of mothering.

When my babies were little I longed for them to grow in the hope it would lessen the perpetual crying, their needing to be in a constant position on my hip, while I loved having them so close to me, their little hands on my face, soft kisses on my cheeks. I felt

remorse and sorrow for wishing away my children's childhoods whilst loving them so deeply that it was painful. It is an all-encompassing love that came with a fierce need to protect them. The dark emotions of mothering were not something I felt I could truly share aside from with a couple of very close friends who had children of similar ages. One of my closest friends had children at the same time as me, and through our second pregnancies and births of our second children we had daily 'confessionals', we cried at what little sleep we had, how, even as nurses we couldn't get our babies to stop crying and the resulting feelings of failure. We laughed at the insanity of our mothering experiences and how dealing with critically ill patients was far easier, less rage inducing, and we felt more valued by society than we did as mothers. We drank an abundance of 'peaceful' coffees together while ignoring our children as they ransacked our houses with their imaginative play.

My mothering experience caused me to have shame inducing rage and although I knew other mothers had this experience, I was unable to honestly share my feelings freely. I know this shame was all part of the expectations society has on mothers (Munt et al., 2019) but still, I lived in constant fear of how people would judge my mothering skills, that if I admitted how I felt I would be labelled as a 'Bad Mother'. Worst still was the thought that due to my own mental health issues prior to having children I would be labelled as what LaChance Adams (2014) describes as a 'Mad Mother'.

As my youngest went to primary school I decided, with the encouragement of my partner, to return to university and study psychology. I had struggled with the biomedical model of health and the androcentrism within the New Zealand healthcare system. I had witnessed women's bodies being dismissed by medical professionals who failed to diagnose serious medical conditions because they believe women are overly sensitive or hysterical. I was hopeful given the increasing number of female psychologists, there would be less sexism within psychology. I soon realised that women were just as subjugated within psychology, that men are still more likely to hold positions of power within psychological establishments and there remains less research produced which holds a deep partnership with women (Oakley, 2016). I knew at this point if I had the opportunity to do a research project it would be in partnership with, and for, women.

As I began researching maternal ambivalence, I became perplexed. I found maternal ambivalence was frequently considered a psychological disturbance attached to theories of women being depressed, anxious, not loving and harming their children

(Hoffman, 2003; Murray & Finn, 2012). My personal experience of maternal ambivalence contradicted the psychological theorising. I knew I was not significantly depressed; I was anxious, exhausted and uncomfortable in my body which had changed dramatically through pregnancy, childbirth and postnatally. But I knew from having a history of depression that this was very different, my embodied experience felt different. I knew that as much as I had times when I wanted to be away from my children, or felt angry, I loved them so deeply that I could never harm them intentionally and I wanted to be near them. I struggled to understand how my experience of maternal ambivalence could be so different from what I was reading. As I started to read LaChance Adams' (2014) phenomenological theorising of maternal ambivalence and motherhood I began understanding how complex our political, social and culturally gendered narratives are. How the narratives ensure a continued androcentric gaze over women's bodies and how this has impacted the expectations I have on myself as a mother and the choices I have 'chosen' to make. LaChance Adams phenomenological theorising of maternal ambivalence made sense to my own experience of maternal ambivalence.

So here I am, mother, partner, student, nurse, living in a body which was once mine, then shared by two children and returned to me changed, pushed and pulled in different directions and is now settling into a middle-aged version of myself. This project is written with my history, my embodied experiences, my own understanding of the world to help frame the experiences shared with me by ten amazing, courageous women, who like myself are walking the complicated journey of motherhood.

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Chapter one: Literature review

Preparation

Maternal ambivalence is not a phrase we use commonly. After having a bad morning trying to get my children ready for school I would not turn to my friends and say, "wow that was rough, my feelings of maternal ambivalence are so high that I need a strong coffee". In fact, many of my friends and colleagues had not heard the term before I started this study. I realised we were living an experience in our day-to-day lives which was being spoken about in academic realms and frequently being theorised as dysfunctional by mental health professionals. Yet here we are, just 'mums', navigating the world of motherhood together. As my preparation and research for this project continued, I became disillusioned with the traditional theorisations of ambivalence and its incongruence with the day-to-day feelings of maternal ambivalence I had experienced. I set about understanding maternal ambivalence not merely as a psychological construct but within the context and history of Western societies gendered and patriarchal politics of mothering.

Hearing past voices to understand present expectations

History allows us to reflect on those who have come before us and how they have shaped the world we live in today. However, when reflecting on our histories we need to be aware of the dominant discourses which may infiltrate and obscure our understanding of a subject due to the sociocultural and gendered way in which it is reproduced (Bacchi & Bonham, 2014). The history of Eurocentric mothering from the late 1800s allows us to see how gendered discourses and societal expectations of mothers has evolved into the contemporary mothering practices we have today. The expectations of women in the role of mothers have moved and morphed over time. Early European history suggests that the majority of mothers did not stay home and raise their children while their husbands worked. Women also worked, often in low paying jobs, to support their families while their children were cared for by friends, family or came with women to their workplaces. Starting in the eighteenth century there was an increasing expansion of the middle class resulting in more families being able to afford for mothers to stay home with their children (Kagan, 2011). The economic shift brought idealist mothering practises based on socioeconomic privilege, such as staying home to look after your child while your husband worked. Mothers who did not have the same economic privilege were cast 'lesser' mothers. These beliefs remain part of our contemporary view of mothering in which a

'good' mother has enough household income to provide for her child while being at home with her child while they are young.

A mother's role in a culturally gendered world

As more women stayed home there was a shift in society to legitimise the 'homemaker' role. One of the ways legitimisation was achieved was through the increasing theorising and commentary regarding the importance of a child's attachment to their mother. Society was taught that good mother-child attachment would stave off 'moodiness' as an adult (Kagan, 2011). Developmental attachment theories became increasingly common and entrenched throughout the late nineteenth and early twentieth century. As the amount of research and theorising increased so too did its consistent teaching that the child's mother was the 'best' person for a child to attach to, preferably within the bounds of a nuclear family (Van der Horst, 2011). While this teaching "legitimised" the need for a mother to be at home with their child, it also acted to control and dominate women, ensuring women's subjugated domestic positioning within society. Not only this, childcare, which was once a community concern, became the full burden of mothers (Kagan, 2011). The motherhood mandate began to take shape, enforcing dominant gendered beliefs that women, given their genetic feminine qualities, were best to say home and raise the children and perform domestic duties (Russo, 1976),. This belief in gendered capabilities was a significant influence across many British Colonies (Rowold, 2013).

In the early twentieth century, Aotearoa New Zealand was also seeing an increasing theorising of child development and a considerable change in the teaching of mothercraft (Paul, 2018). An influential driver of conservative mothercraft, Sir Truby King was a medically trained Pākehā doctor who believed that any child could be raised 'correctly' given the 'right' mothering and nutrition. Notably King had no formal paediatric training even though he considered himself an expert (Bryder, 2020). King taught that a woman's role in life was solely to be a mother. He believed that human bodies had a finite energy source, and a woman's energy needed to be directed to her reproductive organs rather than being sacrificed to her brain (Paul, 2018). This teaching ensured women remained largely uneducated and within the confines of their domestic positioning in society. King also believed women did not require analgesia during labour as this is what a woman's body was designed to do. He did suggest instrumental births should be reduced, although it appears he blamed women's unfitness for pregnancy and childbirth for the use of medical interventions in labour (Paul, 2018). This teaching aligns

with the western biomedical model of health which perceives the female biological form as a problematic, unruly and essentially lesser version of the human form. The biomedical version of health continues to submit women to a medical system in which their bodies are considered disabled compared to a mans and therefore, are not able to birth a child without help from medically trained doctors (Cohen Shabot, 2016).

The subjugation of women through the biomedical androcentric beliefs that arrived in Aotearoa New Zealand with colonisation had an extremely negative impact on wahine Māori. Prior to colonisation wahine Māori had birthing knowledge and traditions that led to wahine Māori being able to birth independently at home (Makereti, 1938). However, traditional Māori home births became considered unclean and unsafe by Pākehā medical professionals. By the 1930s wahine Māori were forced to birth in Pākehā hospitals cared for by Pākehā health professionals (Simmonds, 2011). Makereti (1938) tells how wahine Māori were very modest "a Māori woman of the old order would die rather than let a man see her puke, or feel her, unless the man were her husband. I can name many who have died rather than allow a doctor to touch them" (p. 124). Being forced to birth within a Western hospital, with likely a male doctor in charge, would undoubtedly have been extremely stressful for wahine Māori, especially as tāpuhi (Māori birthing attendants) were not allowed to assist with wahine Māori births as they had not been trained in the European health system. By the 1960s the wahine Māori maternal mortality was three times higher than non-Māori. Yet, instead of considering the stress, marginalisation and removal of culturally appropriate care as possible reasons for such a high mortality rate, wahine Māori were blamed. Part of the blame came from wahine Māori being seen as too shy and docile, rather than the required active and assertive patient our androcentric health care system suggests we all need to be (Simmonds, 2011). Along with the significant increase in wahine Māori deaths there was a dramatic loss of traditional Māori knowledge not just of birthing but also mothering practices (Simmonds, 2011).

In traditional Māori communities' childcare was not the sole responsibility of mothers the whole community participated in their care and education. Children were also often raised by extended family members (Makereti, 1938). However, with colonisation came the androcentric norm of the importance of the nuclear family. Privileging the idea of raising a child within the bounds of the nuclear family diminished the value of raising a child within a collective family approach. Through colonisation and the push to patriarchal society, rather than a societal hierarchy based on whakapapa, the

mana of wahine Māori was reduced and traditional knowledges held by tāpuhi and kuia disregarded by the Pākehā biomedical health system (Simmonds, 2011). Colonisation processes continued to negatively impact Māori mothers. King's widespread teaching that any child could be nurtured to be a 'good citizen of the British empire' with the 'right' mothering. This teaching pushed Māori mothers to covert to Pākehā mothering practices which were considered the 'right' way to mother. However, this forced assimilation did not have positive health our comes for Māori infants whose mortality rate was significantly higher than non-Māori (Bryder, 2003).

Mothers self-surveillance. During colonial times women and infant health was considered important to ensure the reproduction of a healthy British Empire (Rowold, 2013). Over the 1800s and early 1900s breastfeeding became regarded as one of the most important health interventions to reduce infant dysentery death from diarrhoea (Bryder, 2020). While we can see the positive impact of breastfeeding in the health of children it has also been used as a tool to ensure mothers are kept at home with their children. In 1907 King established a national mothercraft assistance service, The New Zealand Society for the Promotion of the Health of Women and Children, subsequently renamed the Plunket Society (Paul, 2018). This society was established to 'save the babies' of the British Empire from poor mothering and malnutrition. Rowold (2013) suggests the Plunket Society was established to ensure New Zealand mothers were raising 'good citizens' through mothers' continued 'surveillance'. Bartky (1990), theorises women's continuous self-surveillance on our bodies based on Foucault's Panopticon theory of discipline. Mothering is no exception to this form of surveillance and having a mothercraft society which advocates strict mothering practices sanctions the disciplining practices on our bodily mothering experiences. To further entrench his teaching and the disciplining of mothers in Aotearoa New Zealand, King, in 1913, developed a manual to help teach mothers 'good mothering' (Bryder, 2020). This manual taught a routine-based mothering style, including practices such as 'self-settling' in which a child is left to cry to sleep in order to learn how to sleep independently. The manual had an overall notion of training a child. These firm practices were believed to result in a child being compliant and obedient and therefore, growing into an adult who was considered an 'upright citizen' of the British Empire (Rowold, 2013). King's manual essentially ensured mothers had a rule book to follow so they were mothering in a 'correct' fashion.

The manual, which was updated by King's daughter, espoused what a 'good and proper' mother should be, outlining expectations regarding how a mother would

compose herself to ensure a stable household for her child. By following King's mothercraft advice not only will the infant be “a joy from morning till night” (King, 1941, p. 5) but the mother will be happy and content. However, there is no acknowledgement in ‘Mothercraft’ (King, 1941) of any potential unhappiness of a mother, unless she does not learn this system of caring. Mothers using this system were taught not to spoil their infants through unnecessary physical affection and were encouraged to use controlled crying to settle their babies (Bryder, 2001) with no consideration of the stress to a mother when her infant cries incessantly. Mothers were also taught to ‘routine feed’ their children, rather than feed them on demand. King had witnessed dairy calves thriving from routine feeds and assumed this form of feeding would result in thriving children (Rowold, 2013). Mothering during this era had begun its transformation into a scientific practice (Held & Rutherford, 2012) aligning with the neoliberal marketplace (Paul et al., 2018) in which individuals are considered as solely responsible for their decisions and for their children. This practice continues to burden mothers with the sole responsibility of raising children, resulting in stress, pressure and likely feelings of maternal ambivalence. Plunket has continued to produce cultural narratives of the “good mother” and has maintained a significant hold on child health care in Aotearoa New Zealand. The dominance of King’s approach to ‘mothercraft’ has resulted in the continuation of our conservative and traditional views on mothering (Bryder, 2003). Many of King’s theories of childcare are still taught today even though they have been challenged by both medical professionals and contemporary psychological theory.

Developmental attachment: A mother’s responsibility

One challenger of King’s theories was an influential British psychiatrist, Dr John Bowlby (Bryder, 2020). Bowlby’s research examined the long-term implications of a child having secure attachment. While King and Bowlby had different theories on how to raise a ‘good’ child, both of their theories had significant implications for women. Both theories are set with the cultural background of patriarchy and the Eurocentric drive to reinforce the role of women as homemakers (Bryder, 2020; Kagan, 2011) resulting in the consistent messaging that a mother is the most appropriate person to care for children. Bowlby was raised by a strict nanny only seeing his mother for one hour per day. As a small child he sought comfort in a very caring junior nanny, to whom he is said to have been deeply attached. However, when he was five this nanny left for a senior position. While Bowlby acknowledges this loss, there appears to be little mention of teaching children to cope with grief and loss within his developmental theories. Rather, he appears solely focused

on ensuring mothers are aware that they must be a constant presence within their child's life or their child will be irreparably damaged. The early twentieth century was also marked by the impact of two significant world wars which shaped some of Bowlby's theory of attachment (Kagan, 2011; Van der Horst, 2011).

Through studying children who had been separated from their mothers during wartime, Bowlby theorised that any 'break' of attachment would negatively impact a child's development. While Bowlby's work appears to show the negative effect traumatic and stressful separation had on infants and children, his work takes little consideration for other stresses within a child's life during wartime. The change of life, separation from other friends and family would undoubtedly have also impacted on a child's ability to cope with maternal separation (Zeanah & Zeanah, 2019). Through generalising the impact of a 'broken' attachment within a trauma setting, psychologist Bowlby and his counterparts appear to only focus on separation from a mother as trauma rather than as a part of normal everyday life with little interruption or trauma for a child who lives in a settled and stable environment (Van der Horst, 2011). Separation without trauma, such as going to daycare, shows no significant negative effects in most children if they are given appropriate emotional support by other caring individuals (Yeary, 2020; Zeanah & Zeanah, 2019). Bowlby fought for children to be kept with their mother during hospital stays and not to be separated from parents during war time. His main research focus remained on the impact of the separation of mother and child (Van der Horst, 2011).

In 1951 Bowlby wrote an influential report to the World Health Organisation describing how children who had a broken attachment with their mother were more likely to have emotional issues leading to delinquency. He suggested homes without a stable mother and father figure would lead to the breakdown of moral fibre within society. Western society solicited that only a mother or mother substitute was able to nurture and care for a child adequately. Without the attachment to their mother, the child would be left damaged and unable to function as a proper member of society (Kagan, 2011; Van der Horst, 2011). This focus on a woman being the main provider of care for children enforces the societal expectations of the women having to be the best form of woman to be a mother. We must be present with our children, be young enough to play with them but old enough to make wise mothering choices. Our bodies must be fit and able and altruistic for the good of our child (Morgan et al., 2012) The notion of the child's mother having to be the main object of a child's attachment was also reinforced by the object-relations theory developed by Donald Winnicott (Wieland, 2002).

The good enough mother

In the early to mid-twentieth century Donald Winnicott, a paediatrician and psychotherapist, was also theorising mothering and child developmental theory through a psychoanalytic lens (Wieland, 2002). Winnicott specifically looked at the idea that a child requires a 'good enough' mother who was able to attend as closely as possible to the developmental requirements of the child and who was the child's primary object of attachment. His theories of object-relations have also been influential in how Western society has pressured mothers to become the sole focus of how a young infant develops appropriately. Within his theory, Winnicott theorises a mother's ambivalence as a reflection of the infant's desire and aggression towards herself (Wieland, 2002). Winnicott describes the importance of the mother's appropriate reaction to the child's aggression. If the mother becomes fearful or aggressive back towards the child, the child's 'true-self' will be unable to be found and they will become overly compliant. Winnicott, while seeking to understand all the dimensions of child development, fails to attend to the mother's dimensions. In an apparent progressive step, Winnicott (1949) wrote a list of reasons why every mother would hate her baby, 'even a boy'. He gives practical reasons in this list for instance 'the baby is not magically produced' or 'the baby hurts her nipples even by suckling, which is at first a chewing activity' (p. 73). His list was a marked movement away from traditional 'only love' feelings from a mother to child. However, he does not appear to acknowledge how these experiences may impact a mother or the emotions she may feel as a consequence of the kind of hate Winnicott allows. He suggests the mother has to learn to tolerate her feelings of hate. He also does not account for ongoing mixed feelings of motherhood, rather it appears that mothers will adjust to motherhood and then more 'negative' feelings would lessen. Still within the bounds of Winnicott's practical list, the complexity of a mother's emotions is unaccounted for and there is a sense that mothers remain the object of our child's needs without having any needs of our own (Wieland, 2002). The mother's presence as a person, our needs and desires, were not accounted or advocated for. We are required to be a continually good mother carrying the burden of raising our children in what has become a solo activity, to be well-rounded, socially appropriate humans (Held & Rutherford, 2012).

A mother's job

Although theorising maternal ambivalence through a psychoanalytic lens remains dominant in the literature, other theorisations have begun to emerge. In the 1960s, with the rise of the second wave of feminism more women fought for higher

education and employment in salaried white-collar jobs. Women sought to have the same freedoms and rights as men, including an increase in women wanting to work before having children. This, however, became another way of society attempting to subjugate women by pathologizing their experiences of feeling disillusioned, ambivalent or unhappy when they first became a mother. It was suggested these feelings arose as women were unaccustomed to being at home doing domestic tasks, therefore, women should stay home once married in order to be well adjusted prior to the birth of their child (Held & Rutherford, 2012). This theory still continues currently with the suggestion that women who have worked in professional roles are more likely to have feelings of maternal ambivalence due to increased feelings of boredom and anxiety as they shift from a professional role to the role of mother (Chapman & Gubi, 2019). These changes in life, feelings of losing yourself, the person you knew before motherhood, the woman who worked who had lunch dates rather than playdates, may result in feelings of grief and sadness. Learning to be at home with children is different for every mother and there may well be a process of grieving while you figure out who you might be as a mother (Oakley, 2016). However, women are frequently not afforded the space for grief as the motherhood role is seen as the dream goal, the experience we have all championed since we were young girls (Gentile, 2016). This is what society believes we were designed for, so we must be happy to finally be mothering, not missing our professional life.

For some mothers who return to work the theorisation of “super mum”, who wants to work and raise a family, made room for another approach to maternal ambivalence. The idea of women being able to “have it all” was fraught with social criticism. However, the reality of trying to have it all resulted in women attending to the vast majority of household and childcare duties even if their partners worked similar hours. Consequently, women felt increasingly overwhelmed, exhausted and ambivalent (Littler, 2020). Society has remained critical and judgemental of working mothers, which may have resulted in working mothers feeling unable to express any negativity towards motherhood. In the mid-twentieth century women lobbied society for the rights to work outside the home, however, there was continued societal encouragement of mothers to stay at home for their child’s attachment and development needs. There appeared to be a societal fear of irreparable emotional damage to the child’s psychic wellbeing if there was a separating of the mother-child attachment (Held & Rutherford, 2012). A mother’s job, within our neoliberal society, requires her to attend to all the needs of her child. She holds sole responsibility for her mothering decisions, her child’s behaviour and decisions

as well as their economic welfare (Ulrich & Weatherall, 2000). Yet, our environment, social structures and culture play a significant part in how we are able to make decisions for our children. Mothering is bound to cultural practices and we mother to raise children who adhere to normative societal practices.

A mother's job is to be in the workforce. Our experience is that of female bodies which are expected to be feminine, contained and relentlessly caring for our children to be a 'good mother' (Page, 2013). However, women are also expected to return to work or to earn some form of income from the time our children are deemed suitably 'old enough' to attend a childcare facility. The neoliberal expectation on women of paid employment leaves us with socially binding pressures to remain at home for the 'good of our child' while needing to work either as a necessity for our families or due to societal expectations of needing to earn a wage for the economic benefits of our country (Page, 2013). This positioning for women becomes an impossible situation in which no woman is ever able to live up to societal expectations of what a 'good' mother is.

Currently, partly because of the influences of our patriarchally developed attachment theory, mothers often remain vilified for returning to work. Vilification is particularly notable if the child is under a year old, even when the child is left in a safe and stable environment. Many women consequently feel guilty for returning to work and we blame ourselves if our child has any emotional distress when they are left with a caregiver (D'Arcy et al., 2012). However, being cared for by a caregiver was normal until the eighteenth century and life's unhappiness was not attributed to how your mother cared for you until the twentieth century. Prior to this, unhappiness was considered within the bounds of our sociocultural environment and external life experiences (Kagan, 2011). The theoretical teachings in which a child's mother is seen as the only person who can truly care for a child, have increased the social conviction that a woman's role in life is to become a mother and dutifully stay at home to care for her child (Van der Horst, 2011).

All mothers know how to mother. The motherhood mandate subjugates our female bodies to the continuation of humanity. We are taught from our childhoods that our female body is for reproduction and having a biological child will bring fulfilment into our lives (Gentile, 2016). We are told that being born in a female body brings with it an assumption of mothering ability. Somehow, our innate femininity brings with it an ability to 'know' how to mother a small human. These assumptions of gendered capabilities are

also why men are not expected to care for their children as it is not in their genetic makeup (Russo, 1979). The motherhood mandate is pervasive throughout Western neo-liberal society, pushing women towards motherhood from the moment we are born. Young female children are encouraged to be nurturing, to play with dolls, given toy kitchens to prepare food for others, and encouraged to play in a gentle 'motherly' fashion. Fairy tales frequently depict women tending to the house and caring for children while male characters work outside the home (Chakraborty, 2017). However, we are also taught not to be too motherly, as we do not want to have a baby too young. As we grow from young girls to teenagers, we are reminded to contain our bodies, to remain non-sexual until we are married, importantly not to have a "teenage pregnancy'.

In Western society teenage pregnancy is a cultural taboo. Society believes teen mothers are incapable of being a 'good enough' mother and raising 'good citizens'. Likewise, becoming pregnant for the first time over the age of forty is considered irresponsible, as we are 'too old' to mother at the level society feels is adequate. Society is particularly ableist when it comes to the 'right' kind of women to mother. Mothers with physical or intellectual disabilities or who have mental health issues fall out of the 'good mother' material. We are seen as 'mad' or 'bad' mothers, unfit to raise children as we may taint them with our madness or badness resulting in their inability to become a 'good citizen' (Krumm et al., 2014; LaChance Adams, 2014). Traditional patriarchal expectations of women's ability to mother a child remains strong in Western society. Women who display what is considered feminine qualities are assumed to be 'better mothers' than those of us who are interested in professional work or have what are socially considered as masculine qualities (Gotlib, 2016). These feminine qualities apparently ensure we will have only loving and caring emotions for our children (Donath, 2015) while maintaining the status quo of societies unequal power balance between men and women.

Assisted reproductive technology

An easy ability to become pregnant is another narrative we are delivered as we grow into womanhood. Society dictates you have your babies while you are young, but not too young! If you wait 'too long' your body clock will run out of time and you will be childless, which remains a naturally unsanctioned option for women (Gotlib, 2016). When you are the 'right' age, but you are unable to fall pregnant naturally, it creates another divergence in our cultural mothering narrative. Our bodies become conceptualised as problematic; they are not doing what we have been taught they should do, they are not feminine enough or maybe they are too much, too big, too wrong to conceive a baby.

Our infertility is seen as a lack of our bodies ability to fulfil our most important task. Our bodies are talked about with loss as 'barren' or sterile' as you have an embodied emptiness by being childless (Ulrich & Weatherall, 2000). If we need a form of assisted reproductive technology (ART) we are taught a resulting pregnancy will right the 'failure' of our bodies. However, only 32% of women aged 35-37 years will have a live birth at the end of their treatment and this number drops to around 1% in women over the age of 40 years (Simon, 2015). Such low numbers are not what is commonly discussed with ART treatments, rather we are told if we cannot become pregnant within this process it is our body that is to blame rather than the fact that the outcome is low to begin with. Men also have infertility issues, although it is commonly discussed as a woman's problem. We are culturally indoctrinated to believe fertility is solely a woman's domain. The cultural silence of male infertility is deafening, resulting in an absence of space for both partners to process fertility changes within the narrative they have been taught (Kaplan, 2015).

ART has become a commonly assumed pathway for middle-class couples who struggle to conceive. While it is increasingly talked about as a simple pathway it is a process which is taxing on your body and mind. It is invasive in the most intimate ways; your body is repeatedly examined and problematised as not being able to become pregnant. Our bodily autonomy is reduced if not removed as our body becomes seen as a necessary vessel for human incubation (Gupta & Richters, 2008). As our body is medically pushed into pregnancy, we are expected to be fully altruistic in providing our body for painful and taxing treatments in order to become pregnant (Toscano & Montgomery, 2009). The repercussions for living through ART are significant for mothers. While there is no research looking at maternal ambivalence following ART treatment there is research which suggests that mothers are less likely to share any feelings of postnatal depression following the birth of a baby conceived through ART (Abraham-Smith & Keville, 2015). When we have lived our lives being taught that our validity and worth is placed on whether we can have a baby, it becomes complicated to discuss darker and taboo aspects of mothering when you 'finally' do have a baby. Alongside not being able to talk about how we really feel about mothering, we may also feel deeply protective of our child given the process taken to conceive which might further hinder our ability to discuss any negative feelings towards our child (Gibson & Ungerer, 2000). We are taught to be grateful for being able to have a baby rather than being allowed to feel sad for the reality of mothering we may have entered into, which is often not the fairy-tale culturally sanctioned narrative of motherhood we are told to expect.

Pregnancy

As women, we are used to our body being in constant change, our body follows a rhythm through each month. Moving into pregnancy changes our physical body again. We are physically different each day of our pregnancy as our body moves to make space for our growing child (Baraitser, 2006). Baraitser (2006) challenges the traditional psychoanalytic theory of the boundaried self when women enter pregnancy. Our bodies become not ours alone, they are shared with another life and it is difficult to know where our body finishes and our baby's begins. Our singular subjectivity becomes a maternal subjectivity, belonging to both ourselves and our child (Raphael-Leff, 2020). From the moment they are conceived, they are embodied within us; we feel them as our body while at the same time as separate, their own body. Having a small human grow inside you makes the relationship between you and your child uniquely intense, and once the baby is born, they remain intertwined within every fibre of your life (Raphael-Leff, 2020). As we navigate the reality of living with another body, we may form deep and intense feelings towards our growing baby. These feelings may become the antecedence for feelings of maternal ambivalence once our baby is born as we are confronted with the reality of mothering and its distance from the cultural narratives we were expecting (Burchard & Maitra, 2018).

As we move into motherhood there can also be a realisation that we have lost the young girl we were (Baraitser, 2006). For some women feelings of ambivalence start in pregnancy. There may be feelings of excitement, happiness mixed with anxiety and fear or desperately wanting to be pregnant while wondering if it is the appropriate time to have a baby (Cutler et al., 2018). We may have been planning a pregnancy for a long time but still feel overwhelmed when it happens. Pregnancy is another era of our lives about which we are indoctrinated from a young age. We are told we will love being pregnant and will be radiant and glowing, knowing we are fulfilling our womanly duty of creating a human. However, for many women this is not the case as we fall away from the storied dream we have envisioned (Tsalkitzi et al., 2020). Morning sickness, the constant nausea and vomiting alongside other possible complications may plague our worlds and we may become hostile towards this child who has invaded our body and created such extreme havoc and illness. Their presence may be less than welcomed if we are acutely unwell and we may seriously consider if continuing the pregnancy is sustainable for our body (Tsalkitzi et al., 2020). Disliking pregnancy, the feeling of having a strange body within your body and the requirement of our body to play host to this

foreign body is not what we are expected to say as mothers about our unborn child. Here, in this part of the mothering story we are told to enjoy the process even if it results in chronic fatigue, pain, and uncertainty (Raphael-Leff, 2020).

Birthing

The birth of our children creates a narrative through which we enter motherhood. Through the decades there have been differing cultural narratives of childbirth, in particular with the need for medical intervention and analgesia. In the late 1800s doctors started using chloroform as analgesia during childbirth, although some doctors still disagreed that women needed any form of pain relief. With the first wave feminist movement there was an increased demand for women to be given analgesia if requested. This began the era of the 'twilight sleep' in which women were given a mixture of morphine and hyoscine which resulted in women becoming so sedated they were semi-conscious through the final stages of labour (Cohen Shabot, 2016; Skowronski, 2015). In the 1960s there was increased concern regarding the risk to women after a high-profile woman died during a 'twilight sleep' birth. These types of births eventually stopped although the repercussions of medical professionals believing they could intervene and deliver babies without mothers being an active participant in birth remained. From the 1960s, as 'twilight sleep' births decreased, there was an increase in epidural use in labour and education in the use of relaxation techniques during childbirth. The use of relaxation and breathing began a push for 'natural births' which claimed to be best for both mother and child (Skowronski, 2015).

The 'natural birth' movement remains strong within our neoliberal biomedical health system. There is a push for each mother to be 'fit' enough to endure birth with the least amount of analgesia and intervention regarded as 'best' for all mothers and infants. However, the narrative of the 'natural' analgesia free birth is not a reality in Aotearoa New Zealand. The Report on Maternity (2017) showed that two-thirds of first births require some form of intervention by health professionals. Cohen Shabot (2016) suggests this higher rate of medicalization is common in health care systems were women are in a 'privileged woman-focused facility' compared to those women in with little or no maternal health care available.

Birth trauma. The increase in medicalisation is due to women's bodies being considered unable to survive birthing and mistrusted by our neoliberal patriarchal healthcare providers. These health care providers are continually taught our birthing

bodies are docile, and weak and therefore in need of medical help. Alongside this, there is a cultural expectation that our bodies are able to be contained and controlled by our androcentric health practices (Cohen Shabot, 2016). The trauma of not being able to have the birth you expected is exacerbated by not only having your body fall away from the cultural expectation of birthing but to have your body fail in a society that teaches there is only one 'safe' way to birth a child, the 'natural vaginal birth'. This one way only teaching of correct birthing may create a silence for women as they feel shame from not birthing correctly (Cohen Shabot, 2016). Birthing is an intimate and private experience for many women, bodies may feel vulnerable during birth, poised at a threshold of change with our bodies being seen both as the creator of a life, as well as a body that may not allow the life to be birthed. Western medical practice sees the life of the unborn child as more important than the life of the mother and will seek to intervene to preserve that life irrespective of the cost it may have on the birthing mothers body (Cohen Shabot & Korem, 2018).

Feelings of trauma can be heightened by obstetric violence which often prevails in the birthing room when medical intervention is required (Cohen Shabot & Korem, 2018). When a mother's body is seen as secondary to their baby's it is often left behind in the thoughts of those in the birthing room. Our bodies become a commodity to the production of humanity. When we are giving birth, our bodies push the boundaries of what is considered feminine. This move away from our feminine normality is frequently disliked by health professionals, who have been taught to contain women's bodies even during the birthing process. This can result in feelings of our bodies being problematic, of being too much, too messy, too loud (Cohen Shabot & Korem, 2018). For women, having a body moving outside of the boundaries of cultural expectations can result in feelings of embodied shame. During a birth, feelings of shame may arise at any point. This may lead to increasing feelings of maternal ambivalence as we distance ourselves to cope with these painful feelings (Dolezal, 2015). Cohen Shabot and Korem (2018) describe these instances as gendered violence; a form of violence directly targeted at women because of living in a female body. Living in a patriarchal society which has had authority over our healthcare system puts women at heightened risk for obstetric violence given we are reliant on this androcentric health system through our pregnancies and as we give birth. Often our bodies have been judged well before we enter the birthing room, for example, in our antenatal appointments or for some women during an in vitro fertilisation process.

When the birth of our child occurs in circumstances outside of our culturally expected narrative it can feel overwhelming or traumatic for women. Being unable to have the birth you planned, where your body has not lived up to your expectations can be a grief filled process, especially if the interactions with medical staff during the birthing process is disenfranchising or lacking empathy (Simpson & Catling, 2016). Even though many women have traumatic births there remains little space to discuss and process the experience. Often if the birth has been what is considered "normal" there is very little, if any, room for a woman to share her sorrow or to grieve. Space for grief is only given to women whose infants do not survive the birthing process. Our grief is not recognised or acknowledged and consequently the grief we feel for the birth we did not have or for the injury sustained to our bodies is not legitimised (DeGroot & Vik, 2017). The loss of our self in motherhood is described by Oakley (2019a) as a woman's need to grieve for the losses and changes that happen as a woman becomes a mother. Whilst she does not directly link this grief process to feelings of ambivalence in motherhood, Oakley does suggest that women require space to deal with all emotions that may arise through mothering.

The depths of our dark emotions

Living day-to-day in the same space as a young human you are caring for in a manner called 'mothering', creates a multitude of emotional experiences, among which may be ambivalence. Having feelings of maternal ambivalence has been described as an exceptionally painful experience (Hollway & Featherstone, 1997). Routinely our disconcerting emotions are framed as dangerous to ourselves and pathologized or, which for many women feels far worse, these dark thoughts lead to society viewing us as a potential threat to our children. It remains culturally unacceptable for mothers to have dark, morbid feelings towards our children (Donath, 2015). Yet, maternal ambivalence holds both the dark fantasies of leaving our children and walking away from motherhood and the deep love for our children (Hollway & Featherstone, 1997). We are not educated on how to hold and manage such conflicting emotions, nor are we taught that we may dislike or hate our children at the same time as loving them deeply (LaChance Adams, 2014). Rich (1976, p.26) in her personal diary eloquently describes her own struggle with contradictory feelings of motherhood

> *My children cause me the most exquisite suffering of which I have any experience. It is the suffering of ambivalence: the murderous alternation*

> *between bitter resentment and raw-edged nerves, and blissful gratification and tenderness.*

As a society, we remain scared of these dark emotions which are a normal experience of motherhood (Held & Rutherford, 2012) and rather than looking to uncover why we might have these feelings we blame women creating a spiral of shame (Munt et al., 2019). We are constantly discouraged from negative feelings towards motherhood: mothers are expected to hold positive feminine emotions, to be nurturing, caring and loving (Cohen Shabot & Korem, 2018). There are gendered restrictions on woman's feelings which limit how we are able to interpret and interact with the world around us. As mothers these restrictions act to contain our emotions, especially our dark emotions, navigating us to stay within the bounds of positive feminine feelings. However, as we do this it dulls our experience of the world through reducing our overall emotional repertoire (Parker, 1995). As we hide our experiences of 'undesirable' emotions for fear of being labelled as a bad mother, we may become shrouded in guilt or shame (Davies, 2008). The feelings of shame and the fear of not being a good enough mother silence our ability to discuss what is a normal and healthy experience of mothering (Harrist, 2006; Hoffman, 2003; Parker, 1995). Holding dark emotions can be hard especially when we are caring for a new infant who has brought significant change into our world.

Baraitser (2006) suggests it is not until we are juggling the care of a demanding infant and unable to necessarily care for our own bodies, that we realise we have lost ourselves to our child. It is at this point we may start to truly understand our own subjectivity as it moves from being shared in pregnancy to a new mothering subjectivity. Some of our mixed feelings towards motherhood may appear at this point, where we realise, we are truly, deeply entrenched in mothering that is all consuming of our bodies and minds. For some women, Baraitser (2006) proposes, this process of understanding our subjectivity is transformational. We become aware and learn about the intricacies of our new mother-body, gaining more understanding about how we relate to other people, both in society and within our families. This time of working through painful change could be a period of personal growth and new beginnings (Burchard & Maitra, 2018). Yet while we feel different in our bodies, they appear as normal postpartum bodies to society. Feeling our embodied difference is complicated to navigate. Society does not talk about this feeling before we have babies, so there is little space to process foreign feelings of not-quite-rightness when our bodies appear as if 'normal'. This is especially so when no one else is talking about these kinds of feelings. The process of moving into a new

maternal self brings about what Baraitser (2006) describes as a radical shift in the self, a shift which attends to our maternal subjectivity. She suggests the process needs to incorporate the binary emotions of mothering, the love/hate, to allow the true understanding of self.

Yet as we are trying to go through a radical self-change into motherhood, we have the ever-present motherhood mandate infiltrating all aspects of our social and cultural experiences, especially focusing on our bodies. It encourages us to keep our bodies fit and active to be able to become pregnant and then tells us our bodies must maintain a perfect pregnancy to have a 'normal' birth (Parker & Pausé, 2018). It sneaks into the postpartum period telling us to get back to our pre-baby body, which is impossible as our body is designed to have a significant physiological change with motherhood (Baraitser, 2006). When we are unable to maintain these bodily standards, shame may permeate through our life. Shame itself remains a taboo (Brown, 2006). It is the anchor of negative feelings within our bodies and for some mothers, shame appears during pregnancy and birth or as our children grow. Shameful feelings may creep into our being when there is a lack of empathy from a health care provider if our body is felt to be wrong or problematic, or when health care professionals do little to attend to our feelings, lacking respect for our body (Dolezal, 2015). The pressure on female bodies is insidiously present in our lives and mirrored through media, and the way women's bodies are socially prescribed to only embrace the feminine (Bartky, 1990).

Shame is an embodied experience, which seeks us to hide away from others, to disappear. Yet when we are labouring and in the process of birthing we cannot hide when we feel shame (Cohen Shabot & Korem, 2018). So it becomes embodied into us becoming a trauma response of moments in life we were told would be wonderful and joyous (Cohen Shabot, 2016). When we leave this birthing space, we may have no place to put our shame but our bodies and attached to our bodies are our children: children who may have arrived as they were 'supposed to' or who may have been ripped out of our bodies in a form of gendered violence. The feelings of trauma from birth are not aligned with the exact procedure or birth we had. Rather they are a result of the care, respect and empathy, or lack of, that we experience in relation to others. As we try to recover from birth there is an expectation that we will feel love and connection with our baby. However, the traumatic experiences of birth may result in an inability to feel many emotions (Cohen Shabot, 2016).

Pathologizing our emotions

The prescription of 'how to mother' and 'how a mother should be' both physically and emotionally has resulted in an increasing number of women's darker feelings, such as maternal ambivalence, being pathologized with an increase in diagnosed psychopathology in women since the 1980s and 1990s (Held & Rutherford, 2012). Although this has resulted in increased research into perinatal anxiety and depression, the vast majority of literature is written within the biomedical model of health often looking at pharmacological or psychological treatment. For example, Underwood et al. (2016) literature review identified studies about antenatal and postnatal depression, this review reflecting the current pathologizing of women's emotions with a lack of understanding of the wider sociocultural gendered inequity of the mothering experience. An approach to emotions that emphasises diagnosis and treatment suggests to society that mothers have the sole responsibility for their own mental health and any darker feelings of mothering are solely our issue and should be treated individually. Psychoanalysis has struggled to accept that aggression is part of the motherhood experience and due to gendered understandings of emotions we also struggle to see that aggression is a normal emotion for women (Hoffman, 2003). Anger in women is often viewed as culturally threatening by both men and women, and therefore as women we often attempt to suppress our angry feelings. From a psychoanalytic perspective, Hoffman (2003) suggests that when we suppress these angry feelings connected to the situation we are living in or experiences of motherhood we did not expect, our anger may cause depression or other mental health issues. Anger in women is seen as deviant, we are only meant to be gentle and kind and when we step out of this narrative, society becomes concerned, fearing that we are not able to regulate our own emotions. We are seen as meek and mild and not able to safely tolerate such emotions or we will inflict our anger onto our children (Davis 2008). Maternal ambivalence has been theorised as an angry emotion, a pent-up rage. By being associated with an affect that is deviant, mother's maternal ambivalence becomes deviant also. However, emotions are not fixed constructs they are feelings that rise and fall like waves on an ocean.

Maternal ambivalence is not a fixed emotion, it is a fluid emotional experience which may wax and wane depending on the relationship you have with your child. It may change depending on our own stage in life, or our child's stage in life and may feel like a totally different experience with one of your children compared to another (Parker, 1995). Making room for feelings of ambivalence is important for women, their partners,

families and health professionals. Through learning to be accommodating of our negative and culturally taboo feelings we may have therapeutic growth, enabling us to feel less shame within our mothering experience (Davis 2008). Personal growth through ambivalence may also help us with our relationships with our children. Parker (1995) suggests that as we allow ourselves to understand our dark feelings that we may have feared or been told to stay away from, we can begin to better understand our mother-child relationship. Learning to understand our ambivalent feelings creates a freedom of emotion, which in turn allows us to speak loudly about our experiences rather than feeling silenced by the pressure to be what society considers a 'good mother'.

The fluidity of ambivalent feelings has been acknowledged by Joan (2010). She describes ambivalence as being dependant not only on how well we are able to tolerate ambivalent feelings but as dependant on the environment we are living in. Living with a crying infant, who keeps us awake for hours at a time is taxing. If we have support people who can come and help, who can cuddle the baby so we can sleep, our feelings of ambivalence may lessen. However, other social situations, such as unemployment or lack of support, may increase our stress resulting in feeling overwhelmed and unable to cope with our infant. As we start to feel we are unable to cope, feelings of maternal ambivalence may heighten, starting a cycle of feeling like a 'bad' mother which again amplifies our feelings of ambivalence. As environmental stress either increases or decreases, our feelings of maternal ambivalence may do the same. Understanding the importance of environmental influences on our feelings of maternal ambivalence is described by LaChance Adams (2014). Her understanding of maternal ambivalence in relation to our environment uses Heidgegger's concept of *Befindlichkeit*; how one sees themselves within the world and within their relationships, life events and one's own knowledge base (Gendlin, 1978). Examining maternal ambivalence as culturally embedded allows us to give attention to our lived experience as mothers. This invites us to understand our feelings through the way our body has moved within the world, it acknowledges the hurdles we feel we have faced such as issues with breastfeeding. It allows us to understand our own maternal subjectivity in relationship to the small human constantly attached to our breast. It also considers how the cultural history and societal expectations of mothering impact on the choices we make when caring for our children. We are allowed to understand how our interactions with our family, our health care professionals or our partners influence the feelings we have about our bodies and our experience of mothering (LaChance Adams, 2014).

Where is the ambivalence?

Speaking about a taboo subject defies many cultural norms and may cost us relationships or leave us feeling uncomfortable or ashamed. This becomes increasingly complicated when the taboo subject does not have a name that is commonly understood. When we can name our experience, it becomes easier to have conversations and to help both ourselves and our friends understand our experiences (Kelly & Radford, 1996). Maternal ambivalence is a lived experience which often goes unnamed. Speaking to an unnamed phenomenon can leave mothers unable to formulate their feelings especially when the phenomenon remains taboo (Welsh, 2017). However, not speaking about an uncomfortable experience or feeling does not make it go away. It stays hiding in plain sight. When we do speak about feelings of maternal ambivalence, we are often given a label of 'depressed mother'. We may also be blamed for any developmental or behavioural issues with our child. Maternal ambivalence has been associated with infanticide and filicide, with communities sharing disbelief when they hear about mothers harming their children. Yet the same communities do not want to discuss mothers' anger and rage. Instead we are told any feelings of anger will result in us harming our child either in a rage or through neglect (LaChance Adams, 2014; Raphael-Leff, 2010). So, we keep quiet as we are frightened of hurting the children we love so deeply (LaChance Adams, 2014). One way in which maternal ambivalence has become more commonly discussed is through stories and on screen.

Ambivalence in stories and on screen

Stories of maternal ambivalence have been hiding in culturally embedded nursery rhymes, fairy tales, movies and literature. Fairy tales have been passed through generations of people and are particularly gendered ways of viewing the world. Often, they portray only binary versions of gender and the extremely loving or powerfully hate-filled mother (Chakraborty, 2017). Paulson (2005) describes the rage and anger of mothers we now see in cinema. Fairy tales retold from the weakened Disney versions we may have learnt as children, are now shown for the real anger and rage they narrate. We now see the stepmother in Snow White as an abhorrently ambivalent mother figure who is left caring for a child they dislike or are jealous of (Paulson, 2005). We see a mother who dares to break away from being the culturally sanctioned 'good mother' to become what society considers a rebellious selfish woman (Mooney, 2016). We learn there is a disturbing mother — the monster, angry, rage filled, abusive woman who, rather than caring and nurturing her child, devours them through hate (Paulson, 2005). This portrayal

of mothering holds a frightening flame for us. We fear being the mother who is so unjust to their child: the child becomes little more than a shell of who they could have been (Buerger, 2017). This version of mother is one that most women want to avoid. We do not want to acknowledge our femininity as having this 'monster' side as part of us. We hide our feelings of ambivalence, fearing of our monster self. Like society we want to see the passive, gentle, feministic narrative of ourselves, yet, for Paulson (2005) we all have anger and rage within our normal everyday life.

Differing maternal subjectivities and experiences of feelings such as maternal ambivalence is becoming more commonly seen in film and television (Greer, 2017; Littler, 2020). Programmes such as, 'The Let Down' (Morrow et al., 2016) which portrays an exhausted and ambivalent mother juggling the everyday realities of mothering, are exploring alternative maternal subjectivities compared to what has been historically seen on screen (Littler, 2020). Throughout the script, co-author Alison Bell (who plays the lead character, Audrey) shares her personal interpretations on the struggles of mothering in today's contemporary society. In one episode, Audrey misreads an email and reads 'Frankenstein' for her mother's group instead of the parenting book she was supposed to. During mothers' group she then quotes 'Frankenstein' *'by the dim and yellow light of the moon…I beheld the wretch-- the miserable monster whom I had created'* (Shelley, 1996). While Audrey laughs as she reads the quote it is met with silence by the other mothers. The silence reflects how current cultural beliefs still hold maternal ambivalence as a taboo, and a vast majority of mothers are uncomfortable to openly share dark feelings. If we do share these feelings, we may well be placed on the fringe of mother friends as the self-surveillance of mothers also ensures we separate ourselves from mothers who might not appear to be the 'right' kind of mother (D'Arcy et al., 2012), even if we secretly also want to share our dark feelings.

Seeing different showings of maternal ambivalence on screen may suggest there is some change in how our society views different maternal subjectivities (Littler, 2020), although this may take some time to been seen within our everyday lives. We know that at any given moment women may well be parenting in a way that is now considered harmful compared to how the same style of parenting was considered in the years prior. Our mothering practices change over time and whilst in the past two centuries the key factor to most theories provided through our patriarchal neoliberal society is that a child needs to be solely attached or cared for by their mother, in order to become a 'whole' emotionally intact adult, we may be seeing a glimmer of hope for change.

Summary

The way we want to see ourselves as mothers, our inner subjectivity, remains shaped by the patriarchal neoliberal world we live in. Our day-to-day experience of mothering remains influenced by the likes of King, Bowlby and Winnicott whose teachings have become so entrenched their theories are taken-for-granted understandings of experiences of mothering. As mothers, we remain ultimately responsible for any misgivings in our children especially if we have fallen out of the current sociocultural expectations of 'good mother'. However, as this chapter highlights, there are differences between 'experts' in the way a child should be raised: and the literature highlights how theories change and develop over time, influenced by historical, social, cultural and economic understandings.

Presently, however, research-based understandings of women's experience of maternal ambivalence remains limited. One theory on why maternal ambivalence has had limited research is because it is hidden in the everyday taken-for-granted experience of caring. Caring is frequently not considered important work within our society and therefore research within this area is not often given priority (Burchard & Maitra, 2018). There remains to very little research understanding the experience of maternal ambivalence from the perspective of mothers who would be considered an 'everyday' mother. Lived experiences tend to be documented and shared by either academics or health professionals who are also mothers (Almond, 2010; Burchard & Maitra, 2018; LaChance Adams, 2014). While there has been some movement away from traditional conceptualisation and portrayal of maternal ambivalence there remains a continuation of maternal objectification through developmental and attachment theory (Held & Rutherford, 2012).

Ambivalence continues to be written about in a divisive manner, where women are portrayed as ambivalent or not, our emotions confined to binary dichotomies which, much like our bodies, are assumed to be problematic and in need of 'fixing' (Burchard & Maitra, 2018). However, maternal ambivalence is not a static psychological construct that can be easily quantified. It is an embodied experience which is transitional throughout our mothering experience (Raphael-Leff, 2020). It may be impacted by the economic ideologies of our society which add underlying and often invisible complexities to the decisions we make. It is also impacted through our lived environments which intertwine a multitude of different gendered expectations on women who carry both the mental and physical load of child raising. Feelings of maternal ambivalence may also be

influenced by the way our bodies are disenfranchised within the biomedical medical system we are reliant on, as within this system our bodies are still considered dishonest and troublesome (Cohen Shabot, 2016).

During the period I was writing this thesis I have noted two new theses written by overseas students exploring women's lived experiences of maternal ambivalence. In Aotearoa New Zealand there appears to be an increasing amount of research about postnatal depression and anxiety. However, I was unable to find any research from Aotearoa New Zealand with any form of valuing women's lived experiences of maternal ambivalence. This thesis aims to better understand how mothers, within Aotearoa New Zealand, experience feelings of both enjoying and disliking their experiences of motherhood within their day-to-day mothering practices.

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Chapter two: Methodology and method

Methodology

As I continued researching maternal ambivalence, there was a moment when I came to the realisation, I was researching an experience I had lived before I was aware of the psychological theorisation of it. I breathed this. I felt it on my body on the days I was struggling with mothering, my body had the trauma of birth connected to it, which I felt as my children cried and I cried for the young girl I once was. It was this realisation that convinced me that my project needed to be undertaken from a paradigm of lived experience, an embodied position of motherhood acknowledging it is not just our minds and thoughts which mother a child, it is the totality of ourselves, our body included. When I commenced this project, I had intended to use a feminist standpoint epistemology with a narrative methodology to inform my study. However, reflecting on my own embodied experience of mothering, the culturally gendered androcentric world we live in and the current literature on maternal ambivalence I realised my first theoretical choices would be unable to guide this project in a manner able to hold the embodied experience of maternal ambivalence.

As I read Harrist's (2006) phenomenological description of ambivalence in eight undergraduate students, I realised that maternal ambivalence could be considered in a similar phenomenological fashion. Harrist (2006) has four phases in his theory of which the first three, background, disorientation and exploration appear to directly align with maternal ambivalence experiences. He describes Heidegger's notion of the use of a hammer as an embodied extension of ourselves. As we use it, it remains congruent with us until for some reason it fails in its job. At this point we become aware of how heavy the hammer is how our hand feels achy now holding it. It has become disjointed from the integrated experience of being part of our body. Drawing on this theory, Harrist (2006), suggests ambivalence occurs due to a period of disorientation from our normal background or taken-for-granted experience of life. The background of mothering is a culturally gendered doctrine that all women will want to have a child and that they will know how to mother as it is an innate part of our female body (Gotlib, 2016). However, when we all of a sudden have a different reality such as realising we cannot become pregnant easily, or pregnancy is unbearable, or the birth is traumatic, or we cannot breastfeed, we may all of a sudden realise that mothering is not what was expected. Harrist (2006) describes this point of disorientation through feelings of "not-quite-rightness" or "feeling like I was just nuts" or "powerlessness and a feeling of being

trapped" (Harrist, 2006, p. 100). Similar descriptors also appear within the works of Parker (2005) as she describes women's experiences of maternal ambivalence.

For Harrist (2006), the next phase is exploration followed by resolution, however, the exploration phase of maternal ambivalence is complicated as it remains a taboo subject which many women will not have an opportunity to explore without being pathologized by Western medical professionals. While Harrist's theory of ambivalence was helpful to consider understanding through a phenomenological perspective, it lacks an understanding of the culturally gendered embeddedness we live with. The experience of maternal ambivalence is not a construct which simply occurs in our minds and bodies. It is impacted by our social environments, the way our female bodies have been taught to behave within our gendered environments. It occurs within the cultural expectations of the motherhood mandate with its presumption of a longing for motherhood from every female body. Through reflecting on Harrist (2006), and Standpoint and Narrative theories I realised I needed an approach which recognizes lived embodied experience while also identifying that the experiences of women are impacted by the patriarchal society we live in, so I opted for a feminist phenomenological epistemological and methodological approaches for this study (Baird & Mitchell, 2014).

Historically there has been tension between feminism and what has been described as the largely androcentric theory of phenomenology (Fisher, 2010). However, Fisher (cited in Sandford, 2015), suggests that the central tenets of feminism can be supported even within traditional phenomenology given its focus on the analysis of subjectivity and essentialism. Being able to apply feminist approaches to phenomenology provides an opportunity to radically rethink traditional phenomenological theory (Oksala, 2004). Through employing feminist phenomenology for this project I was able to see the world as socially constructed (Baird, Creedy, & Mitchell, 2017) and how important understanding the history of mothering and the good mother narrative is in relation to the feelings we have about mothering today. It allowed for understanding women's lived experience of maternal ambivalence while intertwining theoretical knowledge to produce a storied text (Searle, Goldberg, Aston, & Burrow, 2017). This was important to me, as I wanted to be able to keep women's stories whole, rather than cutting them up into disjointed pieces, as is often done in attempts to find common themes or narrative devices.

Feminist phenomenology has emerged out of traditional philosophical phenomenology, which seeks to understand how an individual understands the experience of existing in their world. However, unlike traditional phenomenology, feminist phenomenology posits subjectivity as situated within our body rather than just within thoughts and consciousness (Young 2005). Our body is the first way in which we understand the world, we feel the world around us as we are born, we move in spaces before we are aware we are human, our small bodies flail, unaware they are of us. We are our bodies before we know what a body is. Before our consciousness is aware of the descriptor for body, we become aware of the world through the movement of this body. As we learn about our body, our knowledge becomes based on the environment in which we live. Societal expectations of our bodies teach us how our body is supposed to be and interact with the world (Clark, 2019; Young, 2005).

Within the theoretical paradigms of feminist phenomenology, we are more than an essence, a conscious thought, we are the lived experience of mother. We are the arms that ache from holding the baby and the body that cannot return to its pre-pregnancy form. Our female bodies are contained within society by gendered femininity which restrains our bodies from being any form of masculine (Young, 2005). There remains a fear that should we become too manly, too masculine, our femininity will be reduced, and we will no longer want or be able to bear a child.

Feminist phenomenology acknowledges bodily motion as the first way in which we situate ourselves physically and spatially within the world. It acknowledges how we are culturally embedded in the socially constructed and gendered normative world in which our body moves in on a day-to-day basis. It is inclusive of our experiences within our social situatedness, our ethnicity, our biological sex and our gender (Clark, 2019). Feminist phenomenology opens spaces for bodies to be seen and understood within the environments they have grown, specifically showing the oppression our patriarchal systems have on our bodies and the gendered expectations and subjugation we face (Young, 2005).

Feminist phenomenology allows for an appreciation of the depth of historically embedded androcentric ways in which we view the world and it opens spaces for new approaches which challenge our everyday patriarchal practices. We can take our lived experiences of socially constructed situations and actions and understand them as taken-for-granted experiences. Once we can see them as taken-for-granted experiences we are

able to challenge the assumptions of gender, race and class they may hold. Through seeing these 'normal' activities outside of their designated situations or purpose they are able to become the object of consideration, a phenomenon that could be considered as occurring both as a normative experience and a non-normative experience simultaneously (Sullivan, 2018).

Living in this world, within a human form, we take our lived experience for granted. Munro and Belora (2009) write of our bodies 'disappearing' and getting into line with the narratives of our worlds. They also suggest that this begins with learnt children's stories and rhymes such as Humpty Dumpty who knows better than to sit on a wall prior to his fall and the delicious aromas which enticed Hansel and Gretel into the hot oven within which they could be cooked. These stories teach children about the dangers for their bodies within the world we live, they describe how sitting on a wall may result in a fall, how kitchens are hot, so hot you could be cooked. They are stories told to help create safety, to create a known secure world in which to live, they are teaching through language and body. They are narratives that continue within our worlds and for women narratives around pregnancy, childbirth and mothering are passed through generations. However, some narratives are silenced for fear that women would not want to enter motherhood if they heard the stories. These are the stories which hold how are bodies are supposed to act, how we try and discipline them into behaving in a 'correct' motherly fashion and how difficult that discipline can be for us.

Growing up in a western society we are shaped by a taken for granted experience of mothering. We are led to believe we will be able to become pregnant easily and infertility will only appear if we are 'old'; we're told we will love pregnancy, we will glow and be joyous due to the new life growing inside our bodies. We are assured the nausea is a small price to pay and the medical complications of pregnancy will happen to 'other women'. We are then given the story of birth being natural and how all women can birth 'naturally' which is the best for their infant. In this story it is only 'other' women who have birth complications. Following our infant's birth, we are told we will all be able to breastfeed them, that our babies will sleep, and we will feel amazing. We will float into the fairy tale of mothering and it will be the fulfilment of all our dreams.

The sharing of the painful stories of childbirth are often silenced due to not wanting to strike fear into the heart of young women. However, this perpetuates the 'natural birthing' narratives of childbirth, which may leave women who experience

birthing interventions feeling silenced and excluded, and that their body was defective compared to the dominant birth narratives we are told. It has also silenced women who have been traumatised by childbirth, by experiences that lie outside of the narrative of the expected birthing process (Cohen Shabot, 2016). Cohen Shabot (2016) reflects on how the medicalisation of childbirth in Western society has resulted in obstetric violence which is a narrative that is often silenced by the patriarchal power over women's bodies and the expectation of the biomedical framework of health being the only safe way to birth a child. Fear is often instilled in women, resulting in a mistrust of their own bodies. Meanwhile, society still expects every woman to have a 'natural' birth, as it is 'best' for the baby and mother.

Throughout our pregnancy we have an assumed experience of birthing. We are taught that birthing is naturally how our bodies are designed, whilst a parallel narrative instils fear through the Western medicalisation of childbirth. There are narratives teaching women to fear their own body within this process, telling them that they will need hospitalisation and pain relief as their body will not be able to handle the trauma of the experience. These contradictory narratives create an uncertain atmosphere for pregnant women entering into the birthing process with many feeling that within what is supposed to be a natural process they will have no control and for some women the birthing process becomes an 'outside ' of their body experience, whereby they become totally disconnected with the physical and emotional experience of birth (Bergbom, Modh, Lundgren, & Lindwall, 2017). When we are so disconnected from an experience it may become complex to try and describe our experiences to other people.

Munro & Belora, (2009), when discussing Merleau-Ponty (1974), describe how he theorises language as a form of embodiment which is embedded in our bodies from our time of conception. We hear and understand language prior to our understanding of who we are as individuals. Our understanding of being in our world is tied to narratives we hear throughout our lives. These narratives become part of our lived experience of life - the language we hear is the language we are taught and is the language our bodies experience and express both verbally and non-verbally. Not only is language heard by our ears, but it is felt within our lived bodies. Our bodies work within the language we understand, to move within this world, somewhat as a magical experience, we are able to walk, to see, to breathe, without a constant commentary to tell our bodies to do so (Munro & Belora, 2009). However, as Munro and Belora (2009) also discuss, understanding language as embodied is not to assume that there is only one reality or

world, rather that there remains a plurality within how humans create 'worlds'; there is always a possibility of another formation, another narrative. Therefore, when seeking to understand narratives, to attempt to make sense of the worlds in which we live, feminist phenomenology looks not just for essences of situations and environments, it also seeks a wider, broader understanding and reading of these situations, inclusive of one's bodily experience as well as the social, cultural and environmental forces at work.

Traditional phenomenology describes our body as solely our own and we live life as our own embodied person. However, this theorisation has been challenged by Young (2005) due to the shifting of boundaries of self that occur for women in pregnancy. During pregnancy, our body moves from our own to a shared body. We become host to another being, a small human who is developing and growing within our body, as our own body (Raphael-Leff, 2020). Young (1984) describes pregnancy as a period of split subjectivity. Split subjectivity can be described as a de-centring of one's-self, a maternal subjectivity. Our body independently shifts and changes to make room for this stranger, who you know of but do not yet know. They feel like our body yet as they start to grow, they feel like their own body. We are no longer alone; our body is not truly just ours, however, it remains just ours while our foetus hides within us (Raphael-Leff, 2020); Young, 2005). Rich (1976) describes separating from her child each day of pregnancy, knowing that this baby would leave her, yet understanding this baby was still within her inner being. As our pregnancy continues and our foetus develops there is a change in our physical boundaries of self, a fluidity of where we finish, and our baby begins (Young, 2005). We start to move away from the taken-for-granted self of our world. Our body feels different, our centre of gravity changes and how we can move within the world changes. As the child moves within us in the later stages of pregnancy we may become aware that this child has rhythms and patterns of being, of movement that belongs to this child but is still within us, connected to our body, a movement that becomes normal and relied on and for many women, a reassurance of the life of the child (Raphael-Leff, 2020).

Feminist phenomenology plays a significant role within women's studies. Its epistemology and methodology seek to understand women's embodied experiences living within a Western patriarchal society. Through this feminist phenomenology acknowledges the impact gendered stereotypes have on women. Kelland, Paphitis, and Macleod (2017) used feminist phenomenology in their recent seeking to understand women's lived experience of menstruation. They chose feminist phenomenology as they were aware that menstruation has a duality of being both a situation one lives through,

while being saddled with cultural and gendered expectations of menstrual practices. Baird et al. (2017) conducted a feminist phenomenology study seeking to understand women's experiences of intimate partner violence prenatally, through pregnancy and postnatally, looking specifically at women's pregnancy intention over this time. Like maternal ambivalence, intimate partner violence remains a taboo topic within western society. Baird et al. (2017) used feminist phenomenology as it is a naturalist approach, allowing a story to be understood through the cultural and social constructs within the participants' world. Through using this practice, taboo feelings are seen within the social construct of our social environments rather than as a dis-function or dis-ease of an individual. Through employing a feminist phenomenological methodology, I was able to carefully consider this research process through a specifically feminist and ethical framework (Baird. & Mitchell, 2014).

This project followed the feminist phenomenological processes utilised in Baird and Mitchell (2017) and Benson (2013) and involved talking with other women so they had the opportunity to tell their own stories of their lived experiences. The decisions made were based in feminist research principles such as; the participant recruitment phase was reflective with the safely and wellbeing of possible participants in mind; the interviews time and location were chosen by participants and the interviews were teller-focused (Hyden, 2014) ensuring the mothers were able to guide the conversations to where they felt comfortable. As per Benson (2013), my analysis was based on the thematic analysis procedure by Braun & Clarke (2006). This was a reflective process; firstly, I familiarised myself with the data, which included being the sole person to transcribe the data and started to consider initial thoughts. Following this I began to generate some initial patterns of meaning. I then reflected on these patterns and considered potential themes and how they might now work together, overlap or merge with each other. This process of analysis allowed me to think through the embodied feelings experienced by the mothers while providing room to understand how socially gendered narratives impact on the way in which we experience the world. Doing feminist phenomenology requires researchers to keep interpretations of women's narratives as true to their expression of the experience as possible, while being able to understand that their story is frequently lived through the backdrop of a patriarchal neoliberal society which alters the cultural narratives we are taught to expect (Baird and Mitchell, 2017).

Method

Participants

Convenience sampling was selected as an appropriate way to recruit participants for this project following the guidelines from Braun and Clark (2014). I have numerous acquaintances who I spent time with chatting about my research. During these conversations we would often share our own experiences of feelings maternal ambivalence and sometimes they described how they had conversations with their own friends about maternal ambivalence (even if they had not heard the psychological term before). My acquaintances were willing to ask their 'mum' friends if they would be interested in participating. Through choosing convenience sampling I was able to manage how many mothers were invited to participate. This was important as I was aware I could only cope with eight to ten participants within the timeframe of this project and I wanted every mother who was invited and wanted to participate to be able to.

To invite participants to be part of the study, I emailed or gave paper copies of the participant information sheet (See Appendix A) to my acquaintances. The information sheet outlined the research, the criteria for participating and included my contact details. My acquaintances gave this information sheet to two or three of their friends. Passing information about the research this way helped to ensure there was no feelings of pressure to participate. Maternal ambivalence remains a social taboo, so having an intermediary acquaintance allowed for mothers considering participating to be able to have a sense of who I am as a researcher before participating through reading the information sheet and talking to our mutual acquaintance. Being open and honest about having emotions that are taboo takes great courage and I did not expect women to participate without knowing that I too have shared these experiences. Using this method of recruitment 10 women chose to participate. Although there were no restrictions regarding the type of relationship women were in to participate during their pregnancy, birth and initial few weeks postpartum each woman described being in a relationship with the biological father of their child. At the time of the interviews two mothers were unpartnered and eight were still with the father of their children.

Participants then emailed or texted to register their interest. Once someone had expressed interest, I contacted them and we had a brief conversation either by phone or

email. This conversation covered the participants' understanding of maternal ambivalence, as some women were unsure if their experiences would be considered 'maternal ambivalence'. Negotiating feelings of maternal ambivalence for one person compared to another is complex given the fluidity and abstraction of the concept. This meant we would then have a chat about how we both understood maternal ambivalence, often with shared examples, and then the participant would decide if they felt their experiences fitted with feelings of maternal ambivalence. Having pre-interview conversations with each participant privileged their understanding of maternal ambivalence experiences and confirmed they create their meaning and knowledge and I was seeking to understand what these experiences meant for them.

As part of the cultural 'rules' of mothering women are expected to have their children at the 'right time'. Women who are too young, such as teenage mothers are often discriminated against with an assumed inability to be the right kind of mother who is able to raise a good and proper citizen (Neill-Weston & Morgan, 2017). Mothers who are considered 'old' for first-time motherhood also face societal judgement as there is a myth that they will be unable to be active enough to care for their child (Morgan et al., 2012). As feeling discriminated against due to age might raise other mixed and complicated feelings and experiences in motherhood, women who were over the age of 23 and younger than 39 when they had their first child were invited to participate. Although women in these age brackets are likely to have experiences of feeling maternal ambivalence, I am aware that due to the extra discrimination they often face their feelings could be more complex and distressing. While I realise it is likely these particular groups of mothers need avenues to express their experiences, I do not feel I had the expertise or the research scope to be able to ethically include them in this project.

There are many different types of mothers in the world, however for this project, mothers were invited to participate if they have either a biological or adopted child. The participant needed to have lived with her child for a period of time as living with a child may introduce a new and unique way of being for women - a change from a pre-pregnancy, or pre-adoption or pregnant way of understanding the world. However, mothers of only foster children were excluded as there is added complexity of raising a foster child which was not able to be considered in this study. All the mothers who accepted the invitation to participate had carried their own biological children to a viable gestational age and gave birth in New Zealand. Some women had children who were now teenagers while other women had babies under the age of one. I purposefully chose not

to specify an age requirement of children in the study as Parker (2005) suggests maternal ambivalence has a fluidity and therefore may be present in any stage of the mother-child relationship. Given this, I did not want to assume that feelings of maternal ambivalence may be constrained by the age of the participant's child.

All the mothers could speak and comprehend English well, even if it was their second language. Every participant lived and worked in New Zealand prior to having their children and had chosen to remain, for this period of their life, in New Zealand. Living in New Zealand while raising their children allowed for us to have a shared understanding of the cultural and societal pressures of mothering we face. These environmentally embedded experiences allowed an intimacy within our conversations which as Hyden (2014) suggests when she advocates teller-led narrative interviews. We also shared understanding of New Zealand maternity care and the relationships, or lack of, that we have with obstetric care providers.

Setting

We discussed where each woman would like the interview to take place, once they had agreed to participate. I live and work in the Wellington Region, therefore it was likely that my intermediary acquaintance would approach women based in the Wellington Region. which was an important criterion for this research. Yost & Chmielewski, (2013) discuss the importance of ensuring each participant has a sense of control and empowerment by participating in feminist research. I wanted each participant to be able to choose the physical setting they were going to be comfortable to chat in. This environment needed to be quiet enough for us to chat and also private. Discussing taboo topics in-depth needs privacy to create a safe space where we could be honest about our mixed feelings of motherhood without fear of disapproval by people who may not understand our experiences. I was able to offer all mothers the opportunity to meet at a local Women's Centre, which is a comfortable woman focused space that also has a creche space available, however each participant chose to have the conversations in their own home. Having the conversations at home was practical for some women who had young children as we could chat while they played around us as well as giving each woman the comfort of being in a space that belongs to her. I also discussed bringing some refreshments for us to share together. Within Māori culture sharing food is considered an important part of creating connection between people and it helps to equalise hierarchal power imbalances (King et al., 2015) which was an important consideration for this feminist research.

Support

Current research in Aotearoa New Zealand has shown an increase in postpartum depression and anxiety (Underwood et al., 2016) with which maternal ambivalence is often associated (LaChance Adams, 2014). While it could have been easy to analyse ambivalence through the manifestation of depression or anxiety, the literature and my personal experience suggests that maternal ambivalence is a broader experience than merely postpartum depression and anxiety. It emerges in the small aspects of mothering when we least expected it, and in forms we least imagine (LaChance Adams, 2014). From my perspective maternal ambivalence is an emotion felt by a vast majority of mothers irrespective of underlying mental health diagnosis. While some of the mothers I spoke with in a pre-interview phone call described experiences of feeling anxious or depressed, or having historical experiences of these feelings, I specifically chose not to ask participants if they did or did not have formal diagnoses, as each participant was mothering a child on a day-to-day basis. Therefore, like me, she is a mother with a multitude of feelings, emotions and a personal history which may or may not impact her mothering experiences. It felt important that this research was open to mothers who had feelings of maternal ambivalence irrespective of any coexisting mental health illness because of the focus on women's lived experience rather than expert diagnoses of disorder. Each participant was expected to have the capacity to make their own decision if they felt comfortable participating and I didn't expect that participation would cause significant distress. There was also a consideration that sharing experiences regarding a taboo subject, with another person who has shared similar feelings could create a cathartic process known to emerge from being given space to create and express versions of one's own life experiences (Kruger, 2003; Wickramasinghe, 2010).

However, given that maternal ambivalence remains somewhat a taboo subject (LaChance Adams, 2014) expressing feelings and thoughts which go against society's expectations of mothers may remain uncomfortable or painful for some women. For some participants, issues around underlying mental health, and issues from birth experiences were raised within the interview. Some participants required more support than was able to be given within the research process and they were encouraged to see a mental health professional or to raise a specific issue with the professional they were already seeing. Parts of the recorded interviews were not used as they pertained information discussing this process. At the end of each interview I ensured each participant, irrespective of any issues being raised in the interview, was given contact

numbers for support services should they wish to make use of the services. This was important as it might not have been until a few days later they realised an issue had been brought to the surface and they felt they needed further support.

Support persons

Each participant was given the option to bring a support person to the interview if they chose. Inviting a support person is an important cultural consideration, particularly for Māori and Pacifica peoples, who many identify their mothering experiences as part of a collective family or community rather than an individual experience. I also wanted this option to be open to all participants as I did not want to assume people's underlying cultural beliefs. However, each participant declined this offer. We did, however, have some children at home, or with us during the interview. As we were planning to discuss aspects of mothering which involved their children, each mother decided how comfortable they were to be chatting with their child present. For some interviews, the children slept through us talking or watched television in another room and for some, the children played and chatted with us. Being able to have the children in the interviews was important as the women's comfort was respected and any stress about childcare was relieved. While childcare was able to be organised during our meeting each participant felt uncomfortable, or that their child might not be keen to stay with a person they did not know, so they declined the opportunity for care.

Power dynamics

Research involving a researcher and a participant involves culturally created power dynamics which need to be considered by the researcher (Wolf, 2018). As a researcher I understood I had an obligation to create ethically conscious research and in the case of this study, my priority was to care for and respect the women participants. Understanding power in the research relationship was considered from a feminist epistemological approach. Being reflexive of my own socially historical embedded understanding of the world was a significant consideration (Baird & Mitchell, 2014). I considered my own ways of understanding the world through my experience as a psychology student, nurse, married cis-gendered Pākehā mother and so on. I understand how I live and move in the world with very little discrimination, other than being a woman in a patriarchal society. I was aware the mothers who had chosen to share their experiences with me could come from different backgrounds so I was careful to be aware of my own taken-for-granted assumptions throughout the conversations.

Oakley (2016) describes the gift each participant gives by sharing their stories and part of my ethical considerations was how I keep records of those stories physically safe. This safety was obtained through ensuring each interview was deleted from the audio recorder as soon as it was transcribed, and the audio recorder was kept in a locked cupboard after each interview. Each transcription was kept on a password protected computer. In the process of transcription, the interviewee was de-identified by the use of pseudonyms, for each participant and their family members. Place names and geographical areas were replaced or removed, and specific medical conditions or experiences were generalised. Each participant signed a consent form acknowledging they were happy to participate in the interviews and had understood the information given to them in the information sheet. The consent forms have also been kept in a locked cupboard and will be kept for five years with my supervisor. [1]

Interview process

The interview process was guided by the interview techniques outlined in Braun and Clarke (2013) and Hyden (2014). Each interview started with a general conversation about the interview process and reminding women that this was a conversation in which I was interested to hear their experiences of maternal ambivalence. I reiterated there was no expectation to share any experience they were not comfortable to share, and they could change topic or stop the interview at any point. Each woman was asked to sign a consent form (See Appendix B). This form was a written confirmation that she had been given enough information about the study, that she understood she could stop our conversation at any time and she understood how the information she shared would be treated. The consent form also asked for consent to audio record our conversation. One participant was particularly anxious about being recorded. We had discussed this in our earlier phone call and decided we would turn the recorder on while we got organised before starting the interview. After a period of time but before our conversations about maternal ambivalence started I checked in with her to see how she felt, she decided she was comfortable to go ahead with using the recorder although I reiterated we could stop this at any point.

[1] The procedures throughout this project were formed as part of an ethical protocol which was approved by the Massey University Human Ethics Committee: Southern B, Application #19/18

Each interview was a conversation between two women who have both had feelings of maternal ambivalence. A teller-focused approach was specifically chosen to encourage a sharing of power within the interview (Hyden, 2014). Part of this decision was an acknowledgement that every experience of maternal ambivalence is different and is contextualised by the women's own history, sociocultural background and understanding of her world as explained in the research process of Baird and Mitchell (2014). We all come to motherhood from different places and stages in life and this project sought to hear each woman's story individually. I understood that as a researcher I would be the co-constructor of their narrative as I formed it into an academic text based on careful listening and my own contributions to our conversation as well as the analysis. Some women came to the study with prepared notes, ready to share and we followed these notes through our conversation. For most interviews I did not need to ask any questions (See Appendix C), our conversations just flowed and moved in the way that was comfortable for each participant.

At the end of our conversations, after the recording was completed, I checked in with each woman to make sure they were feeling okay. With some participants I had the privilege of being shown family photos or chatting about life and mothering for a while after the recording was finished. I left each interview with a sense of connection with the participant. I was not surprised by this as we had a shared conversation about a taboo experience of motherhood which creates a sense of familiarity even though there were differences in our contexts and, in some cases our cultural backgrounds. These connections or sparks of friendship within research were discussed by Oakley (2016) who acknowledges the complexity of connections formed among women during research and the need for further research in this area.

Transcription

Through the analytic process, I reflected on Oakley's (2016) considerations of the sacredness of each woman's story and the gift they had given to this project by sharing their experiences. I was aware I needed to keep their stories safe through how I understood and shared their experiences in the analysis and discussion of the project. Power was also considered in the transcription, analysis and discussion process. I realised the participants had entrusted me to share their experiences with other mothers, to open conversations about the reality of maternal ambivalence that we all face, and that these were their stories and they were with me, their voices, since I was a co-collaborator within this process. As such I needed to be aware of my own history and interpretation I

would make of each narrative and the power differential that could be at play if not carefully considered and observed for (Baird & Mitchell, 2014). As I transcribed our conversation word for word and including my own contributions, I used a transcription notation system based on Clarke and Braun's (2013) guidelines. As you read quotes from the transcript in the analysis and discussion please be aware of the following representations; (.) a short pause in speech; ((laughter)) signals the speaker was laughing as they spoke; (( )) were also used to signal other parts of speech or expression for example ((sighs)) or ((coughs)).

Analysis

Thematic analysis (Braun & Clarke, 2006) was employed as a basic framework for analysis, which allowed an openness to see different forms of themes within the transcriptions. Thematic analysis has often been criticized as too subjective and not scientific as it takes into consideration the researcher's influence within the project (Braun & Clarke, 2006, 2013). However, Braun and Clarke (2006) suggest that through clearly using a thematic framework, and acknowledging this process as part of the project, thematic analysis can be a strong research tool. As part of the thematic process I transcribed the interviews verbatim. Through doing the transcription myself I was able to immerse myself into the stories and start to see patterns that might evolve into themes. This process allowed an in-depth knowledge of the conversations, it allowed me to re-hear, to carefully listen and to attend to each story, to be there again. Part of the challenge for being a beginner researcher is learning to hear yourself and to not feel regretful of the comments I made. I struggled with wanting to be able to change my part of the conversation, to listen more and speak less. However, this also allowed me to understand the discomfort the women who participated might have in reading the transcript. I have never been a participant in this style of research, so I was learning both about being a 'researcher' and reflecting on how it might have felt to be a participant. I also found myself being confronted by painful topics which we had often laughed about at the time. At times, I needed long breaks, with walks on the beach, to be able to continue the transcription process. I also discussed my own feelings, rage and frustration about the situations the participants had been through with my supervisors.

Following the transcription, I re-listened to the interviews in full to check for errors in my transcribing. This allowed me to fully immerse myself in the interviews again. After this, I emailed the participant and offered to send her a copy of the transcript to read. I also reiterated their ability to leave the project at this point or for me to use the

transcript in analysis but not to use any part of it in verbatim quotes. The decision to offer each participant the transcript to read and correct was an important ethical consideration emphasised by Hesse-Biber (2007). This became more important after the conversations as the participants shared their experiences so freely I wanted to ensure that, when the 'dust had settled', they were still comfortable for their stories to be shared. Two women chose not to read their transcripts but were happy to sign a transcript release (See Appendix D). Two participants wanted to discuss the transcript and in one case further de-identifying measures were taken prior to the transcript being given approval to be used. The remaining six participants read thought their transcripts and signed the release forms without further discussion or changes required. I printed a copy of each interview so I could write notes and thoughts as I went - this way of writing allows me a creative freedom I do not find when I am using my computer. Through this process I started to clearly see patterns of meanings across the conversations.

Reading our conversations, it became apparent that trying to analyse a story of life, of a journey into mothering and an embodied story, was complicated. Ambivalence was not what we talked about specifically; it was embedded in our lives, it was within moments that pass quickly or agonisingly slowly, and within affects which seemed to hold space to understand the lived experience of maternal ambivalence more than through themes. I first grouped the patterns of meaning seen in the conversations into these lived experiences such as "walking the baby", "Not really feeling "maternal" or "Birth that was different to what was expected". However, as I put these lived experiences together, it became apparent that they often held lived affective experiences. Affects flow through our days, we weave in and out of them and when we are mothering, we weave our own affects with those of our children. We have visceral responses to living in our bodies and coping with mothering. Affects, our embodied responses to living, collected stories of mothering together and allowed them to be distinguished for analysis purposes. Affect allowed an understanding of how maternal ambivalence weaves into so many experiences, like the North Wind looking for a resting place. Given how important affective experiences were to mothers, I then grouped the lived experiences into affective themes. For example, "lack of support", "frustration" and "sleep" all shared the affective theme of "fatigue". I was then able to understand the lived experience of ambivalence through the emotional and embodied experience of each mother.

Once separated into affective themes, trying to organise the themes together into a cohesive sequence so they could be written and shared became complicated. They

did not fit together, at times their edges rubbed against each other rather than becoming smoother. There was a disconnect between the affects and how they were lived as a story of mothering. So, much like how we learn to mother, through transitional temporal mothering experiences, the affective collections were returned to a chronological ordering of the mothering experience pre-pregnancy, pregnancy, childbirth and holding a baby in your arms. The telling of maternal ambivalence through a chronological order allowed the multiplicity of maternal affects to intertwine once again.

Allowing a space for mothers' experiences of maternal ambivalence to be heard was a significant factor in why I was interested in undertaking this research. I wanted to be able to share these normal mothering experiences with other mothers. Baird and Mitchell (2014) and (Fine, 1994) suggest that through writing experiences into texts we are able to readily share our experiences with others. The following two chapters are stories of maternal ambivalence as shared with me by ten amazing mothers. The stories as written text reflect my understanding of how as mothers, we live in a patriarchal neoliberal society which places gendered expectations on our bodies and often contributes to our experience of feeling maternal ambivalence.

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Chapter three: Stories of maternal ambivalence: part one

Laughter as embodied ambivalence

While I have chosen to present the analysis and discussion of this project temporally there was one aspect of our conversations which I have decided to introduce first: our laughter. It flowed through all conversations, it held space for the taboo, sadness, joy and loneliness of mothering as quiet as a whisper or in loud roaring outburst. It afforded us a shared experience of mothering, the painful unglamorous parts and the sun-soaked happiness. Laughter challenged me deeply, as I came to transcription as a listener to our conversations, laugher felt incongruent within our intense discussions. Laughter meandered along our conversations; its dark morbidity used as a coping mechanism for us to cross socially unacceptable boundaries, which Coates (2014) suggests is how humour is used within conversations to canvass taboo topics. Laughter became somewhat of a container for these conversations, a holding space for when things became too painful to talk about. More so than a theme in and of itself, laughter weaved together our understanding of experiences, it allowed our conversations to safely cross into shared taboos.

Laughter held space for us during the interviews, like (Lachmann, 2011) suggests it helped to create an intimacy between two people; researcher and participant. However, as I transcribed them, I had feelings of sadness, grief, loneliness. It was as if somehow, in the re-listening, I could hear another level of experience through the laughter that I had not heard or acknowledged in the moment. I found re-listening to our conversations about such painful experiences, whilst laughing, so incongruent it resulted in my own struggle to transcribe the interviews. At times I stopped transcribing as the emotion felt so raw, even though it was first experienced through laughter, it felt like a story of shared grief, sorrow or sadness. The laughter covered the grief of a lost self, the women we were before we became “Mum”. The laughter; for our lost selves, for girls who held the naivety of motherhood in their palms. I listened to the silences within our conversations hearing what was not said, the gaps, moments of quiet laughter struggling to fill a void where words failed in their appropriateness.

The laughter within these interviews was almost an embodied experience of ambivalence. It was the hurt and pain of motherhood with the laughter and enjoyment of motherhood moving together but separately like watching oil and water mixed in a jar. There was a physicality within our conversations and lived experience of similar situations that were so painful, too painful to describe in words. Our culturally bound language does

not always have the same descriptors for complex emotions which are found in other languages such as bring together feelings of darkness and light (Lomas, 2016). When our English failed to find the emotional descriptor of the situation we searched for, we laughed. Our laughter felt like a balm designed for a small scrape, which we use to try and heal a wound needing suture. At some point in each interview we laughed about our mothering experiences, our crazy never thought in a million-year experiences, conversations with our children, struggles with the reality of mothering and the feelings of ambivalence we were talking about.

There was no one specific aspect of mothering we laughed about more than others and in some conversations we laughed about very serious situations such as Lucy when she describes the life threatening experience of having a major postpartum bleed *“the ward midwife came in and said "you're off to surgery now you've lost too much blood" ((laughs)) and I was just like “okay” ((laughs)).* Although Lucy laughs describing her birth, the reality is surviving birth does not happen for all women and for those who do, our bodies are changed forever (Cohen Shabot, 2016). Laughter also covered the realities of having our bodies exposed so much through birthing and breastfeeding. As Beth describes “*then you've got a baby and they’re feeding and you feel like your half naked all the time ((laughs))*”. Somehow, laughing seems to lessen the pain of how much our bodies and lives change after having a child, there is a black humour here, one we see in death and dying. Birth is grief for many women, a loss of self rather than just the joy of a baby (Baraitser, 2006).

Laughter appeared as we talked about feeling that you need space, of just wanting some quiet time, Lucy recalls wanting just a few minutes more time alone

> *some days you just kinda wana just hide away and to be honest I indirectly do that sometimes- like I'll just start putting all the clothes away in the wardrobe in one of the rooms and then you hear the footsteps going up and down the hallway looking for you and I’m just like I'm just gonna have two more seconds ((laughs)). (Lucy)*

I could feel her need for space from her children, the desire to be alone and not needed for a few minutes: how as mothers we may hide within the most mundane tasks such as laundry. As Lucy spoke, I thought about how many times I do chores for my own comfort and space, how I too tried to hide from my children. As we laughed, I could feel her exasperation, her need for space from being needed.

Sally and I sat in her warm sunny lounge as she described her first few weeks and months of motherhood. I was taken with how amazingly strong and courageous she was as she joked about how hard her first child had been with his incessant crying and inability to sleep. She laughed as she describes wanting to leave her son when he was really little *"I'd go and sit in the car, I'd lock the door. I don't know why in case he got out ((laughs))"* and how she wanted to hide from him

> *I just had this real urge to just gap it to just leave don't know where I was going, into witness protection or something you know ((laughing)) don't let the baby know where I am. (Sally)*

Sally and I laughed deeply, and a resonance was created between us. Yet, as I listened and transcribed our conversations, I became aware of the depth of the pain we shared and how our laughter went deep into our sense of being. Our deep emotions felt like they met with the deep protective love we hold for our children. We live in a society which privileges the 'good mother' ideal and laughing about situations that suggested we were 'less than ideal' mothers was both freeing and painful. The laughter we shared helped to ease the upsetting feelings which arose as we acknowledged motherhood is not the fairy tale we had been told to expect growing up. As you read on, listening to Holly, Anne, Frida, Rosa, Beth, Chloe, Lucy, Sally, Freja, Marie and I share more specific instances of experiences, some of which feel upsetting and distressing, I hope you can hear we were in a place of togetherness with laughter easing our painful yet cathartic conversations. We had a shared space where we were safe to be mothers who so deeply and fiercely love our children while at times desperately wanting to be away from them.

The beginning

Every mother and child hold a unique intertwined story which may start many years before conception or with a surprise pregnancy. Irrespective of when or how the story started, there are cultural beliefs which weave their way onto each page. The motherhood mandate is a particularly common visitor which teaches in our Western pronatalist society that although we may like to have an education and a professional job, our true desire is to mother (Gotlib, 2016). When we are little we are bathed in pink, dolls, and socialised to be maternal by family, by media, by the cultural soup we swim in. We are taught to be good girls; cooking, caring, being obedient so that one day we will become 'good' mothers (LaChance Adams, 2014). It is through this cultural existence we

make a story with our children. We have a story of our self before we were mothers and as we came to find ourselves as mothers.

Holly's story began in her childhood with an ever-present desire to be a Mum. She describes herself as being the 'mother' of her friends, ensuring they were cared for and making sensible decisions in their teenage years. She chose a profession in which she was able to care for others and looked forward to being able to have her own children. When Holly became pregnant, she felt it was the fruition of a dream

> *cos that was a dream I had and it came to pass so I was really excited to be a mother and umm (.) yeah really well no apart from all the spewing I was going to say really enjoyed my pregnancy. (Holly)*

As Holly's baby had been thought of for so many years, she looked forward to the experience of birth and had made numerous plans for how she wanted to mother her children. However, for Holly, the way she wanted to birth and the plans she had for mothering have not always come to fruition. As much as society tells us we will be able to birth and mother in a particular fashion, our bodies, in their true biological female form have different plans. Our bodies are not merely reproductive machines producing small humans in an ordered and contained fashion. Our bodies break the androcentric biomedical 'rules' of pregnancy without our consent. Yet, the rules were made without our consent so, maybe, our fleshy bodies are the rules which the patriarchal systems of health care need to start following.

Sometimes we fall into pregnancy unplanned when we may feel too young, too old, or not in the right space or financial position to have a child. Society pressures women to have children when we are in the 'right' time of our life, we have a stable partner, a home, and are neither too young nor too old (Gotlib, 2016). Chloe shared her experience of going against culturally sanctioned expectations; when she found out she was pregnant her and her partner were not living together, they did not have a house or marriage as was expected by her parents. However, as Chloe describes, they were both already 'old enough' to be considered an appropriate age to have a child (Morgan et al., 2012). Chloe describes finding out about her pregnancy. She talks about it in such a matter of fact way, that although she was not officially prepared for becoming a mother, she was ready to go forwards with it "*I kinda we kinda went right let's adult-up here".* One poignant moment Chloe describes is telling her own mother who was a conservative

woman and believed in ‘traditional family values’ like being married when you have children

> *it was a scandal and it was like this that and the next thing and I still can’t believe that my mother you know in two-thousand [and something] decided that we should get married just because ((starts laughing)) I was like thirty-something ….. it was just a cultural expectation that you would go off and get married. (Chloe)*

The idea that we need to be married reflects our patriarchal society’s teaching of the motherhood mandate telling women after we have a child, we will need a man to look after us we will not be able to financially support ourselves and our child. For Chloe however, getting married was not a priority. She wanted to make sure her relationship was going to work without adding the pressure of marriage to the pressure of having a baby. Having a baby changes our worlds and the way we live in our day-to-day worlds regardless of if we were surprised by becoming pregnant or we planned a pregnancy. Once we are pregnant, irrespective of whether we can or decide to carry the baby to term, our lives are irreversibly changed. Although Beth’s pregnancy was planned, it did little to quell her apprehension and feeling overwhelmed as she faced such a life altering event

> *I remember being very like like we'd decided and it was a whole plan… I couldn’t imagine what it would be like for people who got pregnant and hadn’t planned to because that’s even more heightened experience but like flipping over the test like I was like I need to give myself a moment because this is lif-, literally looking at this is life changing. (Beth)*

Beth’s experience of planning a family was similar to Marie’s. Marie’s story starts with a practical decision to have children rather than an innate feeling of maternalism

> *we had decided to have children but yeah I was always gonna have children but I just umm wasn't like a umm I didn't like babies ((laughs)) and we'd go round to people’s houses and my husband would like scoop yup babies and his nephews which are older and hold them and it would be natural thing in the world and I'd be like going “nah nah take it off me now I'm not sure like I like you and you’re cute to look at but give me an older kid” …like I wasn’t really a kind of ‘yup babies’ kind of person. (Marie)*

Marie knew she was more likely to enjoy her children as they grew rather than longing to care for a small baby. The motherhood mandate infiltrates our life informing us that we must feel maternal, crave the cuddles of our own small infant and if we do not long for this then there is something wrong with our innate being (Gotlib, 2016). Making assumptions about mothering ability before a child is born perpetuates societal subjugation of women to remain 'homemakers' and belittles the ability of men to nurture children. Frida shared a similar experience to Marie of really not wanting to have a child: *"I was always like really definitely didn't want to have a child cos' I umm just sort (.) had no maternal thoughts at all"*. It was only after the age of thirty she started to consider the possibility of wanting a child. Frida joked about being stubborn and knowing her mind, how she had told her parents she was never having children and they had "*given up*" bugging her about it. Frida appears to be describing the pressure many women feel to have a baby. Society mandates motherhood as the goal of a woman's life. Pushing against this socially expected pathway can be hard for women who may be continually encouraged to have children (Gotlib, 2016). As we struggle against societies gendered expectations on our body, we can begin to have feelings of ambivalence towards motherhood. We may already have an embodied knowledge that motherhood is not going to be what we have been told to expect. Beth shared a story about realising that while she wanted to have a family, yet knowing motherhood itself might not be easy for her

> *as I got older when I started umm babysitting and stuff you know as a teenager I think and started hanging out with younger kids more… I think I realised then that I might not find it super easy… like I did actually get a little bit of a like (.) yeah this might not be the easiest thing for me… (Beth)*

Knowing we want to have a family, to be able to build your own small community does not mean that we want to face the pressures and societal expectations faced by all mothering. Even before getting pregnant we are taught to ensure our bodies are fit enough to be a 'good' mother for our unborn foetus. Still, no matter how we may 'prepare' our bodies for pregnancy conception does not happen for all female bodies (Simon, 2015). The struggle to conceive then begins the interrupting of a gendered narrative that all women can and will have a baby as that is what our bodies are designed to do.

When pregnancy is missing

The interruption of infertility and its negative impact on women's bodies was explained by some of the women in this study. This interruption of conception is an embodied experience which lies outside of societies motherhood narrative. Frida, Freja and Anne's stories of assisted reproductive technologies (ART) describe how women's bodies and bodily autonomy are often of little significance to health professionals other than to ensure they become fertile hosts for a human life. Fertility treatment is both physically and emotionally gruelling and often ends in heartbreak (Gotlib, 2016) Anne describes the impact ART had on her body both physically and psychologically

> *yeah it is really intense …..I think the knowledge of the outside world of what going through IVF is really like (.) is minimal, I think people know that it's horrible but the actual horrendousness of it and what you have to put your body through as you go through it people don't have a full understanding of the mental load as well as the physical load of it. (Anne)*

The road to motherhood through fertility treatment is long and complex and as Anne described can be harrowing for our bodies and minds. The traumatic and painful pathway is embedded with the gendered cultural narratives of our western patriarchal society which blames the female body for being difficult when it does not 'want' to become pregnant. Frida disclosed how she had felt for a long time that her body was problematic. Her body had helped her survive a violent trauma and she thought her survival techniques may have caused her infertility. However, testing showed her body was fertile, and her partner was almost infertile. There is a cultural assumption of infertility belonging to the female partner that resonates with Anne's experiences. For example, Western creation stories are based within Christianity; a patriarchal religion which enables the eminence of men while continuing the subjugation of women within our society (Storrs, 2006). Fertility within the Christian creation story comes from the male giver of life, God, who impregnates Mary, a young fertile woman who then develops a deity within her. Mary's womb is seen as the ultimate hospitable environment, her body becoming the example of fertility for all western women (Storrs, 2006). With androcentric religion underpinning our spiritual teaching in the West, it is no wonder our bodies are considered an incubator with their worth reliant on being able to carry the male 'seed'.

After finding out they would need fertility support to get pregnant Frida and her partner were particularly confused by the information that they were not infertile enough to access public ART funding. I listened as Frida described how this conundrum comes to pass, how their fertility is ranked on a scoring system and due to their overall good health, they were ranked a couple of points short being considered infertile. I could feel the doctor's biomedical gaze on Frida's body, how it is still not enough, not infertile enough. As Frida sits, curled up in a soft armchair, she goes on to speak of the next harrowing part of the infertility conversation. Frida questioned the hormone treatment required, describing how she was concerned about the negative impacts on her mental health. She queried the possibility of being given a lesser dose as it was her husband who appeared to have the infertility issue. As I listened to her I felt my anxiety rise, this inner knowledge of what this doctor might be about to say. I could feel the prejudice towards women having mental health issues in motherhood and the weight of societies attitudes to mothers with mental health issues. Frida confirms my own anxiety response as she tells me

> *I think he got sick of me and in the end, he said "if you are this concerned about all these issues to do with your mental health and your emotional state and all of this maybe IVF and having children is not for you" ((quiet laugh)). (Frida)*

I felt this embodied sense of shame and anger as I listened. Frida has learnt over the years how to manage her mental health. Yet, because she was not willing to be a complaint altruistic mother and risk the deterioration of her mental health she was seen as the wrong 'type' of woman to become a mother. Yet health professionals, even if they draw on discourses of 'reproductive autonomy' remain embedded in our dominant cultural assumptions that women with mental health issues could possibly become a 'mad mother' and harm her children and this is not a risk that should be taken (Krumm et al., 2014). This is the epitome of the motherhood mandate commanding women to sacrifice their bodies and their mental health if they "really" want to become a mother. As LaChance Adams (2014) argues, there are three types of mothers, the good mother, the bad mother and the mad mother possible within the motherhood mandate. Society, especially within health care, only has space for good mothers. New Zealand's Western societies dominant cultural understandings of the value of only having 'good' mothers who are seen as fit and able is entrenched through our biomedical healthcare system and the Plunket Society which has had an ever-present surveillance of mothers (Bryder, 2003;

Rowold, 2013). Frida describes leaving the first fertility clinic knowing that it would not be the right place for her to have treatment. As a staunch advocate of women's rights, she was not afraid of making her voice heard. She sought out a different team of infertility specialists who provided care with respect and dignity as paramount for each person they treated, believing that "*every person who came to them had a history of some kind of discrimination or trauma just through the passage of having to go through the IVF [in vitro fertilization] process". (Frida)*

As we chatted, Frida discussed how she felt her feelings of maternal ambivalence beginning during the ART process. For Frida, the loss of control of her body during fertility treatment caused significant distress and anxiety: she describes *"discover[ing] how much of a control freak I am around my personal rights and control of my body*". Frida discussed how the feeling of powerlessness had reminded her of feelings she had when she was sexually assaulted as a young woman. I sat with Frida and contemplated how many women would have a similar experience to Frida. Given the high rates of sexual harm against women and children (Dickson & Willis, 2017) there is a high likelihood woman seeking ART may have sexual trauma histories. According to Van der Kolk (2015) our bodies can retain trauma despite our experiences being psychologically processed. Having to go through such an invasive process such as ART may be too closely linked to a sexual harm incident for many women to either talk about with their health professionals or decide to do. Yet, I was unable to find any research which discussed sexual assault histories prior to ART or looked at how many women choose to minimize or not disclose mental health issues in order to be considered a 'good' candidate for ART.

In some cases, women's bodily autonomy during ART appears to be removed and replaced with medicalised subjectivity creating a disconnection between women and their bodies. Our bodies are expected to attend to painful and invasive medical procedures with complacency and obedience to medical professionals in order to become pregnant (Gotlib, 2016). This expectation on women's bodies is a form of gendered violence which is considered socially acceptable and remain unnoticed, due to the West's underlying pronatalist assumptions beliefs. These experiences, of our bodies being wrong or embarrassing may give rise to feelings of shame about our bodies (Dolezal, 2015) and shame appears to be an experience which may can start the underlying feelings of maternal ambivalence. For Frida, the ART experience has had lasting consequences for her mental health. She is left living with scars from wounds inflicted by medical professionals' patriarchal beliefs and lexicons.

I carried Frida's story of becoming a mother with me for the next nine interviews, as I listened to more stories of how women moved into motherhood. On my last interview with Sally, Frida's story again was first in my mind. I could feel the same surging of rage and anxiety as Sally spoke. Sally and her partner had tried for years to conceive and were referred to a fertility clinic. Tests showed her partner had low sperm count and there was almost no possibility they could conceiving without medical intervention. The fertility clinic suggested Sally have an operation to ensure her body was well enough to undertake fertility treatment. Our bodies are expected to be 'maintained', kept well and fit so we can create a habitat for a human embryo. This maintenance comes at any cost, including surgery on our bodies for pregnancy preparation. I could feel my uncomfortableness rise as Sally explained the next part of her story. I could feel the medical gaze on her body, as even though her partner had a low sperm count, her body was not enough. There were assumptions made about how good or bad Sally's body was. Judgement on female bodies is common, our bodies are taught to be contained as we wait until the time we can become pregnant (Gotlib, 2016).

Pregnancy

When Sally found out she was pregnant a few weeks after her operation, she was excitedly surprised. However, the next appointment with the fertility team negatively impacted Sally. She describes this conversation with visceral anger, resentment and shame, emotions that filled the air as she spoke, recounting being accused of cheating on her partner

> *…and the fertility lady asked me if it was my partner's and I said to her excuse me what do you what did you say and she said "ohh don't mind me do you mind me asking is he the father" it was like "Yes" and she was like "well that's a miracle" and I was like "well whatever I don't care like miracle or not"… (Sally)*

Sally's body was problematised as unable to conceive a child and subsequently, she was regarded as dishonest when she was able to conceive, given the biomedical health belief that her husband's sperm count would be do low to conceive naturally. This form of female body shaming is commonplace as our bodies are viewed as inept and unable to meet their feminine responsibilities, while as a woman we may also be considered overly sexual or willing to do anything to have a child, including having an affair, as our drive to be a mother 'must' be all-consuming.

The feelings of shame inflicted on our female body through the medicalised conception process appeared to start when we are told our body is the problem. As I re-read and reflected on these conversations, I feel the embodied shame which appeared through so many conversations with health care providers. Shame appeared particularly when our bodies were treated with minimal respect and a lack of dignity. Cohen Shabot, (2016) suggests feelings of shame arise when our bodies were considered little more than incubators for an unborn baby by people who judged us on our ability to be a 'good' mother.

Our 'good mothering' ability is judged from preconception but also throughout our pregnancies. Our cultural narrative teaches us that in pregnancy we will glow, our bodies will naturally shift to pregnancy and will feel wonderful. While this may well be the case for some women in some pregnancies, it is not the case for every woman in every pregnancy. Pregnancy for some women is a physical and psychological endurance competition and is often complicated further by feelings of shame and negativity toward the pregnancy (Tsalkitzi et al., 2020). Rosa's experience of pregnancy describes the pressure on women to be thankful for their pregnancy even if they are unwell. Rosa, who has an autoimmune disease, was able to conceive 'naturally' after a period of years. She felt she had to appear grateful and happy to be pregnant even though she struggled continuously with the change in her body and constant fatigue and nausea

> *I actually hated being pregnant which I felt really guilty about because we tried so hard to be pregnant it had been all consuming for you know a good five years and umm it was kinda like this little miracle. (Rosa)*

As Rosa shared her story, I could feel my shoulders stiffen and muscles tighten as anger towards the societal expectations of pregnant mothers raged through my body. There is a taboo about disliking pregnancy (Raphael-Leff, 2020). Pregnancy is described as the most important step in a woman's life to become a mother. We are told we should enjoy pregnancy and be self-sacrificing of our bodies for this child. There is no conversation about dark thoughts of not loving your child or wanting to end a pregnancy (Tsalkitzi et al., 2020). As our bodies struggle through pregnancy, with its unwellness or uncomfortableness we have developed deeply mixed feelings towards motherhood (Raphael-Leff, 2020; Tsalkitzi et al., 2020).

While pregnancy is complicated for many women it may be the beginning of our next chapter in the mother-child story. Rich (1976) describes becoming aware of the

second life with the changing of her body right from the very early days of pregnancy. Our bodies are in constant flux, a monthly rhythm which changes with pregnancy, as our body moves into motherhood. Our bodies move from being one to two with the arrival of a stranger who begins to reside inside us. This small stranger shifts our bodies from being individuals to be an intwined duality of self (Baraitser, 2006; Raphael-Leff, 2010). Even if we forget the baby is there, within us, our bodies hold space for them, creating a home for this baby without our conscious help. Our bodies just go about their job. Our bodily autonomy is erased by this small human who takes its growth requirements from our bodies while we watch on. Our body is no longer ours; it is a host for our baby (Raphael-Leff, 2020).

While we might feel this movement of subjectivity, it does not happen for all women. Sometimes the placenta is positioned in a way which stops us feeling our foetus moving, resulting in fewer feelings of connections with being pregnant. Sally describes how not feeling her baby move was hard for her as she felt like she missed out on connecting with her son before he was born. Frida describes how she never had a shift to feeling like there was her and her child. She put this down to having to go through the ART process. During her treatment Frida started to fear that a child would never be part of her world. When she did conceive her daughter, she describes not feeling connected, even when she could feel her daughter wriggling or kicking, as she did not really think she would actually have a baby. She cognitively knew she was having a baby, however, she needed to keep a distance from the baby in case something happened to her: the fertility process had moved her out of her body and created fear of loss. Despite Western cultural narratives telling us our bodies will naturally be able to birth, for some women feeling ambivalent towards motherhood increase as they look towards birthing. This was the experience Frida felt as she fought to have the type of birth she wanted.

Becoming two

Fighting for our birthing autonomy

Birthing experiences significantly change our worlds. Not just because we are seen as ‘mothers’ at the end of the process but because of the impact birth can have on our physical and emotional self (Cohen Shabot, 2016). Having the ‘choice’ of the type of birth you would like is confined within Western cultural narratives of what is considered a ‘normal’. Women are likely to be unable to choose a planned caesarean as a first option in a first birth (Mander, 2007). The narrative dictates that women will choose a vaginal birth. Available options for women are limited to a choice of the types of analgesia, if any,

we would like. Both being forced into having a vaginal birth or being unable to birth vaginally, creates issues of blame, shame and grief for some women (DeGroot & Vik, 2017). There is a myth of childbirth, a falsehood that is taught through cultural narratives that women will have natural vaginal births. This myth and it's resulting western cultural understandings, emphasises how the medical institution maintains control over women's bodies (Cohen Shabot, 2016). Frida's fight for agency over her birthing process started in pregnancy when she requested a caesarean section for mental health reasons. Frida was sexually assaulted as a young woman and felt that labour and birth may have a negative impact on her mental health.

Frida had the full support of this request from her midwife and mental health team, however the obstetrician continually refused it. *"it was the two of them that umm convinced the obstetrician to approve the caesarean cos he was really against it to begin with umm he just declined it, declined it yeah ((sigh))."* Frida knew the choice of a caesarean section was the right decision for her, her body and her baby. However, the stress and anxiety of not being 'allowed' to have one when it was first requested caused her significant distress as she prepared for her baby's arrival. Frida did not want any male doctors entering her birthing room. Her fear was that if there was an emergency, her room would be flooded with medical staff and she knew she could not cope with this situation. The distress she felt resulted in Frida considering alternative delivery options *"cos otherwise I started making plans to like go off and deliver my own baby ((laughs))".* We remain living in a society where the power imbalance between doctors and women is vast (Cohen Shabot, 2016). Fighting for the right to bodily autonomy for women is complicated especially when it requires revisiting traumatic experiences and going against culturally held narratives, such as 'vaginal birth is not traumatic for women' or 'vaginal births are best for a mother and child' (Cohen Shabot, 2016). Our history, our traumas can play a significant part as to the decisions we make for the wellbeing of our bodies especially when we are about to enter into the experience of the birth of our child.

Going into labour can be an anxiety-driven time for female bodies and minds. There is an expected reality of having a live infant and being a whole intact woman by the end of the process, however, this is not the case for many women and infants. Although there has been a decline in maternal and infant mortality rates, there is still death, trauma and significant injury experienced (Koster et al., 2020) to both our bodies and our infants. The possibility of injury and death are often not discussed or explained in depth by medical professional with us prior to birthing. There appears to remain a lack of

information given to women about possible interventions either before or during birth (Koster et al., 2020). Our pregnant selves are often considered too fragile to cope with the stress of hearing the full reality of what could happen during birth. When we are continually seen as unable to cope, our subjectivity is lessened and other people such as health professionals, start to make our bodily decisions for us. This results in a decrease in our bodily autonomy and increases the power imbalance between birthing women and medical professionals during labour birth and postnatally (Cohen Shabot, 2016; Koster et al., 2020). True autonomy comes from having all the information presented in an understandable manner allowing true informed consent. Without this information, we are at increased risk of obstetric violence during a time when we are extremely vulnerable. We may feel unable to decline procedures as we are told they have to happen for the 'good of the baby' or in some cases the procedures are commenced with little or no consent (Cohen Shabot, 2016).

When our body is forgotten

Beth describes being given no information and not being asked to give informed consent for a medical procedure during the birth of her first child. The ramifications of this procedure on Beth have been significant. Firstly, it resulted in Beth needing emergency surgery. In the days following the birth of her child and this procedure, Beth questioned the obstetrician about what had happened *"cos I think I complained at some point about not having a say"*. Rather than explaining what happened or acknowledging the impact on Beth's body, the obstetrician dismissed her by *"remind[ing] me that umm he [baby] was alive so ((quiet laugh))".* The obstetrician's actions and subsequent comments are in concert with the medicalization and violence against woman's birthing bodies frequently experienced within our androcentric biomedical health system. Obstetric violence is often used against women's bodies with little consideration or understanding of it as a form of violence, rather it is seen as another necessary intervention on a women's incapable body (Cohen Shabot & Korem, 2018). Having your body invaded without consent during the birthing process may result in similar feelings to other forms of violence such as shame, fear, powerlessness and anger (Cohen Shabot, 2016). The feelings can affect our everyday life, our relationships and the way in which we perceive the world.

Beth describes how it feels unreal to think that your whole world can experience an irreversible and immeasurable change in a few hours *"I don't think I've ever been quite the same ((sighs)) since that day"*. Beth describes the birth and its subsequent impact on

her body, reflecting on how long it took for her to realise the magnitude of these long-term impacts brought on by her experiences. She spoke about the embodied shame she felt after being dismissed for asking how her body became so badly damaged and how those feelings of shame have impacted her relationship with her child. Cohen Shabot and Korem (2018) write of gendered shame in the birthing room as pervasive and paralyzing, impacting negatively on how we feel about our bodies. I listened as Beth describes how she lives day-to-day with the feelings of maternal ambivalence, which interweaved with her traumatic birth, the lack of control and being dismissed by medical staff. As women we are so often answered with 'at least you and your baby are alive' if we question aspects of our labour experience. While I do not want to dismiss the fact that having a mother and child alive at the end of a birth is important, we need to acknowledge the injury frequently inflicted on our female bodies for this outcome to occur (Cohen Shabot, 2016). Obstetric violence appears to be so pervasive it is an accepted consequence of the birthing process. There is an inherent lack of empathy for our female bodies occurring concurrently with obstetric violence, almost as if our bodies should have birthed 'nicely' as a 'good' woman's body would. Therefore, any violence perpetrated against our bodies by health professionals in the birthing room is a result of our problematic body, rather than a result of archaic and barbaric gynaecological beliefs and practices (Cohen Shabot, 2016; Cohen Shabot & Korem, 2018).

The assumed right to act on our bodies without consent by medical professionals' behaviour, with its inherent lack of empathy, appears to result in our increasing feelings of shame for us. Brown (2006) suggests shame and empathy are opposing embodied experiences. When we experience empathy, it lessens our feelings of shame. Alternatively, and more likely as the experience of birthing women, when empathy for our body decreases our feelings of shame increase. Since the uses of obstetric violence against women's bodies show very little empathy for our bodies, there is also little empathy for the life we must live after a birthing injury.

For Sally, feelings of shame came from medical professionals disregarding her embodied knowledge of her and her son's body during labour. After struggling with a lengthy labour her son became stuck. An obstetrician arrived, telling Sally everything would be fine, and attempted an instrumental delivery, which failed. Sally could feel her child was stuck and that something was wrong with him. She describes feeling her own anxiety dramatically increase as the labour continued. Sally told staff something was terribly wrong with her son. However, instead of her concerns being heard and her

intuitive embodied knowledge being listened to, Sally was placated with sedatives and told there was nothing to be concerned about

> *then I had to sit there for two hours waiting they were monitoring the baby the baby was in a little bit of distress but more I was just like "get it out get it out" like I just had this really horrible feeling like I just wanted it out of my body because it was just getting so stressful and I was getting really upset anxiety they gave me like all these drug like drugs and stuff which made it worse umm…..((sighs)). (Sally)*

As we sat together, on a beautiful crisp day in her sunny lounge, the nursing side of me was appalled that this situation could happen. The dismissal of her concerns by medical staff is more likely to have increased her anxiety and distress as described by participants in Koster et al (2020). Sally's labour had fallen out of the narrative she had expected. Her distress and anxiety were causing her to feel angry which is described by Cohen Shabot (2016) as a normal reaction in childbirth. The biomedical approach of trying to subdue an anxious patient rather than listening to their concerns increased rather than alleviated her anxiety. She describes being desperate to get this "*thing out of her"* as she knew it was "*not 'right'"*. At the same time as wanting him out, Sally describes looking forward to finally meeting her child and had visions of him laid on her chest, holding his little body close and being able to feed him. However, when the obstetrician delivered her baby there was stress and panic in the room as they realised that the baby was distressed and unwell. He was immediately taken to the NICU, ending Sally's vision of her meeting him and holding him. As we spoke, I could see Sally's body language change, tighten as she describes the feelings of failure as a mother for not being able to birth her child the 'right' way. Sally then spoke of how the obstetrician joked with her, following her caesarean section, that he was going to put in an "extra stitch". This comment demonstrations how society enables jokes about the trauma women's bodies go through and while Sally explained that he was trying to make her laugh to relieve her distress, she still appears to have found the joke uncomfortable. She already had feelings of failure and that something was wrong yet here was a medical professional joking about trying to 'fix' her body by needing to do something 'more' to her. Sally's birthing experience resulted in her body being deemed as unruly and not behaving as a proper female body 'should'. Sally spoke of her birth as having a negative effect on her relationship with her own body and attributed her traumatic birthing experience as the time when her feelings of maternal ambivalence started. When our bodily autonomy is removed by individuals

in positions of power or our expectation of birth is not met, it is normal to have feelings such as grief, sadness and shame emerge (Koster et al., 2020).

Health care in New Zealand is based on a Western patriarchal neo-liberal biomedical model. Although there has been a push by midwives to see pregnancy and labour as a normal experience, society and the biomedical model of health continues to assume pregnancy and labour as a condition that requires medical management (Najmabadi et al., 2020). As Young (2005) describes when women are cared for by a male doctor, there is a reduction in the ability of an empathic relationship. I would also argue that women doctors and nurses trained within the western patriarchal biomedical health system are often likely to use the same patriarchal gaze and assumptions regarding the birthing body. Women health professional having a patriarchal gaze may arise due to the education about women's bodies received through our health education systems which are based on androcentric understandings of human bodies. They are therefore as able to disregard a women's experiential knowledge of her body, and her unborn child's body, within the birthing process, as demonstrated through of Lucy's experience of being left with a midwifery student during the birth of her first child. Lucy describes knowing something was wrong in her labour and telling this to the student midwife. However, because her monitoring was "normal" she was reassured everything was fine

> *….umm the trainee midwife - I had been left with a trainee midwife an - yeah that was the only time actually said to her "look things aren't going right I know they're not can you get someone else" and she said "no its all ok it's yeah you'll be be fine" and I just said "no I need someone else" and then that's when it all shit hit the fan ((laughs)) and then the yeah the ward midwife came. (Lucy)*

She describes how her husband was on the other side of the room during the labour and essentially being alone as the room flooded with medical staff. Lucy was then rushed to emergency surgery

> *the ward midwife came in and said "you're off to surgery now you've lost too much blood" ((laughs)) and I was just like okay ((laughs)) and yeah so they just took Maddie off me and yeah turned around to Jay and said "take your t-shirt off" yeah and gave him like this stretchy bandage thing. (Lucy)*

While Lucy describes knowing she was bleeding too much, her description of truly understanding suggests that the medical staff did not give Lucy a real knowledge of what was happening to her body. As she talks about what happened there is an underlying grief in her description *"I was kinda I spose you're on a an emotional high of yeah and I was just like well this is what needs to happen then this is what needs to happen ((sighs))".* This was happening to her body, by people who had not listened to her about her body when she knew something was wrong. Lucy was then left with the physical and emotional consequences of being taken for emergency surgery and being separated from her newborn infant. It appears that so often women who are in the throes of birthing are given 'choices' that are not choices made by them. They are choices made by medical professionals who assume their decisions will be best for our bodies (Cohen Shabot, 2016).

For Holly, there was a sense of grief for not being able to have a vaginal birth that she had planned. Instead she describes her body just not wanting to go into labour even after her waters had broken, creating a sense of failure or disappointment in her body for not being able birth the 'right' way

> *I was really disappointed about it I-, I wasn't traumatised by it cos a lot of people were like "oh was it traumatic?" and I was like "nar it wasn't it was just so friggin annoying" ((quiet laugh)) it was just like you know (.) I only had a few hours of labour before it was decided that a caesarean is the right call. (Holly)*

Although Holly understood the reason for needing a caesarean, she could see that it also impacted on how she felt about herself, her body. As Holly discussed her birth, she talked of a significant amount of bodily autonomy and respect given to her by the medical professionals caring for her. This appears to have lessened the degree of distress Holly experienced as her body was still in her own care; her body remained hers during this process. But for Holly it appears there was grief that came from not having the birth she longed for, a grief that that was held in her body, like many aspects of mothering, because her body felt problematic for not birthing the 'right' way. Many mothers feel they are unable to grieve for the birth they wanted because the birth they had is considered 'normal' or the 'right decision' within our dominant cultural narratives of what birthing should look like (DeGroot & Vik, 2017). Marie also describes not being particularly traumatised by needing a caesarean as she understood the reasons for

preserving her health and that of her infants. Marie describes her "booked" caesarean for the birth of her last child as an easy and normal process compared to previous births which had been emergency caesareans. She had autotomy over the situation and the birth was calm for her *"went in on the day and you know you turn up at seven you've had your baby by nine you know everything is hunky-dory ((laughs))".* Like Holly, Marie's description of birth is attached to feelings of bodily autonomy over the process which appears to result in decreased feelings of trauma associated with the birth.

Labour and birth are only a small number of hours compared to how many we live in a lifetime. Yet within this time, our world changes so dramatically it can feel like we have fallen down a rabbit hole into a differing reality. Much like Alice in *Through the Looking Glass* (Carroll, 1871/2020), our perspective changes, our bodies take control and throw us into the world of mothering. Recovering from birth takes a significant period of time (Kitzinger, 2006). Lucy suggests that women may not start to process all the change and possible trauma the body has been through straight after birth, it is the days and weeks after, when life has settled down somewhat and "*your mind can wander a bit*". When our body has settled into its mother form and our maternal subjectivity has become ever increasingly apparent, our emotions may feel more intense (Baraitser, 2006). Through this time, we are also coping with the needs of a small human who has become our new ever-present companion, a companion that may be the most demanding and needy human we have ever spent time with.

Mothering this small demanding human started well before they were birthed. It started with our culturally bound narratives subjugating us to believe our bodies are fit for the sole purpose of mothering. Our bodies have been gazed at by our culturally gendered society as human reproductive machines for a long time before we may have considered motherhood. While our feelings of finding mothering hard, of wanting to have our bodies back, yet desperately wanting and loving our child may have started pre-pregnancy or during pregnancy having a baby 'on the outside' of our bodies may increase our mixed feelings towards mothering. When we have to raise a small human in a society that has burdened mothers with the social expectations of how to 'be' a 'good mother' it is exhausting. Society expects every woman to follow the mandated norms of our patriarchal neoliberal society, yet it is hard to meet those expectations given the lack of support many mothers have. It is through the lens of understanding the culturally bound expectations on contemporary mothers that we now shift to looking at motherhood through another transitional time; becoming a mother with a babe in arms.

Chapter four: Stories of maternal ambivalence – part two

And then there was us

While pregnancy physically forces our bodies to make space for another human, maternal subjectivity shifts our bodies to hold space for our children. Our bodies provide our child's earliest nutrition. Our children come into our physical space, firstly, by making room inside our bodies (Raphael-Leff, 2020) and then once we have birthed them they seek space so close to our bodies, to be held, carried, rocked soothed by being close, in our space. Our body remains in their possession, our sense of self is in a state of constant disturbance as this small being continually claims space in our mind and body. Our bodies have transitioned from being sexualised with our breasts being viewed and consumed by society to our bodies being those of mothers, our breasts now consumed by our child (Douglas, 2013; Young, 2005). However, with any change feelings of loss may arise, there may be grief for our loss of self. The transition can be a painful place as we move from womanhood to motherhood (Baraitser, 2006). Part of this transition is learning how to nourish our child and for many women this may be learning how to breastfeed them. Often women describe they are not given adequate information about just how hard breastfeeding is (Powell et al., 2014). Rosa discussed how she felt let down with the lack of information she was given in her antenatal classes about how hard breastfeeding is to establish and how our bodies do not just return spontaneously to their pre-pregnancy form

> *I remember in our antenatal classes….[there is] no way near enough emphasis on feeding and the difficulties and that that's ok and that you could have low supply and you could have these things and you could have these things… I mean you've got a DVD of someone [infant] who can feed fine like… I'm like the-. that was not covered enough… (Rosa)*

We are shown videos of babies latching to the breast easily and feeding well. We are learning new skills of mothering while our bodies ache for rest and sleep. Breastfeeding is often another area of motherhood in which our bodies are problematised. There is an assumption of naturality of women's ability to breastfeed (Guyer et al., 2012). We are led to believe that like all things mothering, breastfeeding will come naturally to all mothers. However, infants and mothers learn breastfeeding together and for many women it is painful and uncomfortable (Guyer et al., 2012). Yet,

again we are led to believe that it is our body that is not working correctly if we cannot breastfeed with ease.

Learning to breastfeed following a traumatic birth can be particularly complicated. When our bodies feel broken or we have been traumatised by our birthing experiences the ability for breastfeeding to be established is much harder for mother and infant (Kitzinger, 2006). Sally's experience of breastfeeding her son was complicated following his traumatic birth. Sally shared how she really wanted to breastfeed her son; she wanted the connection and the feeling of being the 'good mother' that she had seen through the media

> *I did try to breastfeed they really umm I think this is where it all started to go wrong the midwives really encouraged me to breastfeed like so much and I wanted to but I'd already had the feeling that you know my body hadn't done what it was supposed to do the whole time and then with the bad experience with the birth umm I tried for two days to breastfeed once he was out of the incubator and there wasn't enough milk coming through. (Sally)*

Being unable to breastfeed her son left Sally feeling like a failure. Sally's feelings that her body was somehow not right, seemed to be confirmed by a lactation consultant who described her as having the 'wrong' kind of breasts for feeding a child "*another fail another mum fail "ohh now I can't even feed the damn baby," so we put him on formula".* Sally's conversation with the lactation consultant highlights how woman's bodily autonomy is removed within our biomedical healthcare system through professionals independently judging our bodies. Understanding our embodied experience of how, as mothers, we view our breasts and how we hoped to nourish our child would help to reduce mothers' feeling of guilt about breastfeeding experiences (Benoit et al., 2016). When our female body appears to 'fail' we often internalise those feelings as a failure of ourselves, that somehow as a mother we are a failure (Cohen Shabot, 2016).

Learning to breastfeed her daughter was complicated for Frida and resulted in her feeling dismissed by health care professionals. Following her daughter's birth Frida describes significant uterine pain, and each time she breastfed her daughter her pain increased. Frida's pain was dismissed by hospital staff who said it was not possible for her to have this type of pain

> *the midwives were telling me I wasn't, they were telling me it was my first baby so I wasn't having that pain but I was like I am having that pain but they were telling me "you're not" and just telling me I wasn't and I was like "but I am". (Frida)*

While refusing to listen to Frida's knowledge of her own body and treat her pain in a humane fashion, the hospital staff also dismissed Frida's concerns about her baby. Her baby, Zoe, was active, alert and waking for feeds in her first forty-eight hours of life, however she had become increasingly sleepy and feeding poorly. Frida became concerned that the analgesia she was being given was passing through the breast milk to her daughter. She tried to pass on her concerns to the midwives, however they continued to dismiss Frida, telling her the baby was fine

> *and no one was noticing and I kept trying to tell them that baby was sleeping too much "what's wrong?" and they weren't listening to me and Zoe was just rapidly losing too much weight. (Frida).*

When staff finally weighed Zoe, they realised how much weight she had lost. They changed in their attitude towards Frida from dismissal to judgement and blame

> *((spoken quietly)) and then umm called in everyone and yeah told me that umm that "she was starving" and that she couldn't wake up any more and her glucose levels were too low and all this ((sighs))…. and she was starving and "was I starving her" and all this. (Frida)*

The midwives suggested Frida was purposefully not feeding Zoe, even though she had been raising concerns about Zoe falling asleep while feeding. Frida was undoubtedly being cast as what LaChance Adams (2014) describes as societies opinion of a 'mad mother'. She was addressed as a mother with underlying mental health issues who staff did not trust. Health professionals rejected Frida's embodied knowledge about not only her body but her daughter's body which had been part of her own body for nine months. Frida described this incident as being particularly negative for her mental health. She was put on a 'watch' in the hospital with a midwife constantly in her room to ensure she fed her baby. The hospital staff were trying to change the reality of Frida's experience by telling her that her body did not feel a certain way, that her daughter was not feeding the way she was describing. Such undermining of our experiences can lead us to wonder what the reality is and feeling a sense of shame about our bodies because they are not doing what health professionals 'expect' of them (Brown, 2006). Frida's experience also created

a distance between her and her baby as she began to feel that she was unable to be the 'right' kind of mother. Staff had undermined her knowledge of her ability to care for her baby. This period for Frida started feelings of ambivalence, she loved her little baby, but her initial experiences of mothering were very different to the stories she had been told. She did not feel the way she thought other mothers felt which can be a common experience following traumatic births (Kitzinger, 2006).

The pressure to be the 'right' mother was also described by Anne. Learning to breastfeed her first child was complicated for Anne and like many women she needed to give her child a top up of expressed milk at the end of a breastfeed. A regiment of breastfeeding, expressing and topping up is a lengthy process resulting in little sleep for mothers. However, as is the case for many women, Anne described feeling societal pressure to continue breastfeeding, so she persevered for months. Mothers often feel pressure by family, friends or medical professionals to continue to breastfeed as we are taught it is the 'best' form of nutrients for our child (Guyer et al., 2012) The pressure to breastfeed is part of the self-survalince we do continually in order to live up to the societal expectations of the 'good mother'. During this period Anne was getting very little sleep and on reflection she describes a wistful regret of persevering for so long as she feels her mother-baby relationship suffered due to her extreme exhaustion

> *I wish I hadn't done it cos it ruined my enjoyment of him for that time by the end of it I was pumping less and less because… I wasn't getting enough to feed him so I was feeding him formula. (Anne)*

After making the decision to fully formula feed, Anne started to enjoy her baby and told me she felt far less exhausted so her overall health improved. Her second child breastfed well and although Anne enjoyed this experience, she did feel she was more tied to her child, she was the only one who could settle her, and this again took a toll on Anne

> *whereas Ruby was a lot harder… I could breastfeed her, so we had that but she just was a terrible sleeper and so obviously I never slept... and cos she used to take the bottle and then we went back to [states country] and I didn't take the bottle with me no longer would [she] take the bottle ((laughs)) so I sealed my fate there….. it's probably taken me until she was fully weaned and sleeping better to kind of find my own self again. (Anne)*

When we are breastfeeding our child, our body is viewed by society as almost belonging to our infant, we must ensure the ongoing fitness and health of our body by eating correctly and by altruistically providing our body to our child (Young, 2005).

Breastfeeding each of your babies is a unique experience and we are led to believe that it will be an experience that will come naturally, be painless and an enjoyable experience for both mother and baby (Guyer et al., 2012). However, for many women this is not their experience. For some women breastfeeding is taxing on their physical and mental health resulting in increased stress. Stopping breastfeeding before your child is over six months or a year, even if it is harming your mental health, goes against the altruistic mother figure (Benoit et al., 2016; Guyer et al., 2012). An internalised feeling of failure comes from the cultural backdrop of mothering we live in. Health professionals have taught that a mother's milk should be given above all else and anything less than is harmful to our children (Benoit et al., 2016) or as Anne describes *"obviously first child you think the formula…is poison…..because everyone has told you that you must breastfeed ((sighs)) through everything that you read and antenatal classes and everything".*

Rosa's experience learning to breastfeed her son was complicated by her son being born with a tongue tie. Babies who have tongue ties struggle to latch well on the breast which may result in symptoms of reflux such as crying, not gaining weight and general irritableness (Fisher, 2016). Rosa's son was unsettled and cried for significant periods each day. His crying and general fussiness resulted in Rosa feeling like she had a baby no one wanted, one who was inconsolable

> *I was knackered and we were not allowed to let him sleep longer than two hours till we had to get him up to feed umm and then when we got the tongue and lip lasered at six weeks he went completely off the breast for a couple of days and I just about lost the plot. (Rosa)*

The exhaustion from trying to sooth him and feed him took a physical and mental toll on Rosa. She struggled to sleep, even when she had an opportunity, and describes feeling a loss of control. Rosa also shared that she had feelings of inadequacy in her ability to cope with mothering. Being able to feed and sooth our babies are skills we are taught we will have just by virtue of our female body.

While mothering is a socially expected role for women there is very little teaching on how to care for a child on a day-to-day basis. We suddenly shift from woman to mother, losing our-self and gaining a new self that many of us are not prepared for. Our

child is a constant, demanding, helpless limpet we are expected to know how to care for. Our body, while appearing outwardly similar, has changed forever. It has been torn apart, for some women stitched together, firm skin has become jelly like, our breasts become a new shape and size. Our bodies are no longer that of a young girl, we have moved into the body of our mothers, which may feel safe in its softer and wider shape (Baraitser, 2006) but for some women feels unsafe, foreign and frightening (Kitzinger, 2006). Such a shift in our being can feel overwhelming and daunting particularly when navigating and learning about the small infant in our care.

Being able to understand changes in yourself amongst the chaos of mothering is difficult. Beth shared how she felt unable to process all the change, and her loss of self, as she needed to be continuously present for her child. The issues she felt in her body were somewhere down the bottom of her priority list, beneath feeding the baby, changing the baby, trying to get the baby to sleep so she herself could sleep

> *I don't think I've processed it the way I should've and I totally at the time was not like that was really traumatic I need to like really talk this over somebody I-, I literally just like went about it on my own and I suffered but I just like struggled through it you know and umm I you know was so busy because I had (.) real challenges feeding and that took up all my time. (Beth)*

Her own body was left behind, slowly healing its physical wounds while nurturing her baby. Beth had had a traumatic birth, surgery and a baby who required emergency medical treatment, there was no space for emotional processing or to reflect on the repercussions of moving into motherhood (Baraitser, 2006; DeGroot & Vik, 2017). Yet, as these experiences of having traumatic births were shared so too was the love for their children. We wanted what was best for our child even if that meant our own bodies were harmed. The mixed emotions of mothering were palpable, the deepest love and a willingness to sacrifice your body for your child's even though our bodies now felt almost uninhabitable. We had faced experiences that had never been part of our culturally bound stories of motherhood.

Welcome to the neonatal intensive care unit

Some of the mothers shared their experiences of having their new-born infant taken straight for medical treatment in the neonatal intensive care unit (NICU) or a special care baby unit (SCBU). This experience had lasting negative consequences for each

participant. When we move from pregnancy to labour and birth there is an expectation our baby will be healthy, and you will have your newborn placed on your chest straight away. However, when your child is unwell when they are born there is no space for bonding and attachment. There is a team of paediatric health professionals who swoop into your birthing room assessing your baby, often commencing medical treatment as you watch and then your baby is whisked away to another part of the hospital for treatment (Geller et al., 2018).

Kantrowitz-Gordon et al. (2016) described how parents of infants who were admitted to the NICU felt frightened and anxious, worrying their infant may have long term health needs or would die. For mothers there may also be a feeling of surrealness especially if we are too unwell to visit the baby (Geller et al., 2018). Marie described the dreamlike experience of knowing she had a child, having a photo of him but being unable to see him. Late in the evening a staff member asked her

> *“have you seen your baby?" and I said “not yet cos they're like” and I was obviously quite unwell cos I don't remember feeling bad about not having seen my baby… but I did it was just quite a disjointed thing so that’s like this is my baby… but it doesn’t feel like it’s my baby. (Marie)*

The mothers I spoke with whose infants had to be admitted to the NICU, worried about their baby alone in another place in the hospital. Some worried their baby might be mistaken for someone else’s baby. We hear these stories of babies being accidentally swapped or confused so we want to protect against this happening for our baby, to make sure they are safe, so sending your partner feels like the best option

> *so I was left in the umm theatre getting stitched up and they're all sort a try'n be joking around and "ohh he was cute” and whatever and I I sort of was like “well what does he look like? where is it where’s the baby?” and I got really stressed and I said to my partner “go with the baby”. (Sally)*

Not being able to be with your baby straight away is extremely stressful and can have long lasting impacts for mother and child (Geller et al., 2018). Beth described how her first birth and separation for her child had such significant implications for her, however she was unaware of how much until she had a non-traumatic birth with her second child

> *umm because umm the labour with my first was aah very very traumatic umm so it kind of (.) motherhood for me started in quite a difficult way umm (.) so I think that (.) has affected a lot of things for me which I didn't really realise at the time but even after having a second one and having a different experience and learning a whole lot more now the further I get into motherhood umm I realise a lot of things (.) that happened at the start had this like roll on effect umm (.) which makes me a bit sad. (Beth)*

Having your child admitted to the NICU is a complex and distressing situation often the result of a traumatic birthing experience. Suddenly doctors and nurses are caring for your child and the closest you may get to them is one hand gently placed on them through an incubator door (Geller et al., 2018). Whereas, before birth, you were the incubator and you were connected to them continuously, you were them and they were you (Raphael-Leff, 2020). Our biomedical health system appears to refuse or acknowledge the damage separation in the early days of life has on mothers and infants. Once mothers are discharged from the postnatal ward they go home in the evening as there is no place for parents to stay overnight. We fail to acknowledge the importance of mother-child relationships in our NICUs, making mothers return to their home with empty bodies and arms. Marie and Freja both had the experience of being discharged home before their child and they both described this as one of the most painful times of their early mothering

> *things like going home was awful like I think that is the worst thing in the world… and if they could fix anything…. you should never send a mother home when their child is in SCBU ever umm and I still remember that that's awful and both times, it's awful it's the worst thing in the world and… like I'd be heading back [the first time] I lasted two hours ((laughs)). (Marie)*

> *I mean it was horrible having to leave her at night and go back home…. (Freja)*

Mothers have the lonely experience of traveling to and from the hospital just to see their child, of long days in a hot and claustrophobic unit and snatching time with their baby when it is deemed appropriate by medical and nursing staff. The long days roll into long nights when you are still expressing two to three-hourly, creating an exhaustion that

is both physical and emotional (Geller et al., 2018). Freja describes struggling with the exhaustion of having a child in NICU and the lack of support given by her partner

> *but it was really hard for me and and yeah I didn't have any support from him [ex-partner] I just I was exhausted I've you know we'd leave NICU at like ten o'clock at night and then I'd have to get up throughout the night to pump and then go back into NICU in the morning and so it was really hard. (Freja)*

Just having to travel to and from the unit is a physical activity we would not be expecting of mothers if they had their child at home with them. Marie describes the tiredness levels in early days from having a child in NICU *"yeah and the fatigue of going to and from the hospital and the walk from the hospital car park to SCBU you're doing quite a lot in those first three weeks".* We lose a sense of connection with our child, who we deeply love, when they are admitted to NICU. The pain of disconnection may become more apparent as mothers are discharged early. Marie describes how the nursing staff at one hospital tried to keep feelings of attachment between mothers and babies by making notes about what happened for her son when she was not there *"they had a little book a little like umm certificate book for him… they'd have certificates or they'd have whatever or they'd have you know you drank three mils today"*. However, being able to read about your baby does not resolve the pain of not being able to be with them. With her first child Marie shared how her experiences of attachment *"was a bit disjointed"* at first and *"took a long time"* to connect when they were home.

Home alone

Marie spoke of the difference in attachment and exhaustion she had with her first children who went to the NICU compared to her youngest who she had with her from the moment he was born. She describes how healing it was to be able to have her baby right next to her

> *they [midwives] tried to put him down one time in the middle of the night and he started getting his breathing a bit funny you know how it goes a bit grunty and I was like "pick him up he doesn't do that when he's on me put him back" and he snuggled back in and went to sleep he's my snuggler anyway didn't put him down and it was soo healing. (Marie)*

Forming a relationship with a child is about moments together evolving into shared experiences and getting to know each other, bonding grows, shifts and changes

in the mother child relationship (Oakley, 2019a). Sally told of getting to know her son over time as she started to realise what he found funny or what shapes and colours he was drawn to. Whilst we may have a little idea of what a child is like before they are born, they may have been very active or very settled in utero, we do not know the personality they will grow into, we may know their biological sex but we do not know the gender they may grow to align with. In some ways we are inviting a familiar stranger into our lives (Raphael-Leff, 2020). They may look like you and your partner, or your extended families They have a genetic connection to you, they have grown within you but they are still little strangers, they have their own needs and desires, they will see the world through different eyes. Cultural expectations on mothers to feel a magical quick connection has formed an inaccurate narrative of the mother-child relationship. Women may feel distressed when attachment does not happen quickly and this may produce feelings of shame (Oakley, 2019b). Frida told me about her experience of not having an instant connection with her daughter and the shame she felt

> *about two weeks after she was born I text my midwife I was too ashamed to even ring her or wait for her to come over I text her and I was like "you know I don't think I should be a mum I'm so ashamed you know I look at Zoe and I don't feel anything"… "what kind of a terrible person am I?" sort of thing you know "I'm too ashamed to tell you" sort of thing like "what's wrong with me?". (Frida)*

This experience is very common for mothers and especially common for mothers who have experienced a traumatic birth (Kitzinger, 2006). When Frida did talk to her midwife, she was very reassuring

> *she was like "ohh my god you know you poor thing don't worry about it I felt like that too" blah blah blah no one talks about it that's the problem seventy percent of new mums don't feel anything the first week but no one says anything. (Frida)*

We are so worried that we will be perceived as a terrible mother, yet, we all struggle at some point, but especially at the beginning of motherhood. Being reassured that our feelings are normal and are part of an experience of motherhood that many women have is reassuring. Having health professionals which we are able to be honest with is important so that we do not feel that we are alone in this journey. Knowing about real experiences of motherhood, rather than the myths we are frequently told, allows us

to understand our experiences in a way that can feel empowering. The magical bonding myth of motherhood does not allow for understanding how long growing a mother-child attachment may take. For Frida, after her initial experience it took almost two years for her to feel really connected

> *I don't know I think I think probably about age two yeah age two was when we started bonding that's pretty - pretty grim really but umm definitely, I definitely yeah now I definitely feel like we have a connection like we have a bond it's nice like I enjoy building a relationship. (Frida)*

Not 'bonding' was also experienced by Sally. She had a baby who cried incessantly for the first weeks of his life and hardly slept. Sally was awake with him for hours on end and re-counted to me the physical feeling of not sleeping

> *umm and so yeah it was it was really really bad I was just so tired my eyes felt like sand paper like I'd open them and they'd just be burning and really sore I couldn't drive I just couldn't go out of the house. (Sally)*

Sally just kept going, caring and attending to her child's needs even when her own body was aching for sleep. Sleep deprivation as a mother is more than just being tired, having a late night. There is no time for catch up sleep, your infant is there constantly and even if they are asleep there always feels like there is more we should be doing, that no project or task is ever finished, no coffee ever drunk whilst still hot. Your arms are required by your infant to hold them, to sooth them or for them to sleep in. Some women may have the support of another adult, a partner or parent who may help at times with settling the baby. However, often mothers are left to cope with their infant while they themselves are physically and mentally exhausted. As Sally's son's crying worsened her partner left them, citing that he could not cope, however Sally was at breaking point also

> *my partner was like "look I just can't deal with this" and I was like "I don't I can't deal with it I I want to leave", "why don't you" and he said "I'm leaving" and I remember very clearly saying "well are you taking the baby with you?". (Sally)*

But Sally was left, struggling, with the baby who did not sleep, with extended family telling her she just had to cope

> *I couldn't do anything I was really isolated umm and I did ask some family members for help but they didn't want to they said no that it was just something that you have to go through umm yeah so they were quite horrible and nobody would take the baby for me for the night they wouldn't come over and stay. (Sally)*

Sally struggled through desperately not wanting this child and finally admitted to her WellChild nurse how she was feeling. Sally describes the nurse being concerned, caring and getting Sally involved in a parenting organisation. Belonging to an organisation gave Sally a sense of community and the realisation that she was not the only mother struggling. However, Sally was still alone with her baby for long periods and describes feeling angry at her child for not sleeping and frustrated at herself for not being able to settle him

> *I felt like screaming at it a lot like I it's I just sometimes lost my cool and was like ((said with a pretend yell)) "WHAT IS WRONG WITH YOU? WHAT DO YOU WANT? WHAT IS IT? WHAT!" and then it's like "bahahahaha" ((laughing)) you're like looking for any sign like is that a sign for milk? (Sally)*

Sally was angry, however, she told me she was not angry at her baby, but angry at the situation she was in. This was not the mothering experience Sally had expected. She had been given a mothering story of ease and love by her friends and family which was far from the exhausted, chaotic world she was now experiencing. The burden of mothering, the loneliness and isolation we feel from having to 'cope' with our child can be eased through having social connections with people who give a sense of support or community. Yet, our neoliberal society so frequently assumes mothers will cope as that is what 'good mothers' do.

Friends hiding the reality of motherhood

Sally was so upset in the incongruence from what her friends had shared with her and her reality of mothering that she rang friends from her baby-shower questioning why they had not told her how hard motherhood could be

> *it was just I was having this horrible experience because nobody had ever told me I told you I rung people from my baby shower and said "excuse me I need we need to talk. How come you didn't mention this like any of it?" and like you know "this is not a joke this is serious. I don't even want*

> *to be your friend any longer cos you brought me a present and a balloon and… you forgot to say ohh P.S. you might want to kill yourself either way you're probably like gonna hate it". (Sally)*

Sally's experience of not hearing the complexity of mothering before entering into motherhood is not uncommon. Our society still rehearses the narrative that all mothers will enjoy all aspects of mothering, and while many women may enjoy aspects of mothering, it is normal to not enjoy it all (Parker, 2005). Beth also describes how she wishes she had been forewarned about how hard mothering was

> *so interestingly I think I now share quite a bit about what I think even if people don't… want to know it all because I (.) would rather be real… I'm a bit (.) yeah (.) bit more of an open book on the matter if anybody asks something it's like it opens the flood gates a bit because I've found that talking about it is really good for me umm and also I don't want people to think it's like sunshine and rainbows. (Beth)*

These conversations are important given that as mothers we are told not to be angry, not to be angry at the child when they keep you up all night. Our patriarchal neoliberal society has taught us that we are not to be angry at society or the lack of support we may have because it was 'our' decision to have a child even though women are taught to become mothers; we are needed to carry on reproducing human-kind. Pronatalism continues to scorn women if they choose not to have a child with cultural narratives continually reinforcing that motherhood is a 'choice' all women should make (Gotlib, 2016). However, until recently fatherhood has had a very different set of culturally gendered narratives in which their role has been as disciplinarian and financial provider (Ladge et al., 2016).

When Sally's partner left when their baby was nine weeks old, she asked him to take their baby and he refused, he said *"he's like "well how am I gonna take it?".* The motherhood mandate teaches us that mothers will know how to care for a child but for Sally that wasn't the case. Freja was in the same position after her partner left, wondering how she was going to care for her children as a sole mother. Freja had found mothering challenging and her partner had already been of little support. However, when he left she was surprised and angry at some of their friends *"the reaction from friends… you know they're saying "well [he] had to find himself and you know he was depressed and… we're so glad he's happy now".* Our neoliberal patriarchal society has different expectations for

mothers and fathers. Mothers stay with their children to care and nourish them. However, due to our culturally gendered lens fathers have often been considered to be a good father if they provide financially for their family (Ladge et al., 2016). This narrative has left room for men to be absent from the day-to-day care of their children, while still being considered a 'good' father. Consequently, mothers have a significant burden of childcare and the societal pressure of having to raise a 'good' and 'upright' citizen alone in a society where sole mothers are discriminated against and frequently blamed for any issue arising in their child (Hook, 2020). Sole mothers have often been seen as incompetent mothers (Valencia, 2015); however, they are coping with the demands and exhaustion of mothering by themselves. Mothers are left to carry the full weight of parenting, the mental load of running a household and organising her children. Yet, our gendered societal narratives expect that mothers are capable of doing this with little support even though we then have a contradictory narrative of sole mothers being unable to provide adequate care for their children.

Where is the sleep?

How to cope with a baby when you are exhausted was a commonly shared experience. Somehow sleeping babies seem to appear in all the romantic connotations of mothering. We are told babies will sleep deeply and regularly, watched over by an angelic mother, not an exhausted, arm-aching sleep-deprived mother. Not only are we told myths about baby sleep but we are also given so much helpful advice such as 'sleep when the baby sleeps', which is not always helpful if you want to shower, eat, drink a hot beverage, watch or read anything, or get any chores completed. Anne and I met in the evening, chatting and laughing whilst trying not to wake her sleeping children

Anne: ((laughing)) I never want to sleep like a baby
Sarah: ((laughing))
Anne: I'll take the day naps but umm
Sarah: ((in overlap)) ((laughing)) yeah that's right
Anne: ((laughing)) but I'll have the full night sleep as well.

Some babies do not sleep, they are restless and wakeful. They have been used to sleeping next to a loud heart in a temperature controlled, nutrient-rich womb and it takes time to settle into life on the outside. As our bodies change with pregnancy, sleep starts to become a fanciful aspiration with small embellied humans jumping on our bladders at four o'clock in the morning. While there is a myth that being woken by your in-utero baby prepares us for being awake in the night once the baby is born, it feels like a cruel

infliction when sleep is about to become a mythical creature we are unable to capture (Blunden et al., 2011). Sleep is a human need, and along with water and food is essential for human functioning. Mothers are expected to attend to their infants frequently overnight resulting in fragmented sleep patterns. Fragmented sleep produces the same daytime issues as clinical sleep disorders, resulting in fatigue, cognitive impairments, and an overall decrease in quality of life (Montgomery-Downs et al., 2010). Yet, somehow, we expect mothers to cope with prolonged periods of disturbed sleep and just to 'nap when the baby naps' in order to feel less fatigued. However, this age-old napping advice has been questioned by Montgomery-Downs et al. (2010) who suggest that due to the fragmentised sleep in the postnatal period, naps will not reduce maternal fatigue.

Being able to settle your baby quickly so you can also sleep is seen as one of the skills of a "good mother". This narrative also describes babies as "good" if they settle and sleep for extended periods of time. Good babies are the ones that societal myths say we all want, a placid baby who sleeps and then settles easily. Lucy shared the difference in sleep patterns between her two children

> *I think the sleep deprivation is the hardest but umm I can't I can't complain that much because Maddie was a really good baby ((laughs))….yeah Zoe not so much she pretty much had a cold from day dot so she was- yeah we were co-sleeping with her like she had to be like upright on us umm. (Lucy)*

Sometimes unsettled babies are discussed in hushed tones since their mothers are not "coping," as if a mother who was a 'good mother' would be able to settle her child. Having other mothers, your partner, your family discuss how you might not be 'coping' without asking you creates a lonely, exhausted space. A space where you might not be able to ask for help when your body is aching for sleep, and your child just smiles, coos, cries, fights you, fights against the very thing you are desperate for, sleep: Uninterrupted sleep, alone, in your own bed without a baby or child near you. Inside your aching sleep-deprived body is a flicker of rage, that boils and boils as your child remains awake. If people have isolated you by their comments on good mothering it is hard to navigate support. Anger may just simmer like a desperate bodily expression of the overwhelming exhausted knowledge that your body, your life, is demanded and consumed by your child. It is your arms they wish to be held in, your arms they fight against, they demand your presence even when you are desperate to be away from them.

No one told us our arms would never be ours again: that they would become the holders of our baby, the comforters of our children. Getting your child to sleep, and where they sleep remains a contentious issue for many mothers as we are frequently told our choice of sleeping arrangement for our child is 'wrong' (Blunden et al., 2011). Holly told me about the guilt she felt as she struggled sleeping in the same room as her babies

> *I thought I was going to co-sleep cos my best friend co-slept with her babies and I just can't even stand to have my baby in the same room as me for some reason…. and I felt a lot of guilt about that. (Holly)*

Holly, like many mothers, had fallen out of the cultural narratives of where babies should sleep in the need to find some of the much elusive sleep for herself. We all have different narratives about how we should or should not mother which are shaped by society as well as our families of origin. We arrive to motherhood with our own embodied experiences of being mothered. Our memories, our histories influence the choices we make as mothers. For some of us, our previous social and personal experiences mean we have assumed that mothering will happen naturally, that we will just know how to mother as our mothers did before us. Rosa shared her experience of assuming that mothering is 'natural' during our conversation *"my mum loved having kids and …….(.) was a stay at home mum and I guess (.) kind of made that seem like it was just a really natural thing".* Rosa then expected mothering to just happen for her, however this was not her lived experience

> *it didn't feel like how I thought it was gonna feel I thought it would all sort of click into place a lot faster and a lot more smoothly and didn't realise how I would struggle with it so much mentally. (Rosa)*

For Rosa mothering was complicated, especially with an infant who slept very little and was tricky to settle. The mothering experience Rosa expected was far from her reality. The narrative of the natural mother, which is assumed most women will be, suggests that with a rush of postnatal hormones we will all know how to care for an infant, the baby will just settle in our caring arms. Mothering is a skill learnt over time and some women may have grown up around younger children and have been taught mothering skills. However, with the increase of the theories of mothering as a scientific practice, teaching through baby manuals and health professionals mothering moved away from being a skill we learnt from the women before us (Held & Rutherford, 2012). Yet, we are taught we will all know how to care for a child and often succumb to the

feeling that we 'should' be mothering better, differently, like our mothers or not like our mothers.

There is social pressure on mothers to run and maintain a perfect household. However, trying to do so and raise a small human who may not sleep or wants to be continuously held or fed is unattainable for most women. Lucy shared how she had to get used to her house not looking the way it did before having children

> *umm struggling to lower your expectations like the dishes need to be done or the washing needs to be done or ((sighs)) you know so I'd like fill the sink up and put all the dishes in there and then they'd just sit there till ((laughs)) the water went cold and you have to start again kinda thing, umm and it's just to accept that is ok to happen and umm that's a real struggle to kinda get your head around umm ((sighs)). (Lucy)*

Trying to achieve anything in your day can be agonising for a mother and sometimes we have to give some things away. Holly describes the feeling of not being able to achieve all she wanted as a mother

> *I was going to use reusable nappies ((sighs, laughs)) and I was going to going to bake and I was going to have a garden and ((general laughter)) you know like I had all of these, I mean I did use reusable nappies for about a year with Rowan but then they kept on leaking and I got frustrated and so I've just flagged it… I've had to readjust my expectations, I mean there are lots of things that I wanted to do that I do do you know like I wanted to really umm (.) like you know really consciously think about attachment and you know do lots of you know singing and eye contact and talking like with the baby like. (Holly)*

While Holly and I chatted, she shared how forming an attachment with her child was a priority for her, this resulted in her to having to readjust her expectations of mothering. Holly's baby sat on her knee cooing and smiling, well involved in our conversation; happy and contented. I thought about how many mothers I had spoken with described how building a close relationship with their child was so important to them. During the conversations, where children came and played and chatted with us, or they were home watching television or reading in another room they all appeared so comfortable with their mothers. Like Holly's baby, their mother's presence was a safe place to be. Being with our children and holding them, allowing them to be close or just

to be with us, even if we do not manage to fulfil all the activities of mothering we had planned to, helps to make a connection with them. However, allowing your child to be with you so closely can feel overwhelming and there are times where you just want space, want to put the baby down or not have the three-year-old talk to you anymore. Sometimes you need time away from your child.

Walking with the baby

In some of our conversations, women shared how walking their baby in a pram was a way of coping with the overwhelmingness, loneliness, tiredness, the not-quite-rightness of their new maternal worlds. Lucy describes walking with her child as a way of coping with the feelings about the birth of her first child

> *I spose it was that whole indirect post-traumatic stress that you yeah but umm yeah I kinda it will come in waves I spose and I'd just go out go for a walk… yeah in ummm like I didn't really have any friends having kids around the same time umm […] so umm yeah you kinda it was quite lonely sometimes umm but I'd go out and I walk every day I just no matter what the weather cos I I knew she was warm in the pram and I'd just yeah and it's just sanity for me to get some fresh air. (Lucy)*

Needing to find fresh air felt like a description of breaking free from the house, from the dishes in the sink, from the washing. The wind is felt on our bodies, it makes us take a deep breath, sometimes we have to push against it and we can feel it trying to hold us, or it can blow us away, away from the mundaneness of mothering. It can be invigorating, challenging us to move against it. Fresh air lets us be free for a time from mothering, as the baby is snuggled in the pram, and our bodies can move, walk, run against the air feeling the life of the wind.

Frida walked with her baby for long periods to help cope with her feelings, she walked by the beach thinking of ways to be away from mothering, while managing to stay mothering

> *we had a buggy and I would just walk for hours and days just around up and down the beach yup and down the beach and the river umm (.) and (.) just do that a lot. (Frida)*

Having a baby in a pram affords us some space from the baby while keeping them close, we are able to attend to them, but they are not so close as if you had them in a

front pack or sling. When you walk you are also part of the world, the world that keeps going even if your world has become so small with just you and your child. However, there remains a separation from us and the world. You are a mother walking her baby, not just a woman out for a run at lunch time, you are still tied to the baby in the pram. Sally describes thinking this as she walked, she longed to have her old life back as she walked for hours so her son would sleep, she longed to be part of the world again. The loneliness was visceral as she walked. As she spoke I could feel her sadness of being alone, walking with the baby, but also her need to walk with the baby to keep him close, safe, with just a fraction of distance between them so she could have a sense of normality, of her body as her own

> *so I just used to walk around the mall all the time walk around the streets which made me even more tired feel more isolated and I'd see people in their cars and I'd just look at them and think I wish I wish I was you and I wish I was just driving my car like normal like I used to be I used to be a real person and like I just felt really isolated really trapped. (Sally)*

From the outside, walking the baby appears to be the action of a mother who is 'looking after herself' by getting out of the house. We are often taught that people out exercising will be thinking happy, exercise-induced endorphin-thoughts (Maddox et al., 2020). However, while as mothers we do walk to look after ourselves, it was not compliance to the health and diet industry's demands on our bodies. Walking the baby is a time of space, of sanity, of a slice of freedom while still being a 'good mother'.

When friendships keep us together

Sometimes, to find space, we need to have friends around us. Rosa told me how she valued being able to walk into a room of friends and have someone else hold the baby, especially when she was feeling anxious *"they were great cos they would look at my face and just take him".* Having that small amount of space away from her child, whilst having them close, allowed her a sense of comfort knowing her child was safe which helped lessen her anxious feelings.

Mothering can feel like being on an empty ship, afloat at sea in a vast ocean. Where at times you might see another vessel, you might rig together with other Mum yachts for a period of time, share your stories of managing the storms, or the feelings of being becalmed for endless days. Sometimes you are just left with the baby in your arms and your own body which might not be feeling quite-right. Mothering can feel so lonely,

you feel trapped by your child, trapped in your house, trapped by the baby needing to sleep, as Frida said *"I hate missing out on being outside and I felt so trapped… I couldn't just be outside I just felt ahh I hated it".* Loneliness appears to intertwine with maternal ambivalence, feeling distant from others enhances the grief of our lost life, the life before children, where you could pop out for coffees or a movie, where you did not miss out on social connections unless you wanted to, rather than your life being prescribed by your young human. Feeling trapped at home, isolated, can result in feelings of anger, anxiety and frustration at the mothering situation we have found ourselves in.

Anxiety brings a shadow to your body, a feeling of never quite-rightness forming a restlessness and preoccupation with trying to make it right. Mothering however is never right or wrong, there is a constant never-quite-rightness in the normality of mothering, there is no exact science of mothering. However, many mothers still query if we are good enough to raise another human, can we manage this task when we cannot live up to our own expectations of our mother-self? These feelings can be complicated especially when we are with other women who have differing opinions on how children 'should' be raised. Beth recalls attending a play group for her younger child and shrinking back somewhat as she listened to some of the comments being made about parents of older children

> *it's very easy to feel like judgement going on in like mothers' groups and things cos everybody is so opinionated about everything and you just, all you talk about when you're with the mothers' group is your babies and every aspect of motherhood and like (.) it's pretty hard for everybody to be doing the same thing so when people are like "ohh (.) I can't believe they're doing that" or something and you're like ((in a whisper)) "well I did that". (Beth)*

Being around other mothers can be hard if you feel like you are being judged by them. Holly describes how her eldest is in a period of hitting other children which has been difficult for her to cope with

> *he's gone through about a year of the hitting phase…. it's really hard…. ohh it has been like there's been like I have left places in tears numerous times because of having to deal with Rowan and his behaviour and then feeling so upset for my child that this is his (.) reality you know that this is what he's doing this is how he's processing and it's and it's so unacceptable. (Holly)*

As mothers we want our children to make friendships with other children, but it is hard when our child is in a phase where they are likely to harm another child. If a child deviates from what is socially acceptable behaviour it is their mother who is blamed. Chloe also describes feeling the social pressure to raise the 'right' kind of child especially as she was at home fulltime *"yes I was that home mother so I should have perfect children".* She goes on to reveal how she felt her children's behaviour was a *"real reflection on my person, on me".* The guilt and pressure we can feel for having to raise a certain type of child is constant and adds to the overall mental load of mothering.

Finding space for ourselves

The mental load of mothering can be all consuming, the exhaustion of decision making, of knowing where your child is or what they are doing is never ending. Within managing our children and our household, mothers struggle to find space for ourselves where we are still our own person, not just a mother. Chloe describes deciding to wallpaper her house when her children started school

> *Mum and I re-wall papered and painted everything in the house you know what I mean I I needed to be busy during the day because I wasn't working but I also need to umm feel like I was contributing. (Chloe)*

Holly reflected on how she feels like she is not contributing to her household because she is not earning an income. She has full access to a shared bank account but there is part of her that feels some guilt for not earning *"not earning money makes me feel less of an adult less successful dependant not succeeding in life".* This is another loss that women feel entering motherhood, loss of an independent income. Our neoliberal societal narratives often confirm our experiences of feeling like we are not contributing. McDowell et al. (2005) suggests that our society places less value on caring for our dependents and more on our ability to contribute to the economic workforce. For Freja her frustration of being a sole mother and being unable to return to work due to her partner not helping with the care of their children is apparent as she says

> *I never wanted this I wanted to be a family and I wanted to be able to have gone back to work you know but (.) yeah I never intended to be a stay at home Mum for that long …… I wanna you know we'll be better off I mean maybe not we we probably won't have a huge amount of money more than we have now but and it's and it's just important for my sanity too. (Freja)*

We may find a sense of sanity from being away from our children to work. However, being away from your child physically does not mean we have lessened the mental load of the household. Planning daycare, dinners, ensuring the washing is still done is most often still completed by women. Finding space for ourselves, through walking, friendship, learning new skills or employment helps us to keep hold of who we are as adults outside of our mothering self. While we love our children and want to be there for them our bodies and minds need time to be just us without the judgement and disapproval our society often gives us for wanting to be a woman, with a name, not just our child's mother.

Groundhog Day

The mothers I spoke with had all grown up post the second wave feminist era, believing that we can take on everything; work, mothering, study, managing our households. We had all worked or studied in some capacity before having children, our days filled with people and responsibility before our little humans were born. Being thrust into living with a small human can be a lonely or boring experience, there is a mundaneness, a repetitive pattern of chores and daily, weekly, monthly activities (Chapman & Gubi, 2019). Minutes can feel like hours as you fold the washing, daydreaming about being somewhere else, doing something else as the children play or fight in the background. Holly describes going from being a busy professional to having "*the feeling like life is Groundhog Day and the weekend doesn't exist anymore ((laughs))".* Our days can melt into each other, which on a day when you have had little sleep can be a necessity, but there is a monotony of being at home, again. As Beth says, there is a *"constantness"* of having a child wanting to talk to you while you lack adult contact and interaction that produces a feeling of "monotony". Those feelings of being under stimulated and overwhelmed at the same time can also increase our feelings of isolation, loneliness or feeling trapped by our children. Loneliness when mothering is a living paradox; we are never alone. You always have this small human with you, attached to you, demanding your time, your energy, your body, your mind. While you are with them, they are demanding of you, resulting in little time for your own friendships or romantic relationship. When you are away from them, they still sneak into your mind, your thoughts, your feelings. Our feelings of ambivalence towards the *constantness* of motherhood are felt deeply when we long to be alone, as deep as the fierce love we have for our children. We keep our children either physically or mindfully with us even when we need a break, as we want to protect and care for them, such is our love for them.

I feel so frustrated and angry

Theorising of maternal ambivalence has often been associated with anger and violence from a mother towards her child. It appears as stories of neglect, filicide or homicide, newspaper articles of mothers who have "gone crazy" and killed their child or children. It is the stories of mothers who have so much rage they beat their children and are consequently pathologized as unwell, uncaring or evil women (La Chance Adams). Psychoanalysis taught us how mothers who are angry will inflict anger onto their child (Murray & Finn, 2012). However, throughout the conversations I had with mothers in this study, and through my own experience, anger appears to be an emotion that we all attempted to keep from our children. In the times when we did rage, it was followed by intense guilt and hoping that we were not doing lifelong damage to our children. One comment Anne made has continued to weave through my own thoughts as I have considered how maternal ambivalence has been theorised and socially represented as a sign of psychopathology or at least as problematic. Anne was talking about being exhausted

> *I would start getting frustrated with her not not in any kind of way with her but internally in myself I'm just like I just need you to sleep …. like "you're making me angry" which I would never, well I hope that she never felt like I was angry at her, but (.) yeah (.) sometimes I just have to say to Tom my husband "Tom you just have you'll have to do it ….. I can't". (Anne)*

Anne's experience of not wanting her baby to feel at fault for her emotions, to keep her baby safe from herself seemed to describe other women's experiences of wanting their children to know they are deeply loved even in our periods of frustration and anger. We are taught mothers cannot be angry at a baby as they are "just a baby". Yet, maybe we are not angry at the 'crying baby' but angry at being left with the crying baby. The lack of support, the expectations on our bodies to know how to fix the baby are infuriating. If we are not allowed to process our anger we may internalise it and then it may manifest as guilt, shame, blame or any other myriad of feelings that slowly make us feel bad, anxious, depressed (Murray & Finn, 2012). Marie describes feeling frustrated at her children and being able to move away from them knowing that she needed space

> *they would have been one and three or four and two and I would've have been probably home for days on end probably and just and just four*

> *o'clock Sunday lost my shit ((laughs))…. but because I probably hadn't spent enough me time ….you know so all of a sudden but I just remember losing it and I remember thinking they're not even being naughty why am I losing it with my kids could have just been hormones who knows but it was just like ((takes a deep breath)) and then Phil goes "why are you sitting on the step" cos I remember him driving in and I said cos I just can't do he said "are you ok?" and I said "yup" I said "I'm gonna yell keep yelling at our kids if I stayed inside". (Marie)*

Moving away from our children when we feel angry, overwhelmed or their behaviour connects to an emotion within ourselves that we feel overwhelmed with, shows a way in which we want to be thoughtful of our own reactions to our child. We are able to see that it is the world around us, the background of overtiredness, lack of support or social expectations that shape how we cope with mothering (Takseva, 2017).

Sally talked about the times she decided it was best to leave her son safely in his cot, crying, as she needed a break

> *when it got too much cos I could still hear him crying when I was outside smoking this is when he was really little I'd go and sit in the car I'd lock the door I don't know why in case he got out ((laughs)). (Sally)*

The frustration we feel at our child can be from the fatigue of living with the constant crying and lack of sleep. It wears away at every inch of our being. The lived experience of mothering; the exhaustion, grief, loneliness, seems to heighten our mixed feelings towards motherhood. While we live these experiences, we try to shelter our children, even if we choose to be transparent with other adults about some of our feelings. Frida has been transparent about her struggles with motherhood on social media, but she is careful to only share what she would be ok with telling her child

> *I've not said anything actually that I wouldn't be happy saying to her I've not said like "I hate you" or anything umm all you know I've just been open about struggling it's just because people are afraid to say things you know. (Frida)*

Our society holds mothers to a standard of being perfect mothers, of not having negative feelings toward mothering as this is considered the epitome of bad mothering (Davies, 2008). Angry mothers are often vilified as bad, mad or abusive mothers. Yet there

is no space for women to be angry, no emotional space for her to voice her anger without judgement. Mothers are expected to maintain their minds and bodies in a way that does not reflect anger or frustration. Frida discussed how, by sharing her experience of struggling with motherhood, people threatened to report her

> *although I've been very open on my Facebook or whatever about our struggles and people it's been interesting some people have threatened to report me or whatever to go god knows where (.) umm and it's interesting it's like for what? (Frida)*

Society does not accept that women may have mixed emotions towards motherhood. We are not allowed to regret choosing to become a mother or we become vilified as a bad mother (Donath, 2015), a mother who should not be allowed to have her children as there may be a risk that we harm them (Davies, 2008). However, these conditions on our motherhood are taught to us from a patriarchal society in which women and children are harmed more frequently and to a greater degree by men than women (McLean et al., 2018). We are told mothers are at higher risk for mental health issues which will result in us harming our children. Yet being harmed by men increases the likelihood we will have a mental health diagnosis (Cerulli et al., 2011).

Telling women that we are likely to receive a mental health diagnosis if our feelings about mothering include anger or frustration only acknowledges the symptoms we feel, not the causes of women feeling depressed, anxious or obsessive. We are tired, pressured, expected to be a constant good mother, told that we must work, mother, fix our bodies, in a society that values paid employment more than the unpaid care we provide for our family and communities (McDowell et al., 2005). Women are seen as more likely to have mental health issues because we are more emotional, unable to cope with stress. However, in most heteronormative households it is the woman who does all the caring, organising, carrying the mental load of mothering and often undertaking paid employment.

During the later parts of each conversation we seemed to end up discussing what each participant may do in the years ahead such as; more children (no more children!), returning to previous employment or looking at new avenues. I asked each woman if there was any part of motherhood that they really enjoyed, even if it was just when the children slept. They all describe one of the best parts of mothering is watching their children grow, develop and become their own person.

A growing goodbye

The cynic in me wonders if we love watching growth because as children grow, they become more independent, increasingly capable resulting in and leaving us with less physically taxing parenting. As we connect with our baby, toddler, child, teenager we create a relationship which is different to our other relationships. It is not a friendship, but it is closer and has a deep intimacy, yet, is more challenging than any other relationships. There is a power dynamic dancing between you, as you wrestle with moving through life together, of two beings once encased together now vying to be individuals. This is a dance of intimacy and separation ebbing and flowing as you both grow into each other and away from each other. Watching your child grow is a beautiful but painful process. You see them achieving, learning who they are, moving in the world by themselves. When they are small you are the centre of their world, maybe even you are them, they are you, but it is the one relationship which is designed to end in separation. Knowing you will be separated physically as your child ventures out of your home as an adult makes watching them grow bittersweet, you are able to love them for that time and love them enough to let them go (Parker, 2005). Chloe and I chatted about our children becoming teenagers and the change in dynamic that adolescence brings in your relationship, how we worry so much but know that we cannot keep them 'wrapped up' for ever, rather we become taxi drivers and caterers which somehow makes us still feel useful and connected to our child's world

> *Chloe: there is quite a bit of restriction for teenagers when they have got friends in [other suburbs and] they can't get directly to their friends on public transport… umm so they do rely on you*
> *Sarah: the 'mum uber'*
> *Chloe: umm which still creates me feeling wanted.*

It is almost as if there is a grief, a loss or mourning of not being able to be with them while there is a grief, a loss and mourning of having to be with them. We become lost in the world of mother, lost to be both ourselves and part of our child. Then slowly, we begin letting go and separating from this shared self. As we chatted curled up on her sofa, fire crackling, Beth describes her longing for her children to stay small whilst wishing they would grow

> *but I already am in a mourning process for when there not small anymore like if I think about it it makes me really emotional umm because I know*

> *that I can kiss them all day long at the moment and that's not gonna be like that forever and they're not gonna be cute… like my two-year-old-, like the way he cuddles me at the moment with his whole body and I just… I have to cherish that and it's really hard to think about. (Beth)*

Each step of a child growing is a milestone to be celebrated and grieved for. Within this process we also find ourselves as an older mother, a mother moving into new phases of life as Marie recounted while she spoke of watching a speaker who said

> *"I love my children but I'm not in love with my children" …. and I was just kinda thinking it struck a chord with me cos I thought yeah that's actually how I feel you know actually my kids are great and I love them and they're awesome and you'd do anything for them within reason….. but the reason we have children is because of our relationship and at the end of this twenty-year period of our life I still want a relationship. (Marie)*

Maintaining a connection to ourselves, to our other relationships, whether that is with the father of our children or other significant relationships, is important for our wellbeing. Marie continued on saying

> *I don't want my relationship with my kids to be to the detriment of everything else that surrounds me and I still wanna have a job… and I think there's other things that we can teach our kids you know so ((sighs)) you know, the yes it's important how we treat each other and that kinda thing but also yup Mum and Dad have both got degrees and we've both got an education and we both can work, and no Mum's job isn't just to stay home, and dad can cook. (Marie)*

Our love for our children can be shown through being true to ourselves and teaching our children to be true to themselves. Mothering is filled with a complexity of emotions which are influenced by how we see ourselves within our deeply ingrained patriarchal society. Our bodies are frequently dismissed and subjugated by the androcentrism underlying our biomedical healthcare system. Our emotional needs, to have friendships or romantic relationships are regularly considered secondary to the needs of our children. However, as we lose our needs to our children's it is easy for mixed feelings of motherhood to arise. We long for space and time away just so we can feel more like a person than just a mother, yet the love we have for our small humans runs deeply into our embodied state of being, even in our moments of escape.

Motherhood is a transitional state of being. It moves and shifts with our bodies as we live in this culturally gendered world which continues to apply pressure on our bodies to be contained, to be the ‘good mother’. Mothering changes us, it changes our bodies, our understanding of the world and the worlds gaze on us. The way in which we move through our mothering spaces, interact with our friends, are treated by health professionals shapes the way we feel about our mothering experiences either by encouraging us or by continuing to dismiss and deny our lived experiences of mothering.

As we come to the concluding parts of our mothering narratives it appears easy to see how, given the pressures and expectations of mothering, there are times we dislike the experience. Feelings of disliking mothering should be expected in a world where mothering is considered a scientific practice and commodity of our neoliberal society. Mothering experiences include how our female bodies capabilities are taken for granted by our androcentric biomedical health care system which expects that violence against our bodies, in order to reproduce, is still acceptable practice. This practice may result in us struggling to be ok in our bodies as we attend to the children we love intensely.

Conclusion

As I write this conclusion, I have reflected on the beginning stages of this project: How this project sought to understand the experience of both enjoying and disliking motherhood, and my secret fear that maybe I was one of the few mothers who felt this way. Yet, as I spoke with more people, mothers, friends, about my research I began to realise we just did not often talk about maternal ambivalence. As I started reading and researching, I realised maternal ambivalence appeared to be an embodied experience. Part of our bodies' responses to ambivalent feelings was influenced by our patriarchal neoliberal society's culturally gendered expectations of how women should move in our world. At this point and in respect of embodied sociocultural experiences, I realised this project would be best suited to a feminist phenomenological approach.

Feminist phenomenology incorporates feminist research principles ensuring women are seen as makers of their own knowledge, that they are part of the making process of research. The mothers who participated in the current study led the research with their knowledge of having lived experiences of maternal ambivalence. Feminist principles ensured I looked at the bigger societal influences on mothering, how our patriarchal neoliberal society has created the contemporary pressure of needing to be a constantly 'good' mother. The phenomenological principles allowed an understanding of how our female bodies move into mothering and the lived experience of this process. It attended to the experience of how becoming a mother within our androcentric biomedical healthcare systems subjugates our bodies, often moving us away from deeply experiencing our own fleshiness, to feeling that somehow our strong female bodies have failed us. Feminist phenomenology gave space for women to share, knowing that their experiences were privileged and validated for the value and knowledge they hold.

The interview process of this project allowed space for mothers to tell their personal experiences of some less than culturally sanctioned feelings of motherhood. Ensuring mothers knew they were in control of the conversations, created what felt like a safe space to be. The interviews felt powerful as I talked with the women. They shone a light into some of the dark crevasses of motherhood creating a sense of freedom within our conversation. They were a space of being allowed to share the dark, painful experiences of mothering that would otherwise be considered too grim to talk about in day-to-day conversations. I felt an overwhelming privilege for being allowed to enter this space and in some instances to hear experiences that had not been shared with anyone

else before. The interviewing space also had a cathartic feeling of being able to share what was often held back because of anxiety about how people may react to you. Our society, with its dominant beliefs of the 'good' mother does not sanction discussing dark undesirable feelings of motherhood. Through our conversations it appears that experiences of maternal ambivalence do not fit into a fixed construct, rather there is a fluidity that shifts and changes with events and interactions within a mother's world. Maternal ambivalence appears to be present with other affective experiences that change from hour-to-hour or from day-to-day as we live our lives.

Feeling ambivalent towards motherhood was shared within experiences that would be considered 'normal' events of mothering; the boredom and monotony of household chores and tasks that seem to have a never-ending quality about them; the feelings of loneliness during the night when we are awake to feed our baby and the world sleeps, yet, we are expected to deal with the baby overnight as society's culturally gendered narratives tell us our role is to attend to our infants irrespective of how exhausted we are. The shared feelings of maternal ambivalence also appeared when society told us culturally expected narratives that were incongruent to our own lived experiences such as; it is a luxury to be at home with our small children and we should be grateful for this time, while we experienced overwhelming feelings of loneliness and isolation. The mothers in this project also shared experiences of feeling maternal ambivalence in events that felt significantly painful or traumatising.

The events women shared appeared to include experiences where our bodies moved out of the culturally expected way we had been told they would 'behave'. Being unable to easily become pregnant was the first glimmer of feelings of maternal ambivalence for some mothers. Our bodies are often blamed for infertility, as society has an assumption of gendered capabilities, telling us our bodies are designed to become pregnant and if we cannot it must be something wrong with our female body. Yet, by society seeing infertility as a female issue the voices of men who face infertility are silenced. The birth of our child was another experience shared as a starting point for having mixed feelings about mothering. These experiences often came with feelings of blame, shame or guilt for our bodies behaving in a way that fell away from the cultural narratives of birthing. The impact of how we were treated emotionally and physically by health professionals had significant repercussions for our feelings towards motherhood.

As we move into motherhood our bodies have also changed into a new 'mother' body. This new body can be complicated to navigate, especially if we have felt traumatised or dismissed during our pregnancy or birth. We may have feelings of shame or guilt which infiltrate into our mothering days, increasing our feelings of maternal ambivalence. As we attend to the challenges of caring for a small human, we are faced with a multitude of feelings. We may feel trapped by our child, unable to live the life of mothering we had been led to expect through society's cultural mothering narratives. We may grieve for the loss of our pre-mother life while feeling exhausted from the sleep deprivation and *constantness* that is mothering. As we navigate our mothering experiences, we are under societal pressure to be a 'good' mother creating a continued self-surveillance of our own mothering practices. We may feel a mix of anxiety and grief if we feel we are not living up to our own mothering expectations. As our feelings and experiences of mothering shift away from our expectations, our feelings of disliking motherhood may increase. Yet, throughout feeling disillusioned with mothering the love for our child is deep and fierce.

Our desire to build loving and caring relationships with our child appears to be a priority even when we feel too exhausted to carry on. The love for our child is apparent even when we cannot imagine what love feels like. It is an embodied response of loving actions, such as moving away from our child when we feel angry and frustrated or ensuring they are able to sleep even when it means we have little sleep for ourselves. The love for our children appears to grow through the passage of time as we watch them develop into their own human form, with their own abilities and personalities. Feelings of motherhood such as our deep love mixed with frustration, anger and multitude of emotions ebb and flow as we move through our mothering journey.

Looking towards the future

This project has allowed us to understand mothers' experiences of maternal ambivalence within their day-to-day life and at the same time has offered some direction for future research. Each woman in this research was cared for by numerous health care professionals. While it appeared some professionals, such as Frida's midwife, had an understanding of women's mixed feelings towards mothering, she appeared to be unusual among the many health professionals' mothers encountered. Research seeking to understand how healthcare professionals who work with mothers understand experiences of maternal ambivalence may help to further deepen our understanding in this area. Working with health care providers may also help us to understand any

prejudices women may face if they do raise having mixed feelings of motherhood with those who are caring for them and their children.

It appears many women still feel isolated from the realities of our female bodies. This became apparent with how mothers discussed feeling let down by the minimal information they were given about how their bodies would change during birth and post birth. Lack of teaching about diverse experiences of pregnancy, birthing and post-birth recovery results in women being unable to make informed choices about their bodies during pregnancy, birth and postpartum. I also reflected on how it appeared many mothers may have lost their sense of bodily autonomy during experiences relating to motherhood such as ART. This area has very little research, as does women's experience of obstetric violence, particularly in the birthing environment. Further research in these areas may help us to understand how we can increase women's bodily autonomy and reduce experiences of gendered violence in ATR and obstetric care.

The way our bodies are treated by medical professionals, and the experiences described by some women made me consider the impact ART, pregnancy and birth may have on women who have experienced sexual violence prior to considering motherhood. During this project I tried to find research in this area and there is very little. Feminist phenomenological research should be considered as a methodological approach in this area as it privileges the women's experiences of living in a culturally gendered society, it understands that our knowledge of the world is created by experiences within our body and by societal pressures that continually attempt to subjugate our bodies. This framework, as used within this current project, allows for taboo topics such as sexual assault or obstetric violence to be shared in environments that are both safe and empowering for women.

The lived experience of mothers being forced to leave hospital prior to their infant when their infant is in the NICU or SCBU appears to have been extremely challenging on mothers physical and mental health. This area of motherhood appears to have very scant research. We are able to stay with our older children if they are admitted to hospital, yet mothers of newborn babies are not given this same right to be with their child. While we have a cultural narrative which privileges mother-child attachment, the process of forcing new mothers to live away from their infant is conflicting to this narrative. Further research could seek to understand mothers' experiences of separation and/or the reasoning for separating mother and infant within our healthcare system.

This project raised an experience for me that I had not considered prior to starting to transcribe the women's interviews and I was taken back by how we used laughter within our conversations. There is very little literature on laughter and motherhood and a complete dearth of research on the use of humour or laughter and maternal ambivalence. The research that appeared in my searches was looking at laughter from a child's developmental perspective such as Addyman and Addyman (2013). Understanding women's experiences of laughter to cope with less culturally sanctioned feelings within motherhood could add to the limited body of maternal research within Aotearoa New Zealand.

Limitations

This project has numerous limitations that have weaved throughout the research process. The complexity of limitations is especially important to consider as motherhood is a vastly complicated experience which is navigated within cultural and socioeconomic bounds of the societal environments in which we live. I chose not to look at the experience of mothers who fall outside of the socially sanctioned appropriate age of motherhood. These mothers may have differing experiences of ambivalence due to the social discrimination they may encounter in their day-to-day life. This project also did not include any mothers who birthed multiples which would change the day-to-day experience of mothering.

Due to my choice of convenience sampling the mothers who decided to participate were more similar to myself, and each other, than may have occurred with a different sampling procedure or another researcher. While this was helpful as we shared a cultural understanding of mothering, it has resulted in this study missing a raft of other cultural experiences of mothering found within Aotearoa New Zealand such as; mothers who have moved here as refugees or from non-European countries; mothers who do not currently identify as cis-gendered heterosexual women; sole mothers by choice; mothers from very low or very upper economic classes; mothers forced into motherhood by coercive pressure or rape. I feel regretful that the voices of these mothers are unable to be heard in this project. I say this with an acknowledgement of the need for research to attend to their experiences going forward.

There remains a quantity of unused quotes and experiences from the mothers for which I have been unable to find space in the final written document, since they were subsumed within the thematic approach to representing the narrative of the analysis. I

feel a sense of anguish that I have not been able to use all the experiences the participating mothers shared with me, but I hope each mother can see the essences of her experiences throughout. I am also aware of my own influence on the narrative of this project and how my own sociocultural and life experiences of mothering, nursing within a biomedical health system and my study of psychology shape how I understand and theorise within this project.

Parting comments

Here we are together, at the end of our narrative about experiencing feelings of maternal ambivalence written with ten amazing, courageously strong women. I had the privilege of listening to these women share their experiences and was given the opportunity to bring their stories with me, to transcribe them, analyse them, and represent them on these pages so their experiences could be shared with you. The stories shared reflect the bravery and audacity shown by all the mothers in this project as they navigated the conception, pregnancy, birth and mothering of their children. Thank you, reader for coming on this journey with us, for seeking to understand how we experience feelings of both loving and struggling with our lives as mothers. Finally, to the wonderful mothers of this project; I remain amazed at your survival techniques, your resilience and ability to cope with situations which appeared devastatingly life changing, yet you just kept going, kept facing each day. The way in which you so deeply, and fiercely love your children even in the moments when you were feeling broken by the world, the lack of support, the dismissal of your bodies and your experiences. You taught me so much about life, mothering, laughter and how women have a strength to just keep going even through the darkest of times. Thank you.

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Appendices

Appendix A – Participant information Sheet

Mothers' experiences of feeling maternal ambivalence

INFORMATION SHEET

Researcher:

Tēnā koe. My name is Sarah Gilmour. I am conducting this research for the fulfilment of the requirements for a Master of Art degree, under the supervision of Dr Ann Rogerson and Professor Mandy Morgan from the School of Psychology, Massey University, Palmerston North. I worked as a Registered Nurse, mostly in paediatrics, for over 15 years prior to returning to study. I am also a mother who has experienced feelings of maternal ambivalence.

If you have any queries about the research, please feel free to contact either myself, Ann or Mandy by phone or email. Our details are on the last page.

Research project:

Motherhood is a time of change and uncertainty for many women, and often comes with social expectations about how a mother should behave, think and feel towards their child. Mothers are often stereotyped as 'good' or 'bad' mothers depending on their thoughts, feelings and behaviour. Mixed feelings about being a mother are often not talked about, since saying that you might not always enjoy your children, could mean you are labelled a 'bad' mother. This research aims to better understand how mothers experience feelings of both enjoying and disliking motherhood within their day-to-day mothering practices. This will be achieved through non-judgmental and confidential listening to stories, thoughts and feelings of mothers' experiences during an interview with the researcher. Interviews will then be analysed to better understand the similarities and differences in women's experiences of maternal ambivalence.

Participants:

To participate you need to:

- be a mother who lives, or has lived, with a biological or adoptive child;
- have had your first child when you were over 22 years-old and before 39-years-old;
- have lived or be living with your child;
- currently live in the Wellington Region; and
- feel comfortable speaking English.

This research focuses on the mother's experience, so the age of your child now does not matter. I will be recruiting up to 10 participants through asking trusted intermediary colleagues to provide this information sheet to mothers who they think may be interested in participating. You have been given this sheet because a mutual person, whom I trust, thinks you may be interested in participating.

What this study will involve:

Should you decide to participate in this study, you will first be invited to an initial meeting with me, Sarah, to discuss the interview process. In this meeting, we will also identify any needs you may have, including support, cultural considerations and child care. If you agree to participate we will also arrange formal consent, and the interview time and place. This interview will be a conversational style and will take around an hour. I will put time aside if you would like to talk for longer. Refreshments will be provided during the interview and you will be given a $25 grocery voucher as appreciation for your participation.

Talking about mothering experiences may raise thoughts and feelings that are uncomfortable or distressing, so we will allow time at the end of the interview to debrief about how you are feeling. If you feel you would like further support following this interview, please feel free to discuss options with me. Some support agencies are listed on the last page and a cost may be associated with their use. If you decide to use their services, any costs would be your responsibility. I cannot contact the support agencies for you. However, I can support you through the process by being present as you call the agencies or providing the use of a phone to do this.

Project procedures:

Should you decide to participate, it is important you have a clear understanding of the research purpose and process. This will be carefully explained to you in the initial meeting. Participating in this research is confidential, and your privacy will be protected throughout. If you consent, the interview will be digitally audio recorded and stored in a password protected format. If you do not want the interview to be sound recorded, I will ask for your consent to take notes during our conversation. I will transcribe the interview myself into a written digital format and you will be offered the opportunity to read, contemplate, discuss and make edits to the transcripts. If you are happy with the transcripts at this point, I will ask you to sign a Transcript Release Form and return the transcripts to me. The choice to participate is voluntary and you can withdraw from the study if you wish. However, after your transcript has been released for analysis withdrawal becomes complicated. Given this, if you have reservations about continuing, a time period will be negotiated for you to reflect and come to a decision about your continued participation.

- Identifying material will be removed during transcription.
- Digital audio-recording will be deleted after transcription.
- Digital notes will be kept in a password protected format until my thesis has been graded then the notes will be destroyed.
- My supervisor will keep consent forms and transcriptions secure for five years and then they will be destroyed
- Only myself and my supervisors will have access to the consent forms, transcripts, notes, and will participate in the analysis of your interviews.
- Once the research is completed, I will contact you to discuss the outcome of the research and to ask for feedback.

You are welcome to bring a support person or persons with you to all our meetings together. The support person or persons will also be asked to sign a form which outlines confidentiality and expectations of being a support person.

This study has been designed to respect mothers' knowledge and understanding of their own mothering experience and is inclusive of mothers from diverse backgrounds.

Limitations of confidentiality:

The information obtained in this study will be treated confidentially. However, if there is a situation in which it becomes apparent that the participant is at risk of harm to herself or to others, my supervisors, the participant's support person, or an outside support agency may need to be contacted. The process would be done with the participant and the researcher would remain as a support person until safety of the participant had been established.

Participants' Rights:

Although you have been given this information you are under no obligation to accept the invitation. However, if you would like to participate you have the right to:

- Not discuss any topic or answer any question that you would rather not talk about
- Ask questions regarding the study at any point in the process
- Understand the process thoroughly
- Understand that your name or identifiable information will not be used
- Have time to read, consider, discuss and edit the transcripts prior to analysis
- Ask for the audio tape to be stopped at any point
- Have a copy to a summary of the research findings when the research finishes
- Withdraw from the research at any point up until you have signed the release of transcript form
- You are welcome to bring a support person or persons with you to each meeting

Thank you for taking the time to read this information sheet. Participating in this research is voluntary and confidential. The person who gave you the sheet does not need to know if you intend to contact me and I will not tell them who contacts me. If you decide you would like to participate or discuss the research with me in person, please contact me either via email, phone or text and we can arrange an initial meeting to talk through the research process.

Ngā mihi nui

Sarah Gilmour

Researcher Contact details

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This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 19/18. If you have any concerns about the conduct of this research, please contact Dr Rochelle Stewart-Withers, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83657, email humanethicsouthb@massey.ac.nz

If you need further information about Massey Code of Ethical Conduct it can be found here; http://www.massey.ac.nz/massey/research/research-ethics/human-ethics/code-ethical-conduct.cfm

Support Organisations: Please note, if you decide to use these services, any costs would be your responsibility.

Little Shadow

This organisation offers low cost counselling ($35 -$80 per session) and support for parents in the early years of parenting experiencing perinatal distress. Kaupapa Māori support is offered through this organisation. More information can be found at https://www.littleshadow.org.nz/

Mothers Helper

This organisation works with women to find practical and emotional support if they have feelings of distress within motherhood**.** More information can be found at http://www.mothershelpers.co.nz/

Greenstone doors

This is an organisation giving support and counseling to women and families. Please note this is a Christian based organization, however, they do not discriminate and offer support to all individuals irrespective of religious beliefs. More information can be found at http://www.greenstonedoors.co.nz/

Mental Health foundation

This organisation helps connect individuals with mental health support as well as promoting general mental health and wellbeing. More information can be found at https://www.mentalhealth.org.nz/

Talking Works

This website has information and contact details about therapists throughout the Wellington region. More information can be found at https://www.talkingworks.co.nz/dir/wellington.html

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Appendix B – Participant consent form

Mothers' experiences of feeling maternal ambivalence

PARTICIPANT CONSENT FORM

I have read the research information sheet or have had it read to me in my first language. I understand the information sheet contents and the nature and purpose of the study. All my questions have been answered adequately and I understand I can ask questions at any point throughout the research process.

I have been given sufficient time to consider participating in this research. I understand that participation in this study is voluntary and I can withdraw at any point until I release my transcript to be used in the study.

- I agree/do not agree to the interview being digitally audio-recorded
- I understand that I can ask for the audio-recorder to be turned off at any point in the interview
- I understand that the audio-recording will be destroyed once my interview has been transcribed
- I understand that all information I give will be treated confidentially
- I understand that I can read, discuss and make edits to the transcript or notes of my interview if I choose
- I understand I will have access to a summary of the research at its completion
- I understand and am happy to participate in the research under the conditions described in the Information Sheet provided

Declaration by Participant:

I _____ agree to participate in this research as explained in the Information sheet

Signature: _____ **Date:** _____

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Appendix C - Interview schedule

Mothers' experiences of feeling maternal ambivalence

Conversational semi-structured interview schedule

The interview will start with an informal chat, a catch up from the first initial meeting together. This will be a time to make a drink, offer a biscuit and we settle to comfortable places to sit for the interview. This time may also be; meeting the support person/s; settling children with the carer we have provided; ensuring all people involved are feeling safe and settled.

Background information

This part of the interview will start with a "thank you" from me for participating in the project. I will check if they have any more questions about the process in general.

Then we will move into the conversation with questions loosely based on the following starter: "had you ever thought about, or maybe thought for a long time that you wanted to be a mum"

Prompt Questions

"could to tell be a bit about your first experiences of being a mum?"

"what was your experience of birth like?" (if they have a biological child)

"what was your experience of meeting your child for the first time like" (if they have an adopted child)

"Can you tell me about describe a time that you really loved being a mother"

"Can you tell me about a time in which you didn't really enjoy mothering?"

"Can you recall a time where you feel like mothering is a difficult balancing act?"

"Can you tell me one of the funniest memories you have of mothering?'

"Can you recall a time when you have felt a few emotions about mothering at the same time? This might be like really wanting to go out to the movies and looking forward to being away from your children, but feeling really sad, worried or guilty that you are leaving them behind"

"Reflecting now, on your experience of mothering, how different do you think it is compared to how you imagined mothering?"

"can you describe an experience where other people have influenced how you felt about mothering?"

Closing

As we draw to the end of the interview time I will ask if there is anything else they would like to share "It's almost the end of our time and we have discussed so much together, I just wanted to check if there was anything else you would like to share today?"

Following this I will check-in with the participant and see how they are feeling, if anything has left them feeling uncomfortable or distressed. If issues have arisen for them and they would like some assistance to find support, we will spend the final part of our time together talking this through and making arrangements.

Finally, a supermarket gift card will be given as a token of appreciation for the time given by the participant

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Appendix C – Authority for the release of transcripts

Mothers' experiences of feeling maternal ambivalence

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview conducted with me.

I agree that extracts from the edited transcript may be used in reports and publications arising from the research.

Signature: ..... **Date:** .....

Full name - printed .....