

## **Becoming a Mother**

When I first began ruminating on the subject of becoming a mother, I thought that in the twenty-first century this process could be a complicated matter with a plethora of considerations to be made before, during, and after birth. As an academic feminist undertaking research on women's experience of childbirth I am aware of the multidimensional and personal aspects of becoming a mother, along with some of the socio-cultural pressures to meet that "feminine imperative." As more women are no longer ruled by the biological inevitability of motherhood, with the twentieth-century advent of contraceptive technology, they are faced with many new and sometimes contradictory choices. Prior to my re-entry into the academy, I had been a certified childbirth educator since 1977 and a postpartum parent educator working with mothers and their babies since 1981. Witnessing the transition to motherhood has given me a personal perspective on women's issues during this time in their life cycle, while feminist research within higher education has substantially broadened and deepened that viewpoint. This maternalist/feminist perspective is an unconventional combination and it is from this expanded viewpoint that I will consider some of the salient issues that confront women on the threshold of becoming a mother.

When I became a mother back in 1974, the process seemed to be a much simpler one, and the decisions reflected that relative simplicity. Once I chose the doctor who would attend my birth and which of the two hospitals where he had privileges, the rest fell into place. There certainly was a limited amount of literature on the subject—about a handful of books. Women were unaware of fetal alcohol syndrome, the effects of caffeine, or the dangers of teratogenous substances. Choice seemed to be focused on what kind of baby paraphernalia to buy or what to include in the layette. But things have changed since then.

Two years later I was making new choices, this time for something quite avantgarde—I was planning to have my baby in a birth center with midwives. This decision had to be defended on a regular basis as the hegemonic obstetric stance of hospitalized birth using physicians made my choice look unsafe. Maternity services were beginning to expand in the 1970s as the place of birth and the choice of birth attendants were no longer restricted to hospitals and doctors. This was a response to the women's liberation, women's health and childbirth reform movements that were challenging the way in which childbirth was being conducted with its long list of potential interventions, the indiscriminate use of technology, and the epidemic of cesarean sections. Becoming a mother was becoming a complex matter indeed.

In 1981, when I was having my third child, childbirth options had expanded even further, and some of the challenges from the women's movements had been institutionalized. These changes included the use of birthing rooms in hospitals, vaginal birth after cesarean deliveries, the rebirth of midwifery care, and sibling visitation. When my fourth child was born at home in 1988, he had all his siblings present to welcome him, and the midwives who attended my birth had been practicing home birth for some time.

However, the decisions about childbirth are not the only considerations facing women as they approach motherhood. Now, more than a quarter century since that relatively simple time, all sorts of issues confront women. In this article I will be focusing on the following matters: 1) How are women influenced by the cultural imperative to become mothers? 2) What choices do women face about childbirth and infant feeding? 3) How is a woman's identity changed by the role of mothering?

This list of issues is not exhaustive of those women in the twenty-first century have to face, but they incorporate many of the complexities for women becoming mothers. Because childbirth is the event that initiates women into motherhood, this article will highlight the issues around the second category in much more detail.

### **The Motherhood Mandate**

In the 1970s, feminism began to focus on the cultural pressure to become mothers, now that contraception had given women more control over the biological choice. Nancy F. Russo articulated the centrality of motherhood in the definition of female adulthood in her significant writings on the "Motherhood Mandate" (Russo, 1976, 1979). With more control over when a woman might become pregnant, she is still compelled by the primacy of this role within a pronatalist social context (Russo, 1976, 1979; (Contratto) Weiskoff 1980; Chodorow and Contratto 1989). The social and cultural institutions that enforced the motherhood mandate made "the idea of a woman being something other than primarily mother and wife ... literally unthinkable" (Russo, 1976: 145). Feminism revealed the "woman-as-mother" assumption (Russo, 1976) as heterosexist (Simons, 1984; Lazaro 1986), recognizing diversity

among women, particularly within lesbian consciousness where childbearing (at least in those days) was not part of their identity, and those women who chose to remain childless (Simons, 1984). “Insofar as voluntary childlessness is considered a valued option for women in our society, motherhood itself becomes an option rather than a mandate” (Russo, 1979: 12).

The illusion that motherhood is a freely chosen option tends to collapse for women who do not have access to reproductive technology and for whom motherhood might be the only valued option when constrained by employment at the lower end of the economic scale. The kind of advanced education, training or experience required to attain a job that would be an attractive alternative to motherhood is not anticipated or accessible for women in lower socio-economic groups (Russo, 1976, 1979). Social class plays a part not only in access to contraception and abortion but for choices in childbirth as well, a topic I will return to later in this discussion. Within the political and social context of black and Hispanic communities, giving birth can be one of the most meaningful actions for a woman denied most other meaningful opportunities (Simons, 1984). As more (privileged) women have entered the labour force in careers that provide the kind of achievement and satisfaction that enriches their sense of self, choosing not to mother has become an important alternative, even if only a small proportion of the population exercise the option (Simons, 1984; Lazaro, 1986). Because in the end, “for most women, the decision to become mothers is more a matter of social pressure than a free decision” (Lazaro, 1986: 98).

Feminist writing has been influenced by the ideas of Simone de Beauvoir (1952), who focused on the oppressive conditions that motherhood has traditionally imposed on women.

The absence of women who successfully combined a professional career with motherhood and Beauvoir’s own profound alienation from woman’s traditional role of wife and mother can provide insight into her angry, ambivalent, but largely negative view of motherhood in *The Second Sex*. (Simons, 1984: 352)

Beauvoir’s attitude towards motherhood has been the subject of feminist debates for years (O’Brien, 1981; Simons, 1984; Lazaro, 1986). However, it was Adrienne Rich (1976) who distinguished between the institution of motherhood within patriarchy, which Beauvoir was condemning, and the experience of motherhood, which has the potential to be richly rewarding. As women’s options have increased during the last quarter of the twentieth century, the motherhood mandate has loosened its grip on the identity of adult females who now grapple with various roles in their busy lives.

### **Choices in pregnancy, childbirth, and lactation**

Women in the twenty-first century have a smorgasbord of choices to

consider when it comes to how they are going to give birth. There are decisions to make during pregnancy about where to have a baby (hospital, birth center or home), with whom (doctor or midwife), and how (naturally, with medication, high tech or cesarean). Often the “how” is formulated during childbirth preparation classes where information is imparted on the process of birth and what they can expect when they go into labour. In North America there are a diversity of classes available—different methods such as Lamaze, Bradley, and various eclectic orientations, hospital classes, independent classes, classes in doctors’ offices. Sometimes women will also seek exercise classes to keep fit while their contours are changing shape dramatically. In addition, there are prenatal diagnostic tests galore: serum alpha-fetoprotein, amniocentesis, chorion villus sampling, ultrasound, glucose tolerance tests, group b streptococcus, and treatments such as Rhogam shots for mothers who are rhesus negative, the North American equivalent to anti-D immunoglobulin (Enkin *et al.*, 2000). Towards the end of pregnancy there might be a fetal biophysical profile for high-risk mothers—a composite of five variables that test the condition of the fetus, stress tests, nonstress tests and other assessments of the fetus (Enkin *et al.*, 2000). This is before birth begins.

Once a woman is in labour, she has various other choices to make about how she would like her birth to be, who might be there, and what interventions she wants. If she has drawn up a birth plan ahead of time, her birth attendants might already know her preferences through discussions over the specifics of her plan. She might have decided to have a doula (an experienced woman who assists the labouring mother) at her birth for support and advocacy, and in order to maximize the potential for non-interventionist childbirth (Raphael, 1976, 1988; Klaus *et al.*, 1993). What was unknown prior to the beginning of labour will assert itself once her contractions begin, and whether or not she has the tools to persevere in the face of unbelievable pain will depend on her belief system, her determination, and the conduct of the human environment surrounding her. The medicalization of childbirth in the twentieth century has influenced a woman’s choice of childbirth setting (Mackey, 1990); and a woman’s choice of birth attendants will reflect her perception of risk and how much she subscribes to the medical model of childbirth (Howell-White, 1997). Her definition of childbirth will often be determined by dominant cultural meanings, and in some cases she will resist them and in others will align with them (Davis-Floyd, 1992; Howell-White, 1997; Monto, 1997; Machin and Scamell, 1997, 1998).

Modern maternity care, driven by obstetric discourse and focused on the medical aspects of childbirth, has failed to acknowledge the psychological component in our understandings of the complexity of childbirth (Waldenstrom, 1996). As a perinatal psychologist myself, I have shared a psychophysiological perspective with my clients in the childbirth preparation that I taught, in order to prepare them for the many non-medical aspects of birth that happen. Since women always give birth in accordance with the way they live (Peterson, 1981),

the issues that are consonant with their life prior to delivery will surely play out during the drama of birth, a grand magnification of those issues. An awareness of the probability of these dramatic events, which obstetric discourse ignores as irrelevant, allows couples to recognize things that might interfere with the process. They can choose to work on them before they go into labour, or they can deal with them in the moment in order to release their hold on the labouring woman. Midwives tend to be more in tune with these matters, as their approach to birth is often holistic (Rothman, 1982) and personal.

The social class of childbearing women will affect both their expectations and their experience of childbirth (Lazarus, 1994; Zadoroznyj, 1999). Much of the feminist discourse on women repossessing their bodies is based on middle-class attitudes toward control that vary from the kind of control that lower class women are seeking. Social class differences were reflected in the kinds of concerns that women had as well access to and desire for knowledge (Lazarus 1994). Zadoroznyj found a more encouraging outcome in her study, where working class women having subsequent babies were empowered by the previous experience. "They became better informed, gained knowledge and confidence, and developed a sense of their right to affect the management of their own births. Their first birth, then, ... marked a turning point in the development of these women's identities" (Zadoroznyj 1999: 281).

In another study by Fox and Worts (1999), they revisit the critique of medicalized childbirth and find that it is the privatization of motherhood that affects what a woman will experience in labour. When a woman is anticipating support after childbirth because the division of labour has been supportive beforehand, she is less likely to request medical intervention. The biomedical model of childbirth can disempower a woman by reinforcing dependency and inadequacy at just the time when her responsibility to a helpless new person is activated. "Medicalized childbirth 'gives birth' to a mother who typically has just had her own dependency underlined, at a time when she is about to undertake what may be the most demanding task of her life" (Fox and Worts, 1999: 331). They also found that women with strong support from their partners were less likely to suffer postpartum depression. These issues of support at all times surrounding the perinatal period are key elements in developing a policy for maternity care.

In 1980, Ann Oakley found that women who had experienced a highly technological childbirth were more likely to experience postpartum depression; this was the first time that a spotlight was shined on the correlation between technology and psychological sequelae. As Fox and Worts (1999) note nearly 20 years later, when a woman feels her autonomy compromised at a moment of high vulnerability she is likely to feel overwhelmed by the responsibility of privatized mothering unless she has strong social support in place. Oakley (1992, 1993) has gone on to study how social support benefits women and their babies in childbirth, also recognizing the importance of psychosocial factors in perinatal outcomes. Contrary to the old paradigm that viewed postpartum

depression as a product of hormonal imbalances, the influence of medicalized childbirth and the presence of social support are key factors that need to be integrated into how we assist women who experience depression following childbirth (Nicolson, 1986). What is often revealed in postpartum depression is the dissonance between expectations and reality, contradictions experienced once a woman becomes a mother (Oakley, 1980; Nicolson, 1986).

Depression is one of various social influences on a woman's decision to breastfeed her baby. Certainly an "empowered birth" will enhance that first contact with her baby, as the embodied experience of a powerful childbirth continues into the moments afterward when a woman is primed for receiving her child. The contemporary sexualization of breasts, issues of body image, partners' attitudes to breastfeeding, the lack of exposure in western cultures to the sight of breastfeeding, and social class are some of the issues that affect women about the choice to breastfeed (Dykes and Griffiths, 1998; Stearns, 1999). Feminism had a part to play in moving women away from nursing their babies, liberating them from being tied to their infants; however, there has been a resurgence in feminist interest of a positive kind in breastfeeding (Blum, 1993; Blum and Vandewater, 1993; Stearns, 1999). The difficulties of combining paid work with breastfeeding are cited as reasons why women discontinue nursing, as the workplace is usually not compatible with the demands of breastfeeding mothers (Blum, 1993; Dykes and Griffiths, 1998).

Lactation is an embodied female experience that has been understudied, probably because of the essentialist trap of exclusive motherhood (Blum, 1993; Kahn, 1995; Stearns, 1999). When feminists examine the maternalist organization La Leche League, a self-help organization that began in the 1950s by mothers for mothers, they are torn between traditionalist attitudes towards motherhood that veer towards biological determinism and the promotion of a woman-centered knowledge of childbirth and lactation that challenges androcentric attitudes. La Leche League has been disapproving of women's employment for decades and has slowly moved toward acknowledging that some breastfeeding mothers also need to work (Blum, 1993; Blum and Vandewater, 1993). Their slogan, "good mothering through breastfeeding," is not violated by employment if the mother chooses to make the effort to continue nursing (which is not an easy choice for reasons already mentioned). I can remember attending League meetings in both California and New York in which women were rebuked by League leaders for deciding to work, when they were genuinely looking for help in combining work and breastfeeding. I saw these women's efforts as success stories, but the League leaders' attitudes were condemning, and this was one of the reasons why I stopped attending meetings. I am pleased to see that they are meeting the challenge for change, because women can really benefit from the important breastfeeding information imparted in La Leche League meetings, and it is a cause worth promoting if they have broadened their attitudes to include the needs of working mothers.

The maternal body is exemplified through breastfeeding; however, women

have to negotiate the different cultural values attached to breasts in the decision both to initiate breastfeeding and to continue against the odds (Young, 1998; Stearns, 1999). “To the extent that breastfeeding occurs in the presence of others and/or symbolizes good mothering, it is also a visual performance of mothering with the maternal body at center stage” (Stearns, 1999: 308-309). Although women must go through all kinds of gyrations in order to remain discreet while nursing in public, the fact that breastfeeding is becoming a more public phenomena means that in the future more people will be accustomed to witnessing women nursing their babies, with the potential to reduce the stigma currently attached to it. I nursed four children over five years of my life and I became quite skilled in learning where it would be comfortable to nurse in public and where it would not. I wouldn’t have given up that intimate contact with my children for anything.

However, one of the biggest deterrents to breastfeeding is the perception that mothers cannot be sexual beings, and the splitting of women’s identity into mother or sexual person, but not both. This patriarchal Madonna/Whore split has been the subject of feminist writing for a generation, and the sexualization of breasts creates a dilemma for women making feeding choices (Rich, 1976; [Contratto] Weisskopf, 1980; Ferguson, 1986; Chodorow and Contratto, 1989; Young, 1998; Stearns, 1999). This separation of women’s sexuality and maternity is an important focus in the changes in a woman’s identity experienced once she becomes a mother, and I will discuss this in more detail in the next section of this article.

### **Women’s changed identity in motherhood**

When a woman becomes a mother she enters the period of change called “matrescence,” the process by which she takes on the full responsibility of mothering in the face of numerous changes to her identity (Raphael, 1976). As she takes on this role in the full sense of the experience on all levels of her experience, she is confronted with various adjustments in her changing sense of self.

Childbirth brings about a series of very dramatic changes in the new mother’s physical being, in her emotional life, in her status within the group, even in her own female identity. I distinguish this period of transition from others by terming it *matrescence* to emphasize the mother and to focus on *her* new life style. (Raphael, 1976: 19)

When Raphael wrote these comments in 1976, she introduced the idea of the doula, an experienced woman who mothers the mother, providing insulation from the pressures of the external world while assisting the mother to move through the process of matrescence. It was some years later that the idea became popularized, with services providing doulas both for labour and delivery as well as postpartum home care. I worked as a doula before this new specialty was

created and found that one of the advantages that Raphael was concerned with, the satisfactory experience of breastfeeding, was assured by this kind of special care. However, the more important concern of assisting at this time is in helping women make that adjustment to a new, intense, and irreversible role.

Who is this new person? If she was a working woman prior to birth, she will be on maternity leave, and much of the next several months of that leave will be concerned with whether or not to go back to work, and on what terms—part-time, full-time, job share. Her perception of herself as an employed individual receiving acknowledgement and recognition in the world will be temporarily lost to the demands of a needy infant on a 24-hour schedule. In my experience of working with new mothers I found that a woman's sense of identity is so wrapped up in her worldly position that the role of mother offers few rewards by comparison. Going back to work is a means of maintaining those aspects of her identity while she is trying on the role of mother. Often by the time their second child is born, they have become an experienced mother and are more ready to quit their job and stay home with both children. I have watched hundreds of women confront these decisions about returning to employment and the issues around childcare that surround them (Grace, 1998).

As a woman-turned-mother, she is no longer free to come and go as she pleases, being responsible for a dependent new infant. Whether that responsibility is shared or not will depend on how she negotiates parenting with her partner, assuming she has one, and the division of labour within the family (Ortner, 1974; Rosaldo, 1974; Chodorow, 1978; Chodorow and Contratto, 1989; Fox and Worts, 1999). This might be her first realization of the devalued status of mothering (Lazaro, 1986; Chodorow and Contratto, 1989; Grace, 1998) and the invisibility of the work that she does domestically. Despite the Motherhood Mandate, the patriarchal institution of motherhood reinforces women's subordinate position in male dominated society (Rich, 1976). Women in this transition experience the full measure of the distinction between public and private profoundly (Blum, 1993, Grace, 1998). "The extent to which men share in domestic responsibilities affects not only the balance of power in the household but also the way women approach motherhood, beginning with the day they give birth" (Fox and Worts, 1999: 344).

And what about her sexual identity as a woman? The patriarchal prohibition on mothers being sexual has been referred to already as regards lactation but affects women generally as well, including mothers who do not breastfeed (Rich, 1976; [Contratto] Weisskopf, 1980; Ferguson, 1986; Chodorow and Contratto, 1989; Young, 1998; Stearns, 1999). The debate was perfectly encapsulated in the title of Susan (Contratto) Weisskopf's review essay "Maternal Sexuality and Asexual Motherhood." Sexuality and motherhood are mutually exclusive experiences in a patriarchal society that dates back to the Puritan colonial era when motherhood and sexuality were assumed to go together and fathers intervened in the mother/child relationship (Ferguson,

1986). Is this not the original meaning of the “law of the father” (Young 1998)? No doubt there is a dampening effect on feeling sexy and aroused when children can be heard in the next room; that is the reality of maternal sexuality. And for many women the experience of breastfeeding activates sexual feelings and can be confusing within a maternal context (Rich, 1976; [Contratto] Weisskopf, 1980; Young, 1998). The demand for asexual motherhood can be seen as a means of preventing women from coming into an integrated sense of their identity, newly expanded by motherhood instead of split by it. “Nor would maternal sexuality be such a problematic topic if there were not exclusively mother-raised children and if the power of the mother in child rearing were not so exaggerated” ([Contratto] Weisskopf, 1980: 781). I believe in and work towards an empowered and integrated sexual experience for new mothers, so that they do not need to sacrifice one part of their identity while embracing another all-encompassing one.

### **Conclusion**

In a society that defines motherhood as the quintessential role for adult women, there are assumptions underpinning this cultural imperative that there is something called the “perfect mother.” There isn’t. Mothers are human and flawed, and are learning on the job—no other adult “career” would lack intensive training ahead of time. Because mothering is a trial and error experience, we need to respect that at best it will be “imperfect.” Some feminist writers in the past felt that “mothering could be wonderful if women could recognize and take pleasure in their procreative and maternal capacities and if these were not taken over by institutional constraints and alienated understandings of mothering” (Chodorow and Contratto, 1980: 84). When Nancy Chodorow and Susan Contratto wrote these words in 1980, they probably could not have imagined to what extremes women would be driven by the Motherhood Mandate in the twenty-first century. As more women have delayed motherhood until after the establishment of a career, they have confronted infertility in increasing numbers. Medicine has obliged with the advent of new reproductive technologies, prompting an ongoing debate within feminism since the mid-1980s. It is alarming how much money couples will spend on infertility treatments that have an appallingly low success rate, in “attempts” to become parents. I read a news report recently regarding a dispute over a couple in their fifties who had lied about their ages in order to receive in vitro fertilization, and were now carrying twins. The Motherhood Mandate has taken on new and perplexing meanings for women in the 25 years since Nancy Russo first wrote about it.

In the twenty-first century, women in our post-industrial society have so many choices and even more concerns as they find themselves addressing the complexity of the transition to motherhood. Compared to the simplicity of my experience in the 1970s, it seems like an awesome task. Negotiating the multitude of decisions about the location of birth, the choice of birth practi-

tioner, childbirth preparation, prenatal diagnostic testing, and the plethora of interventions during childbirth itself can be daunting. How a woman defines childbirth will be influenced by cultural meanings, and if she is having her first baby she is facing the great unknown as she goes into labour. That is the paradox: we know so much about pregnancy and childbirth now, and yet the medicalization of childbirth does little to alleviate the fears that women have—fear of the pain, fear of the power, and fear of the unknown. Perhaps the twenty-first century will find maternity care incorporating the social and emotional concerns of mothers within the definition of childbirth as a holistic event in women's lives.

It is my belief that if childbirth was redefined within this broader context, then the identity changes women encounter as they take on the role of mother could be empowering. An 'empowered birth' ignites new personal resources for a new mother who is experiencing an enhanced sense of self-confidence and personal power from the successful completion of childbirth. She takes that heightened awareness into the transition to motherhood. It is one means of preventing depression following childbirth, as the adjustments of matrescence are met with a new sense of strength and perseverance (a trait keenly needed during the early days of breastfeeding). Hopefully the refinements she is making to her sense of self will allow her to integrate her sexuality with her motherhood creatively and positively.

Becoming a mother can be an all-embracing experience even as it becomes a complex endeavor. We need to facilitate this transition, because one thing remains constant for humanity at all times, and that is when a woman gives birth to a child she gives birth to herself as a mother.

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