Journal of the Motherhood Initiative for Research and Community Involvement

Pregnancy, Childbirth, and Post-Partum

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Arla Patch *Godbody,* 2012, coil drawing, a technique that comprises coils of colored polymer clay used to depict form.

CHRISTINA DOONAN, JULIA TEMPLE NEWHOOK, LEIGH ANNE ALLWOOD-NEWHOOK, ANNE DROVER, LAURIE TWELLS, AND KEVIN CHAN

Communication, Relationships, and Priorities: Parental and Provider Experiences of Infant Feeding Support on the Northeast Avalon

Infant feeding is a subject of great interest and importance to those who advocate for the health and wellness of parents and babies. The infant feeding journey begins in pregnancy, as most pregnant individuals decide how they intend to feed their child before they give birth. Moreover, acquiring knowledge about the realities of infant feeding before birth is a key to success, however defined. Drawing on a longitudinal study in the Northeast Avalon region of Newfoundland, this report presents seven recommended actions to better support infant feeding, from a perspective within a province with the lowest breastfeeding rates in Canada. Informed by feminist participatory action research, the recommendations may be insightful for other regions struggling to better support infant feeding.

Introduction

The realities of infant feeding often take parents by surprise, leading to discrepancies between infant feeding plans and realities. This longitudinal study examined the infant feeding support experiences of eleven birthing parents and ten healthcare and community support providers in the Northeast Avalon region of Newfoundland and Labrador. It was designed to gather rich, in-depth qualitative data to explore the complexities of accessing and providing infant feeding supports, and to identify strengths and gaps in infant feeding supports in the Northeast Avalon region of the province. The insights gleaned from this region may prove helpful in other regions struggling to improve infant feeding support. We use gender-inclusive language in acknowledgment of and respect for all genders and all families.

Literature Review

Breastfeeding has been the norm throughout history (Small; Stuart-Macadam and Dettwyler), but with the development of the infant formula industry, formula feeding has become much more common in many parts of the world (Cattaneo; Van Esterik). Infant feeding is a complex issue influenced by personal, social, and cultural factors (Callaghan and Lazard; Choudry and Wallace; Dykes; MacGregor and Hughes; Stuart-Macadam and Dettwyler). Messages promoting breastfeeding have contributed to the medicalization of infant feeding practices and to parents' responsibility for the "risk" associated with formula feeding (Knaak; Lee; Murphy; Sheehan et al.). According to the Provincial Perinatal Program, breastfeeding rates in the province of Newfoundland and Labrador are the lowest in Canada. Results from the Feeding infants in Newfoundland and Labrador (FiNal) study indicate a wide discrepancy between prenatal intention to breastfeed and actual feeding method throughout infancy. Although 65.8 percent of FiNaL prenatal survey respondents intended to exclusively breastfeed their infants for six months (Newhook et al.), by one month of life, the majority of Newfoundland and Labrador infants (50.5 percent) had been fed formula (Feeding infants in Newfoundland and Labrador database). This data indicate a need to better support mothers' and birthing parents' intentions for feeding and nurturing their infants. As a multidisciplinary team of health researchers who are concerned with the health and wellbeing of women, their babies, and their families, we are committed to protecting, promoting, and supporting breastfeeding for its health benefits, but we also aim to respect and support all new parents irrespective of their infant feeding experience. In this article, we explore the parental and healthcare provider experiences of infant feeding support on the Northeast Avalon in the province of Newfoundland and Labrador, Canada. In the long term, our purpose is to use the knowledge gained to improve healthcare professional support for new families.

Research Objectives

The objectives of this study were to

1. Explore the narratives of mothers/birthing parents about their experiences of accessing infant feeding supports in the Northeast Avalon region.
2. Explore the narratives of healthcare providers and community supporters about their experiences in providing infant feeding supports in the Northeast Avalon region.
3. Identify strengths and gaps in infant feeding supports in the Northeast Avalon region.

Methods

Feminist participatory action research respects the value of foundational knowledge—individuals' expertise on their own lives. This approach also emphasizes the importance of collaborative, participatory research in revealing sociocultural structures and ideologies, and inspiring social and policy change to reduce health inequities (Reid; Baum et al.). We used convenience sampling methods to recruit parents, via local community organizations working with pregnant women and birthing parents. Posters (electronic and paper versions) were distributed to community organizations including Breastfeeding Support NL, the Baby-Friendly Council of NL, Formula Feeding Moms NL, Healthy Baby Clubs, Family Resource Centres, and La Leche League. Potential participants contacted Dr. Doonan via telephone or e-mail.

A total of twenty-six interviews were conducted with eleven parent participants, including two to three in-depth interviews each: one interview during the third trimester of pregnancy, and one to two interviews in the postpartum stage. Dr. Doonan questioned participants on their experiences of infant feeding support within and external to the healthcare system, and invited them to share their suggestions for improved infant feeding support services. Interviews were conducted in person or by telephone, as per the preference of the participant. In this report, all participants are referred to by a pseudonym.[1]

Our small sample of parent participants in this study represents a relatively homogenous population. All parents in this study were adult cisgender women living in the St. John's area, ranging in age from twenty-nine to thirty-seven years; they were married to male partners, and had completed at least some postsecondary education, with annual household incomes above $80,000. It is important to recognize that additional challenges would be experienced by birthing parents facing systemic barriers based on race, indigeneity, socioeconomic class, gender, sexual orientation, ability, or immigration status. Adolescent birthing parents would also face additional barriers.

Ten healthcare providers and community supporters with expertise in supporting infant feeding were selected as key informants, representing a wide range of providers and community supporters involved in infant feeding support:

- family physician
- lactation consultants (public and private)
- paediatrician
- labour, delivery, and postpartum nurse
- community health nurse
- doula
- La Leche League leader

- Healthy Baby Club—Resource Mom
- volunteer peer counsellor from Breastfeeding Support NL

Dr. Temple Newhook conducted one interview with each healthcare provider and community supporter. The healthcare providers were interviewed as individuals, whereas the community supporters participated in an interactive group interview. Dr. Temple Newhook questioned participants on their experiences of supporting infant feeding, the challenges and concerns that they face, and their suggestions for improving infant feeding support services in this region. Interviews were conducted in person.

Feedback and Validation

All participants were provided with a draft copy of this report and given the opportunity to provide feedback before publication. This step helped to form part of the process of feedback and validation of research results.

Results and Discussion

Themes

Three key themes emerge from participants' reflections: communication, relationships, and priorities. Participants emphasize the importance of communication to empower new parents and build their confidence. They also describe the need to foster respect for relationships in infant feeding support: both the parent-child relationship and the provider-parent relationship. Finally, participants' experiences suggest that despite public promotion of breastfeeding, in practice, infant feeding (and the broader area of birthing and postpartum care) remains at the margins in terms of priorities in the healthcare system.

Actions

In line with our feminist participatory action research framework, this study has been organized around "actions." Our results are, therefore, presented according to seven actions recommended by study participants, as described below. We draw directly on the words of respondents to foreground their voices.

1. Improve communication regarding infant feeding with communication skills workshops for healthcare and community care providers on empowerment, respect, active listening, and building parents' confidence in their own abilities.

Participants told us that it is not always what is said to a new parent that is most influential, but how. The experience of adapting to new parenthood, and

to infant feeding specifically, can be confusing and emotionally fraught. Parents need clear guidance and supportive messages from healthcare providers. Providers and parents alike talked at length about the importance of emotion in communicating effectively to support new parents with infant feeding:

> You have to listen to a mother. You have to listen to what she's saying. She knows her baby and she also knows her own goals, and so, we have to be supportive of that because that's our role. I think at the end of the day—that to me defines what's breastfeeding success—is when a mother feels that she's given the best she can, from a health perspective, or in terms of her mothering and parenting; she's content or satisfied, and she feels that people have partnered with her.
>
> —Lactation Consultant

Although technical infant feeding skills are important, participants recommended that equal value be given to communications skills workshops for all health and community care providers involved infant feeding support:

> I hear that a lot of moms especially, the first forty-eight hours, they say, "The first person that came in told me this, and then somebody actually told me I wasn't holding my baby right," and then just shattering the [mother's] confidence completely! … No one seems to realize that one sentence that a mother hears while she's in labour, or that a mother hears in those first few hours, will have months of impact. She will come back to that, over and over again. And I am learning that so frequently.
>
> —Community Peer Supporter

2. Improve the consistency of messages regarding infant feeding, with a focus on providing evidence-based information.

Closely tied to the issue of empowering communication, parents frequently reported receiving different and contradictory messages from various members of their healthcare team. This can be particularly overwhelming in the vulnerable period of new parenthood:

> It's really sometimes frustrating … inconsistent information from the people that you would normally go see with questions.
>
> —Amy

> I found the nurses were sporadic and not consistent with their information.
>
> —Joanne

> I hear from clients and moms: mixed messages. Don't know who to pick because they're telling you different things. And it's really confusing … everybody you talk to; everybody's got a different opinion, and it's hard to know what's the right answer.
>
> —Community Peer Supporter

Health and community care providers recommended improving consistency of information and accessibility of evidence-based breastfeeding advice.

3. Increase prenatal support and education

Without exception, every parent participant in our study reported minimal to zero discussion of infant feeding with their primary prenatal healthcare providers:

> I went and I sought out the information. But there are a lot of people who aren't like that and are kind of afraid to ask. And neither my GP or my OB has mentioned anything about [breastfeeding], so if it wasn't for the fact that I went out and found all this information on my own, I'd be thirty-eight weeks pregnant and nobody would have talked to me about it yet … for somebody who's not as curious as I am, or doesn't have the same support system that I have, it can make a huge difference—cause you could be thirty-eight weeks pregnant, due any day, and not have any idea about any of this. And maybe be too shy or too uncomfortable to ask your doctor or ask anybody about it.
>
> —Nicole

Participants recommended providing all expectant parents with a list of infant feeding resources. They explained that new parents need to know more, in advance, about newborn behaviour in the first seventy-two hours, reassurance about what is normal, and that bringing the baby to the breast more often will bring the milk in faster. They also recommended a clear list to distinguish between normal infant behaviour and the urgent signs that breastfeeding is in trouble and needs immediate help:

> Many women and couples are not prepared enough mentally because it is a skill; it will take time, it is not automatic. You and your baby will take a few days to learn all the aspects. Don't worry if it doesn't happen straight away. Many people have little confidence in this as a natural process … [they] want to see and measure quantities. … Many new parents don't understand the normal fussy behaviours of the baby which may not have much to do with breastfeeding.
>
> —Paediatrician

Participants emphasized that parents need information in the prenatal period and that the immediate postpartum period is not the moment for extensive education:

> As a nurse in the postpartum unit or in the labour and delivery unit, it's so important, in the prenatal period, for women to be given the proper breastfeeding education and supports because their decision is made when they come to me; it's made … in that moment when they're in pain and labour and uncomfortable afterwards, whether they've had a section or stitches or whatever … that's not the time.
>
> —Labour and Delivery Nurse

Finally, most parents noted the importance of support from family and friends. Increasing education on breastfeeding and normal breastfed infant behaviour, particularly in rural areas, may offset lost generations of breastfeeding and enhance acceptance and support of breastfeeding:

> I know it's hard [to breastfeed in rural communities], cause even when I travelled back to that community with my first baby, people were just like, "Why are you doing that?" and "What is this?" And I don't think it was that they were offended or even trying to be negative. I think it's just they're so underexposed to breastfeeding … when people who you normally really trust or people who have always been like great supports start to say things like that, you start to question, "Oh my god. Maybe that's true and maybe if that's what they did, then that's what I should do too," and … if you don't already have a really strong experience, that can easily start a downward spiral, I think, and then you start to feel not confident and … it can be detrimental.
>
> —Amy

> [Working in another region], the young women had grown up seeing [breastfeeding]. It wasn't a foreign thing. They learned it pretty quickly cause they had seen it when they were kids. Whereas I found in Newfoundland, there was a lost generation of breastfeeding there, so the women had more of a difficult time latching babies on and learning because they had never really seen it ever before.
>
> —Labour and Delivery Nurse

4. Increase off-hours support for the first eight weeks

Participants emphasized that the first eight weeks postpartum are a crucial time for new parents, and there is a need for increased urgent breastfeeding support at the critical moments, including during off hours and on weekends. In situations where support was needed outside of 9:00 a.m. to 5:00 p.m.,

Monday to Friday, parent participants described an overwhelming sense of isolation and helplessness:

> I have large breasts, and it literally felt like I had two watermelons on my chest. … my back was killing me. I was really uncomfortable … no one told me, "you're definitely gonna be engorged like this."… When I left the hospital, they were like, "Everything's great! You're rocking it." … no one even said, "Your milk is coming in. and this is what's gonna happen." So I was really disappointed with that. When I was here on Friday, I felt very alone. I felt like I had nobody to call. I was three and a half hours trying to get her to latch on … with the hormones and the sleep deprivation anyway, I was just in a really, really bad way.
>
> —Audrey

> You see so many people in the worst hours of the day, which are overnight … with a new baby, they have nowhere to go. They have nobody to turn to … that's the hardest, most alone scary time… especially for a first-time mama, you have no idea where to go, what to do.
>
> —Tillie

Participants recommended making one-on-one support available for the first eight weeks postpartum, preferably at home, and including hands-on clinical support:

> [We need] access to support at the critical point. That moment, in the middle of the night—that moment, when the mom feels like she's tried everything that's easily accessible, she's read the books, she's looked on-line, but she needs to sit down with someone for a one-on-one, hour-long consult that is not very accessible. It's really not.
>
> —Community Peer Supporter

5. Increase priority on parent-infant relationship and parents' mental health and wellness

Parents reported several issues related to mental health and wellness, such as depression, anxiety, fear, disappointment, and isolation:

> I've been really, really struggling. I might start to cry … but I've been really, really [voice wavers] struggling with the breastfeeding… and she's a month old, so I figured hopefully I would have had it figured out by now, but, mentally, it's very hard. I'm not enjoying it, [crying]… and I was very eager and very excited to nurse her when I was pregnant. … I don't feel any bonding … even when she latches, I'm kinda like,

> watching the clock, "Okay, you done yet? Like okay, get off me now." … I did not expect it to be like this at all. It's such a shock to the system. It's a whole different layer of being a mother that I did not anticipate at all.... I feel like I'm in shock about it, to be honest…. I was really looking forward to that aspect of parenthood. Like, "Oh I'm gonna take my baby, and we're gonna go to the nursery in our new glider and put on the little night light, and we're gonna sit there and we're gonna quietly nurse and it's gonna be wonderful, and I can't wait to do it, and we're gonna bond" and it's just …out the window. That whole image and that whole expectation that I had just failed. So, I guess that's why it's been so hard.
>
> —Audrey

> The mental health of the mother while they're breastfeeding nobody really talks about. Cause it's exhausting and it's draining and it's not easy. And nobody really talks about it. The public health nurse asks you the first day that you get there, if you're okay and if you think you're gonna shake your baby. Basically, that's all that they ask you. But there's never any question on, "How are you doing emotionally with it?" … I think for new moms' mental health I think the biggest thing is feeling that you're just tied down. You can't move. The growth spurt days, they're feeding every hour and you literally just feel like you're a walking milk station. And you can't do anything. I didn't shower for three days when she had her growth spurt because I couldn't. I couldn't put her down. So, that really, really weighs on you. And it's hard not to get in a slump when that happens. You're dirty and you're tired and you just have a baby hanging off of you for one to three to five days, depending on how long their growth spurt is…. Her first growth spurt when she was three weeks, I literally just sat in bed for a twenty-four-hour period and cried and fed her and cried and fed her…. it's just exhausting and you don't think, I guess, that you'll get to that point.
>
> —Nicole

6. Address workload and organizational concerns of professionals providing birthing and postpartum care

Participants reminded us that empowering birthing parents goes hand-in-hand with empowering the professionals who care for them. Care providers who are feeling overworked and underresourced are unlikely to be able to provide the nurturing and empowering care that parents and infants require in the early postpartum stage:

> In healthcare, our whole workload measurement is task oriented. So everything is quantifiable … but as a nurse, the relationship and that quality of care is supposed to be fundamental. It's not supposed to be that I saw eight patients and got them through … our numbers often get used in dangerous ways and who falls vulnerable to it? The people with little voice and that would be our little people and their parents that are vulnerable.
>
> —Public Health Nurse

> You can't provide breastfeeding support to six women, all at once, if they're having problems. … And if the women don't have the family support there … I find it just falls apart.
>
> —Postnatal Ward Nurse

> [I want parents to know that] we are haggling on their behalf here in the hospital and we're battling against various forces.
>
> —Paediatrician

> I think the nurses feel like we feel like we have to be miracle workers and get [breastfeeding] going…. Early discharges have become the norm. Increase pressure.... Mom doesn't have the time to learn and experiment with support there. The hospital is then I think offloading the problem to the community.
>
> —Postnatal Ward Nurse

7. Affirm formula feeding families

Although exclusive breastfeeding is the acknowledged physiological norm in infant feeding, many parents incorporate formula for a variety of reasons, including physical, cultural, emotional, and socioeconomic. These parents reported requiring support and information in formula feeding. Unfortunately, stigmatizing formula can have the consequence of stigmatizing formula-using parents, who may face isolation and lack resources.

Some parents feel isolated due to the perception that formula feeding moms are not welcome to use infant feeding support resources, for instance the breastfeeding support clinics where babies can be weighed and where parents can ask questions about baby's health:

> We've ended up having to go back to our family doctor to do the weight checks because we knew, of course, that he was having surgery, so she wanted to make sure that he was gaining weight appropriately so she was doing weight checks more frequently. We ended up doing

> doctor appointments because we weren't … I didn't think we would be welcome at clinic.
>
> —Suzie

Parents reflected on feeling coerced or pressured to breastfeed, which brought about feelings of shame:

> There was an element of pressure when the lactation consultants would come in and see me when I was in ICU and stuff like that, checking the medications I was on to ensure that they were safe for [my husband] to bring home to the baby, and there was an element … I don't know if pressure or expectation. I wanted to breastfeed, and there was an element of expectation there that I should continue, but no one ever once stopped to say, "Are you well enough to do this?" And I really, technically, wasn't. … Every two hours, I had to get up and pump and things like that, technically, I should have been resting.
>
> —Claire

Some parents described how a silence around formula use from healthcare providers can translate into a lack of critical knowledge about the proper "how to" of formula feeding:

> I wonder how much education people are getting at the hospital about formula feeding… yes, of course, they tell you to sterilize things, sure, but what are they telling you about mixing formula? … I used formula on my first, in addition to breast at the beginning, but the second time around, I still couldn't remember, "Okay at what point can I introduce powder?" Cause powder is way cheaper.
>
> —Suzie

Overall, parents conveyed the sentiment that they feel capable of making the best decision for their children and would like a full range of information about their infant feeding options, with acceptance and support for their decision once made.

Conclusion

This in-depth interview study of parents and care providers on the Northeast Avalon region of Newfoundland reveals the importance of communication, confidence, respect, and relationships in infant feeding support. Parents and providers offered seven recommended actions to help ensure that infant feeding support move from the margins to becoming a true priority in the healthcare system and in our culture at large.

Endnote

[1] Ethics approval for this study was provided by the Health Research Ethics Authority of Newfoundland and Labrador, no. 2016.015.

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MELANIE BAYLY AND PAMELA DOWNE

"Most Often People Would Tell Me I Was Crazy": Defending against Deviance Ascribed to Alternative Birth Choices

Childbirth-related discourses and practices have fluctuated over time in Canada. A medicalized model currently dominates, but there is increasing plurality in how birth is conceptualized and enacted. From a sample of twenty-one first-time mothers who were interviewed about their childbirth-related experiences, we explored how women described and defended their alternative birth choices within the broader social context of medicalized birth. Data were thematically analyzed and explored in relation to theoretical work on stigma and deviance, since these concepts emerged as salient to women's narrated experiences. Findings illustrate that mothers who make alternative childbirth choices are often marked as deviant and may elicit moralizing judgments from others, which largely stem from perceptions of risk and/or safety. To counter or avoid feared and experienced deviance, women managed information about the birth of their child through passing, covering, normalizing through reframing, and condemning the condemners. This information management allowed women to present themselves as responsible, competent mothers in the face of deviance. Although previous research has demonstrated birth-related stigma in relation to the choice to birth at home or unassisted, our findings suggest that ascriptions of deviance may also extend to women's choice of midwifery and doula care despite their increasing prevalence as part of maternity care in Canada. Since these birth options are progressively available and used, and have some empirically documented benefits for mothers, further exploration of how they and other alternative childbirth options are perceived, experienced, and morally valued by women and the general public is warranted.

The landscape of Canadian maternity care has undergone significant flux over the past century. There has been a shift toward an increasingly medicalized[1] system characterized by high rates of in-hospital, obstetrician-attended birth and medical interventions (Delclerq et al.; Ye et al.). Most Canadian births occur in hospital; only approximately 2 percent of births in 2014 occurred outside of this setting (Statistics Canada). Moreover, women giving birth in hospital tend to undergo high rates of medical and technological intervention. In a recent pan-Canadian survey of childbirth intervention rates, almost half of the women sampled (44.8 percent) had their labour induced, 57.3 percent had epidural analgesia, and 90.8 percent were strapped to an electronic fetal monitor (Chalmers et al. 205). High Caesarean-section rates are also a significant indicator of the extent to which childbirth has become medicalized, accounting for 27.9 percent of all Canadian births in 2015 (Canadian Institute for Health Information). Evidence suggests that medically justified Caesarean section rates should fall between 10 and 15 percent, and that rates higher than this are neither medically justified nor beneficial (Ye et al. 243).

Interventionist practices and medicalized birth are strongly rooted in the prevailing belief that birth is risky, which elicits close monitoring of the birth process, a lack of distinction between risk factors and actual pathology, and expert intervention (Cartwright and Thomas 222; Lothian 45-46; Rooks 371). Risk discourse dominates the medical model of childbirth, and is propagated within obstetrics and by other medical officials (Craven 199; Reiger and Dempsey 369), hospitals (Rutherford and Gallo-Cruz), the media (Luce et al. 7-8), and the general public (DeJoy; Stoll et al. 223). Medicalized conceptions of birth risk also inform birth-related decisions such as the choice of Caesarean section, hospital birth, and obstetrical or physician-led maternity care (Chadwick and Thomas 73-76; Coxon et al. 57-61).

Partially in response to the medicalization of birth, the midwifery movement advances an alternative model in which birth is redefined as a normal physiological process. This model does not presuppose the need for technological intervention; it positions women and their bodies as capable, and prioritizes informed choice and woman-centred care (Macdonald 237; Rooks 370). By 1994, midwifery achieved the status of a publicly funded, self-regulating health profession in Ontario (Bourgeault and Fynes 1059). It has since expanded and is currently available in all but three Canadian provinces and territories[2]; the proportion of births attended by midwives has been increasing in Canada despite little or no access in some locations. From 2015 to 16, midwives were the primary care providers for approximately 10 percent of all Canadian births (Canadian Association of Midwives). The midwifery model propagates a public discourse that centres on birth as a natural but momentous event, includes the family in the birth process, and avoids interventions. The ascendance of this discourse influences maternity care and

how women think about birth (Rutherford and Gallo-Cruz; T. Miller 343), but researchers have argued that birth practices in North America remain highly medicalized, as childbirth is culturally positioned as a medical event best experienced in hospital (Coxon et al. 65).

In this article, we explore how first-time mothers in Saskatchewan describe and defend their choices for nonmedicalized births in the broader social context of medicalized birth. Our focus is on how the research participants position their decisions in contrast and response to the ascription of deviance that they routinely encountered.

Moral Valuation of Birth-Related Choices and Experiences

Within a context of multiple cultural discourses and practices around birth, there is the potential for greater choice in perinatal care and labour. Markella Rutherford and Selina Gallo-Cruz suggest that choice and ability to "shop around" in the pursuit of one's ideal birth is an important feature of contemporary childbirth (87). An increased emphasis on freedom of choice, however, heightens women's individualized responsibility to make the right choice (Lupton 331). As Claudia Malacrida and Tiffany Boulton state, "The combination of an increasingly technocratic medical approach to birthing, an individualized and blaming model of patient/consumer risk evaluation and the contested discourses concerning the 'ideal' way of giving birth can make patient 'choice' and risk evaluation more difficult" ("The Best Laid Plans" 46).

Notions of individualized responsibility and need to produce a so-called good birth and child align with another feature of contemporary culture which comes to bear upon women's experiences of childbirth: intensive mothering. As Sharon Hays (8) points out in her landmark work, intensive mothering defines good mothering as "child centred, expert-guided, emotionally absorbing, labour intensive, and financially expensive." A "good" mother must, therefore, focus on the needs of her child above her own, and is responsible for maximizing the outcome of the pregnancy (i.e., as close to a perfect delivery and baby as possible). This cultural logic is visible in the ways in which women negotiate risk through their (non)consumption practices (Gram et al. 446), choices about birth setting (Miller and Shriver), and understandings of birth options and experiences (Malacrida and Boulton, "Women's Perceptions"). In a context where women are responsible for assessing risk and making the best choices for their babies, these choices are both morally valued and tied to mothering identity.

In line with this, women appear to experience negative judgments from others for some childbirth-related decisions. Women choosing homebirth may receive negative feedback from family, friends, and health professionals, who perceive their decision as irresponsible (DiFilippo 59; Viisainen 806).

Similarly, women choosing to have a deliberately unassisted homebirth may fear and experience a significant degree of negative judgment (O'Boyle 184; A. Miller 411), and may be called an "unfit mother," which could elicit involvement from authorities (Feeley and Thomson 19). Amy Chasteen Miller describes how women who choose unassisted birth face "layered stigma"—stigma from within their own network of homebirth advocates in addition to broader societal stigma (421). Although these examples are not specifically within a Canadian setting (with the exception of Shawna Healey DiFilippo's work), they illustrate the degree to which childbirth-related options may be morally charged and viewed in relation to culturally widespread ideas around birth, motherhood, responsibility, and risk.

The Current Research: Deviance and Alternative Childbirth Decisions

The purpose of this article is to explore childbirth-related deviance (a concept closely related to stigma) within the birth narratives of a sample of Canadian first-time mothers who birthed their children within a medicalized context, which increasingly incorporates alternative discourses and care practices. This research is part of a broader study investigating the ways that women understand and morally position their childbirth-related decisions and experiences in relation to dominant discourses. Although exploring stigma and deviance was not explicitly the focus, these concepts were salient to the experiences of women who made alternative decisions deviating from medicalized birth.

Erving Goffman describes "stigma" as a deeply discrediting attribute, which through processes of social interactions marks an individual as both different from, and inferior to, others (3). Stigma can be understood as a moral issue; it threatens the loss or diminution of what is at stake or valued within an experience or encounter (Yang et al. 1530). As such, individuals work to manage their stigmatized identity and to protect it from the dangers posed by stigma (Goffman). Although many stigmas are "tribal" (of race, nation, and religion) or of the body (e.g., HIV/AIDS or other chronic conditions), Goffman also describes stigmas of individual character—a failing to live up to the values, norms, and standards upheld by a community. In this case, the norms are around childbirth practices and ideals of what constitute responsible mothering. More recently, however, Graham Scambler and Frederique Paoli differentiate between "stigma," which they argue refers to an "ontological deficit" beyond the control of the individual that engenders shame, and "deviance," which refers to an "achieved or moral deficit" based on an individual's behaviours that engenders blame (1850). Although the theoretical concepts of stigma and deviance are strongly related, and both may threaten identity and require information management, the latter term more precisely

pertains to non-normative and morally judged behaviours. The focus of the current analysis is therefore two-fold: (1) to illustrate the presence of deviance as described by women who chose alternative childbirth options; and (2) to delineate the ways in which these women managed information to preserve their identity as good mothers.

Methodology and Data Analysis

This qualitative research was positioned within a social constructionist framework, which locates meaning in people's interpretations and understandings (Crotty 43). We operated from the assumption that childbirth is grounded in meanings that are culturally, socially, and individually negotiated and that these meanings inform experiences and identity. Narratives were chosen as a method of inquiry, since they are a tool people employ to understand, reflect upon, and order life events and the emotions associated with them (Riessman 10).

Data were derived from the narratives of a smaller subset of the broader study sample. This sample consisted of twenty-one mothers (M_{age} = 29.48) currently living in the Canadian prairies who had given birth to their first child within the past eighteen months. Participants were recruited through pamphlets distributed through midwifery care and postpartum public health nurse visits, posters at leisure centres, Kijiji, and snowball sampling. From the broader sample, eleven of the twenty-one women interviewed had deviated from the dominant model of an obstetrician or physician-attended, in-hospital birth, either in choice of care provider (midwife-led birth) or type of birth (home or unattended). Four women from this subset also employed doulas, as did two women who chose hospital births with a physician or obstetrician. Data from these women who made alternative birth choices informed the present analyses.

Prior to participant recruitment, ethical approval was obtained for this research from a University Behavioural Research Ethics Board. Data were generated through audio-recorded narrative interviews, which lasted approximately an hour, conducted by the first author (MB). Interviews consisted of seven broad, open-ended questions about women's experiences with pregnancy, birth, and the transition to motherhood; four of these questions focused on birth-related options and experiences. One of the questions most pertinent to the current data, for example, asked women to describe any plans they had made regarding their labour and birth. Since most participants responded to these questions at length and in detail, the interviewer adopted a relatively passive approach so that interviews were shaped primarily by participants.

All interviews were transcribed verbatim, and initial analytic notes were

compiled. A general thematic analysis (Braun and Clarke) was then conducted, in which data were coded inductively using NVivo software and organized into themes. During this process, deviance emerged as a salient concept for the subset of women who made choices diverging from medicalized norms. Despite the theoretical distinctions between stigma and deviance drawn by Scambler and Paoli, scholars have largely retained the language of stigma in examinations of reproduction-related moral judgments and discrimination; the processes by which stigma is managed also appear to apply equally to deviance. Therefore, although the concept of deviance was chosen to discuss the social processes observed, both deviance and stigma theory were used to explore the techniques women used to manage information and identity.

Findings

Eight of the thirteen women who made alternative birth choices (working with doulas or midwives and/or having a homebirth or an unassisted one) described negative judgments about these choices, which threatened their status as normative and responsible mothers. The deviance they described was both enacted (episodes of moral judgments, blame, and discrimination by others) and felt (a sense of blame and fear of enacted deviance) (Scambler and Paoli 1850). Homebirth and unassisted birth[3] commonly elicited negative moral judgments from others. Brenda, for example, made a last-minute decision during labour to remain at home and deliver the baby with the assistance of her doula. Brenda described the pervasiveness of negative judgments from others about her choice, which called her maternal fitness into question: "So many people that I had talked to along the way or even now if they hear about our birth story are like, that is so dangerous. Or, you know, 'How irresponsible of you to do that, like I would never do that' and stuff…. Yeah, people who are genuinely like 'That's neglectful almost, like you should—it's scary that you would do that.'"

Women who chose homebirth or unassisted birth in this study felt passionately and positively about their choice. However, they also indicated that their decision was viewed negatively by at least some of the people with whom they interacted. These moral judgments mainly centred on difference (i.e., deviations from the norm of physician or obstetrician-attended, in-hospital birth) and on people's beliefs about childbirth-related risk. Although the feedback that women described tended to be quite moralizing, Carmen described a more subtle ascription of deviance in which her positive outcome with an unassisted homebirth was held up as an exception: "People are very quick to either dismiss it, as an anomaly and not obtainable for the general population, which I disagree with, or they are quick to tell me how lucky I am that everything worked out because birth is so dangerous." Overall, however,

Carmen belonged to a strong homebirth- and midwifery-aligned community, and had like-minded peers she could freely talk with.

Stigmatizing judgments of deviance (both enacted and feared) were more problematic when they came from healthcare providers who hold considerable power. Like Carmen, Melinda was part of an alternative peer group whose members were generally supportive of homebirth, but she described her frustration during a consult with an obstetrician during her pregnancy:

> She was supportive of me having a midwife. I don't know, her words were something like "I have no problem with midwives, but no one should have a homebirth" … When we asked questions and asked for evidence and gave our concerns, she disregarded them and told us that we needed to think of our baby. [She] used scare tactics, [and] gave us information that actually is incorrect.

Women were unappreciative of healthcare providers who disparaged midwives or homebirth, particularly when they experienced this as enacted deviance. Elizabeth felt both she and her midwives were viewed as incapable and irresponsible when she had to endure a hospital transfer upon failure to progress: "I felt as though my homebirth transfer made me almost a leper to them…. My midwives got treated like shit. Yeah, it was bad. And my doulas. They were asked to leave, and they didn't, because I said no." Although not all maternity care providers practicing in the hospital made moralizing judgments regarding alternative birth practices, enacted deviance had a negative impact on the care relationship when it did occur.

Although women often described deviance related to homebirth and/or unassisted birth, several women described negative judgments arising from their choice of a midwife or a doula as their primary care provider. Kella had planned a hospital birth, but the inclusion of a doula in her labour invoked judgments, which marked her as deviant: "Lots of people don't know what a doula is either. So then they thought I was doing something uh, way out there. Birth in the woods or something." Christina also described both felt and enacted deviance over her choice of midwives as primary caregivers and a doula:

> I was definitely cautious about, um, who to … tell that we were working with midwives, and that we were thinking about a homebirth…. And we did actually have quite a bit of confrontation with [partner's] mom over that … she found out we hired a doula and like … completely lost it. Yeah, she was like highly against me consulting anyone other than a doctor, about the birth—the birthing process.

The influence of medical hegemony is clear in this passage; healthcare providers working within the traditional medical model are often perceived as

the only safe and acceptable practitioners. The experiences described by these participants illustrate how even working with midwives and/or a doula may elicit negative judgments from others.

The processes of deviance women described in relation to alternative birth choices were rooted in their failure to make decisions that aligned with the dominant model. Negative judgments primarily resulted from evaluations of the deviations being risky and irresponsible. In a context of individualized responsibility and intensive mothering, this deviation threatened women's moral status and good mother identity. As such, felt and enacted deviance associated with women's alternative birth choices necessitated identity work in their interactions with others to preserve a positive identity.

The "Projects" of Women Who Chose Alternative Birth: Managing Deviance

In relation to both stigma and deviance, norm violation threatens the ability of individuals to present a positive identity, and stigmatized individuals often engage in various information management techniques to preserve or foster a positive and moral self (e.g., Ashforth and Kreiner 414; Clair et al. 79; Goffman 41-104; Hylton 625; Miller 421; Sykes and Matza, 667; Toyoki and Brown 729). Scrambler and Paoli refer to the employment of such techniques as the "projects" of individuals: the use of strategies to avoid or combat enacted stigma and deviance while minimizing the psychosocial impact of felt deviance (1851). The women in this research engaged in these projects as they described, enacted, perceived, and feared judgments from others about their birth-related decisions.

Passing

Although women's pregnancies were highly visible, their actual choice of alternative birth was not. They therefore had maximum control in most contexts over how they managed discreditable information. As such, they had the option to pass (Goffman 42, 74): to conceal, fabricate, or not disclose details of their intended or actual birth. Five women described passing in particular contexts or with specific people to avoid negative and moralizing judgments. Passing could entail both discretion, in which women did not offer information about their birth or plans, and concealment, in which women lied or hid information (Zerubavel 105).

Karen explained the nondisclosure of her planned homebirth in the face of felt and enacted deviance:

> I definitely wasn't a homebirth type person and we had to keep that, you know, keep that decision from different people because it worries people…. I shouldn't say we kept it from people; the only people we were purposefully trying to keep it from were my husband's parents

> because we didn't want them to panic and say that we were risking the baby's life and to forbid us from having a homebirth or anything like that. So they were the only people that we didn't actually tell. Other people that we would chat with, we would say you know, we're thinking about having the baby at home, and a look of terror would cross their face, and they would say "Oh my God you cannot do that, oh my God, you can't do that, you have to go to the hospital." And we would say "Well, why," and they'd be like, "Well you just have to go to the hospital, and it's so dangerous, and you're risking the baby's life."… So we just sort of selectively learned to stop talking with people about it.

Since Karen and her husband expected his parents to react negatively to her planned homebirth, they did not disclose it and passed as normal expectant parents who would birth in hospital. Participants would use discretion (i.e., not bring it up) or lie when they encountered people whom they perceived as particularly judgmental regarding alternative birth choices. To pass more consistently and, thereby, mitigate enacted deviance, Karen explained that she ultimately stopped disclosing her birth plans altogether.

Covering

As a middle ground between passing and disclosure, deviant and stigmatized individuals may choose to cover: to reveal some discrediting information but in ways that minimize its deviance and obscure the real stigma or its most damaging aspects (Goffman 102). Covering by framing plans as tentative allowed women to be more honest about their impending birth while they could minimize its significance and impact on a moral identity. As Christina, for example, explained: "But most other people, I was really cautious about being like, 'Yeah, we're thinking about maybe doing a homebirth, I don't know'. And you know, I was pretty nonchalant about it, because I didn't want any confrontation." By presenting her plan to birth at home with a midwife as an option rather than a decision, Christina minimized association with the deviant identity of homebirther. Similar to other participants, Christina used different strategies of information control depending on the audience and used covering or passing when social cues were negative or unclear.

Annabel also covered by framing her birth plans as tentative to manage discrediting information. Additionally, because her birthing experience—a homebirth with a birth attendant rather than a maternity care provider licensed to deliver babies—was considered particularly deviant[4] (A. Miller 421), she concealed the most negatively perceived detail of her birth from most people:

> So mostly only the people who knew our situation were close friends and family, and afterward, the majority of the time [her partner] and I would just tell people that it was just us two to protect our birth attendant's anonymity. So that way, it's not coming down on her for anything if people are like "What, it was just you and your husband", the grief is only coming on to us.… And so it's almost a little more given in a good light than even saying we had a birth attendant. They're like, "a birth attendant, what's that?" So just learning the ways to be discreet enough but only give enough information that you solidify that it was a very safe positive environment.

Since Annabel perceived fewer moralized judgments about giving birth at home than she did saying she had an unregistered birth attendant, she only revealed some aspects of her son's birth. As such, she accepted deviance ascribed to a homebirther identity, but covering allowed her to edit out the information she felt would engender further moralizing judgment without having to fabricate her birth experience entirely.

Normalizing through Reframing

Although passing appears to be the most common strategy for managing stigma or deviance (A. Miller 407), individuals may choose to disclose—that is, communicate information about themselves that is otherwise not directly observable or known (Herek 198). All of the participants who described managing information through covering or passing also disclosed to some people in particular contexts. If the audience was not already receptive to, or supportive of, their birth choices upon disclosure, the women worked to manage deviance and promote a positive identity by reframing their choices and experiences as positive, safe, and normal. Reframing involves the transformation of meaning attached to a stigmatized attribute or deviant behaviour, either through infusing (imbuing the stigma with positive value) or neutralizing (negating the negative value of the stigma) (Ashforth and Kreiner 421-22).

One of the ways childbearing women normalized deviance through reframing was to play an educative role. They explained their alternative birth decisions to others, emphasizing that they were not strange, irresponsible, or unsafe. As Brenda described:

> We tried to explain that she's [doula] there emotionally, and you know, for some physical relief, whether it's hip compressions or whatever it was, she was there to help with that. She wouldn't be doing any of the fetal heart monitoring or anything like that. I had to explain to a lot of people what a doula was, and what a midwife did, and that they could deliver babies without a doctor there, as long as there were no complications.

Since most of the deviance attached to alternative birth decisions related to perceptions of risk and safety, education generally meant trying to reframe the decisions as equally safe or even safer than medicalized options. As Elizabeth stated, "I would just spout off some statistics about homebirth and how it's safe, and the infant mortality rate is the same either way, and birth outcomes are better at home anyway." Education was, therefore, a way of neutralizing negative meanings of alternative birth options. Because of the discourse of risk underpinning the ascription of deviance to alternative birth, reframing through neutralization often involved "denial of injury" (Sykes and Matza 667): the women often explained that no harm would come or had come to pass.

Women also reframed deviance through infusing their decisions with positive value (Ashworth and Kreiner 421). They did so by drawing on shared understandings of good mothering: they prioritised the safety and health of their baby just like other mothers. As Annabel explained, "They just want to be reassured that yeah absolutely I was concerned about emergency. As a parent, I did lots of research, I'm not high risk, we're very close to a hospital—kind of tell them the things that they want to hear." By aligning herself with other parents and emphasizing the health of the baby, Annabel presented herself as a responsible mother and normalized her birth-related decisions. Similarly, Brenda made it clear that the health and safety of her baby were her priority, and they were maximised through her decision to birth at home: "So I don't even really take it personally, like that they think it's irresponsible. It's like no, it's not actually. It's the best thing we could have done for our baby." Drawing on valued social roles and morality is one way to combat deviance and bolster a positive identity (Toyoki and Brown 731). By explicitly invoking their maternal status and drawing upon shared understandings of mothering wherein the baby's needs and safety are prioritized, women countered accusations of irresponsibility communicated by others.

Condemning the Condemners

Finally, women managed a positive maternal identity in the face of deviance by criticizing the character, knowledge, and authority of outsiders who judged their birth-related decisions. Gresham Sykes and David Matza label this the "condemnation of the condemners" and suggest that it redirects the concern onto the motives, behaviours, and flaws of those who are enacting deviance (668). Elizabeth defended her desired midwife-attended homebirth by both focusing on the positives of her experience and by criticizing the people who had suggested it was unsafe and inappropriate: "My labour at home was lots of fun. Like it was painful and long, whatever, but it was everything I wanted it to be. And I've had a few people say things like, 'don't you wish you would have just scheduled a C-section.' Like people are so stupid and insensitive." By

criticizing the character of people who criticized her birth choices, Elizabeth reaffirmed her own authority and capacity to make good maternal decisions.

Since many of the people involved in enacted deviance were friends and family, women often condemned the condemners specifically in relation to their lack of knowledge about birth (as opposed to broader aspersions on their character). Brenda, for example, said the following:

> Most of the negative reactions we get are from people who either are expecting a baby of their own or are kind of around that age who are going to do it, and basically just think that it's totally old school and crazy. And that it's not safe. "[What] if something went wrong", that's what everyone says…. But I mean when they say that stuff I just say no, you have to educate yourself. Because I know you don't know. You need to learn more, like I've studied the whole birth thing. I was crazy about it. I just wanted to know more and more, I couldn't know enough. And it's like ignorance; they just don't know.

By situating others' moralizing judgments as a function of their lack of knowledge, women protected themselves against internalizing blame and threats to their maternal identity. Moreover, women juxtaposed the ignorance of others against their own birth-related research, planning, and knowledge, and presented themselves as experts in the context of their decisions.

Discussion

Even in a context where midwifery and doula services are becoming increasingly common, women who make childbirth choices deviating from a medicalized model are often marked as deviant, and they elicit moralizing judgments from others. These negative judgments largely stem from the dominance of the medical model of birth (so that alternative decisions are markers of alterity) and centre on perceptions of risk and/or safety. Researchers have previously described birth-related stigma related to the choice of homebirth and, especially, unassisted birth (O'Boyle; A. Miller; Viisainen). Our study illustrates similar social processes in a contemporary Canadian context, but it suggests that stigma and deviance may also extend to the choice of midwifery and doula care. This is consistent with research in Canada and the United States, which finds that midwifery continues to be seen as a risky, if personally gratifying, choice (Dejoy 119; Sangster and Bayly 44).

Although scholars have used the concept of stigma to describe such social processes, we suggest that Scambler and Paoli's concept of "deviance"—as an achieved or moral deficit based on behaviours deviating from cultural norms—best reflects the processes described by childbearing women (1850). Rather than shame (as experienced with stigma), deviance engenders blame, which

was evident in the moral judgments and accusations of risky behaviour and baby endangerment. In addition to enacted deviance, women also described felt deviance; they feared the negative moral judgments and blame expressed by others (Scambler and Paoli 1850). However, participants did not appear to internalize any sense of blame, and as with women in other studies, they had confidence in and were proud of their choices (Jouhki e60; A. Miller 417).

It is unclear whether blame would have been internalized in the advent of negative birth outcomes; this is a question for future research. Most participants even in the broader study had clearly been exposed to alternative birth discourses, which may have increased self-confidence in choosing alternative options. These women had also researched birth options and were likely familiar with informal or peer-reviewed evidence suggesting positive outcomes and low risks of homebirth, midwifery, and doula care (see, e.g., de Jonge et al. 726; Elder et al.306; Fortier and Godwin e292; Hutton et al. el86; Sandell et al. 23; Snowden et al. 2645[5]). DiFilippo (56-57) describes a "relearning" that takes place as women seek information about alternative options through peers, alternative childbirth advice literature and other media, and empirical research. This relearning may involve a reconfiguration of which practices are normal and acceptable.

Despite the apparent lack of internalized blame in women's birth narratives, the presence of felt or enacted deviance necessitated information management in the form of passing, covering, normalizing through reframing, and condemning the condemners (Ashforth and Kreiner 421-22; Goffman 41-104; Sykes and Matza 667-68). The information management allowed participants to present themselves as responsible, competent mothers in the face of deviance. As Malacrida and Boulton argue, childbirth is understood in relation to cultural proscriptions around femininity and motherhood ("Women's Perceptions" 749). A positive and moral mothering identity could be implicitly and explicitly threatened by disclosure of alternative birth choices. The connection between identity work and mothering ideals was particularly salient when participants normalized their decisions by aligning themselves with other mothers, denying harm, and explaining how their baby came first. Women who actively reframe alternative birth options may not directly challenge child-centred mothering ideology, but they contribute to positive constructions of alternative childbirth. In doing so, they challenge the dominant medical model and the discourses it engenders. Hearing positive alternative birth experiences is an important part of learning about different options and unlearning the dominant narrative of birth as risky (DiFilippo 53), even though it may take a long time to demarginalize and culturally position alternative birth settings as normal given the dominance of risk discourse (Coxon et al. 65). Although the experiences of women in the current study suggest that these options may still engender ascriptions of deviance,

positive constructions through reframing counter negative moralizing judgments reinforcing the status quo.

Ultimately, it is important to critically examine the social processes of deviance surrounding women's alternate childbirth decisions in Canada. The current work was not without limitations; many of the participants were located in one province (Saskatchewan), and it is unclear how representative their experiences of deviance were of Canadians more broadly. Since evidence suggests that alternative models of childbirth may benefit women and are an increasingly viable option within the healthcare system, further exploration of how women's alternative childbirth decisions are experienced, perceived, and morally valued remains a top priority for scholars of motherhood, mothering, and mothers.

Endnotes

[1] A concept that is frequently invoked to describe modern childbirth, medicalization can be defined as a social process wherein a problem, behaviour, or condition (including natural bodily processes) become defined and treated within a medical framework (Conrad 196).

[2] Regulated midwifery care is not currently available in Newfoundland and Labrador, the Yukon, and Prince Edward Island (Canadian Association of Midwives).

[3] Refers here to a birth where a doula or birth attendant was in the residence, but no healthcare provider who is legally mandated to perform deliveries. Real names of participants have been replaced with pseudonyms.

[4] Although skilled birth attendants and lay midwives delivered many babies prior to the legalization and regulation of midwifery in 2008, all individuals working as midwives in Saskatchewan must now be registered with the Saskatchewan College of Midwives.

[5] Although Snowden et al.'s work indicates slightly higher risks for several outcomes in planned out-of-hospital birth, serious adverse outcomes are low in all settings and absolute differences in risk are small, as noted by the authors (2650).

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MELISSA SAWERS AND GINA WONG

Pregnancy and Childbirth: Postpartum Anxiety (PPA) and Support for New Mothers

Perinatal mood and anxiety disorders (PMADs) are a significant mental health concern worldwide. In Canada, researchers, maternal mental health advocates, and practitioners are working to increase understanding of mental health in the perinatal period. This article focuses on the necessity to expand and build upon current understanding of PMADs, particularly postpartum anxiety disorders (PPA). The traditional construct of postpartum depression (PPD) is inadequate to understand, assess, diagnose, and treat the wide range of postpartum mood disorders. Anxiety disorders may be underdiagnosed among new mothers. Specific risk factors are explored for this population and support interventions are provided for PPA. Additionally, this article explores ways to improve understanding of PMADs from a sociocultural perspective and to improve protective factors that may enhance a new mother's mental health. Addressing the gaps and needs in postpartum mental health will positively affect mothers, fathers, their families, and our communities.

Pregnancy and Childbirth: Postpartum Anxiety (PPA) and Support for New Mothers

Perinatal mental health is vitally important and has significant impact on the pregnancy, postpartum, transition to mothering, and parent-child attachment (Fairbrother et al., "Depression"; Marchesi et al; Mollard). Researchers demonstrate that postpartum anxiety (PPA) disorders receive considerably less attention than postpartum depression (PPD), despite how common anxiety disorders are among pregnant and postpartum women (Fairbrother et al., "Depression"; Farr et al.; Pilkington et al., "A Review"). Postpartum depression screening has long been the standard for new mother's postnatal adjustments—potentially neglecting the factors of anxiety and stress during this crucial transition time (Miller et al.). In fact, Stephen Matthey and

colleagues underscore that although many new mothers may not meet the criteria for PPD, they do meet the criteria for PPA. Monique Seymour et al. advance anxiety as "one of the most frequently reported mental health difficulties experienced by parents following childbirth" ("Maternal Anxiety" 314). As such, PPA is a public health concern and a needed area of emphasis for maternal advocates.

The rise of perinatal mood and anxiety disorders (PMADs), specifically PPA, is a significant area of concern for women's mental health. Indeed, 17.1 percent of postpartum women have experienced an anxiety disorder compared to 4.8 percent of women suffering from PPD (Fairbrother et al., "Perinatal"). Likewise, researchers have observed anxiety disorders in 16 percent of their community sample, as opposed to 13 percent prevalence of postpartum depression (Highet et al.). A mother's distress significantly impacts her mental health and can also have implications for parenting behaviours and infant development (Grant et al.; Mollard). The emphasis in this article is to provide insight into experiences of distress, loss, and frustration in the perinatal period that can be risk factors for PPA. Additionally, we discuss the significance of intimate partner support as both risk and protective factors against PPA to further understand the supports needed in the perinatal period in a woman's life.

The Perfect Mother

Society has represented motherhood as an exciting, pleasurable experience that brings immense joy (Choi et al.). Distressed and discontented new mothers experience feelings that contradict society's beliefs and messages that she should be happy and fulfilled after becoming a mother (Ruybal and Siegel). Sociocultural ideals of the perfect mother commonly frame the new mother's perception of her personal inadequacies, which may contribute to feelings of loss, frustration, and anxiety (Highet et al.). Internalizing the ideals of what a good mother should look and feel like, combined with fears of judgment, can lead to intense feelings of guilt and shame in new mothers (Wong). These feelings significantly increase a woman's risk of experiencing PMADs (Dunford and Granger). Andrea O'Reilly and others write prolifically about the impossible standards of perfection in patriarchal "good mothering". In *Of Woman Born* (1976), Adrienne Rich describes a summer retreat from male and cultural exigencies. Rich writes about the freedom she experienced being away from sociocultural pressures: "we fell into what I felt to be a delicious and sinful rhythm… . This is what living with children could be-without school hours, fixed routines, naps, and the conflict of being both mother and wife with no room for being simply, myself" (156).

Rich describes re-entering regular city life and languishing in the institution of motherhood: "my own mistrust of myself as a 'good mother' returned, along

with my resentment for the archetype" (157). Rich also aptly articulates the intensity of changes and ferocity in the experience of becoming and being a new mother:

> Nothing to be sure, had prepared me for the intensity of the relationship already existing between me and a creature I had carried in my body and now held in my arms and fed from my breasts. Throughout pregnancy and nursing, women are urged to relax, to mime the serenity of madonnas. No one mentions the psychic crisis of bearing a first child, the excitation of long-buried feelings about one's own mother, the sense of confused power and powerlessness, of being taken over on the other hand and of touching new and physical and psychic potentialities on the other, a heightened sensibility which can be exhilarating, bewildering, and exhausting. (14)

Betty Friedan (1963) similarly highlights how societal values and definitions of what it means to be a woman can lead to depression and other psychological issues. Indeed, a mother's attitude and beliefs about perfect mothering is a predictive factor for PMADs (Sockol et al.). Motherhood experiences are often overshadowed by sociocultural myths that good mothers are happy mothers and that mothers should seek goodness and happiness at all costs (Held and Rutherford). Many women feel unprepared for motherhood and have unrealistic expectations based on these cultural myths (Mollard). As a result, mothers feel inadequate when they compare themselves to these myths, and they work harder to compensate for anything less than perfect by being "supereverything" (Choi et al., 167). Additionally, new mothers may struggle to cope with the changes and perceived loss of control in their lives (Bilszta et al.). Motherhood has been described as a period of loss and frustration (Highet et al.). The perinatal period brings with it a new reality that may be vastly different from what they envisioned, and difficulty adjusting to the loss of their old life may heighten distress. The transition to motherhood often means unexpected and unwelcome changes for many women. Changes occur in new mothers' bodies, activities, workload, and social roles, which can lead to dissatisfaction with the actual experience of being a mother and to increased disappointment and frustration (Highet et al.). Discrepancies between expectations and experience often lead to feelings of shame, making a woman feel like a bad mother (Dunford and Granger). Even admitting to feeling anxious or depressed can make a new mother feel like a failure, which reinforces her feelings of shame and guilt (Dunford and Granger).

In addition to potential feelings of loss and frustration, a psychological shift occurs for new mothers when the child becomes the primary focus. This shift leads to new concerns and demands for which the mother feels unprepared (Haga et al.). Mothering skills and tasks, such as breastfeeding, may not feel

like they come naturally—again contrary to society's images of females as natural mothers with innate abilities to care for their child (Choi et al.; Ruybal and Siegel). Poignantly addressed, P. Choi and colleagues have emphasized that the "realization of motherhood" (172) and the "reality of motherhood" (173) are fraught with psychological stress, conflict, and distress. Many mothers believe they are failing if they struggle with baby management and the adjustment to this new role (Bilszta et al.). These internalized expectations and judgments about mothering efficacy are linked to depressive symptoms (Dunford and Granger). This cognitive dissonance—the discrepancy between personal expectations and actual lived experience of motherhood—puts mothers at greater risk for developing PMADs (Haga et al.).

This Is My New Identity?

Changes to a woman's identity and roles significantly affect perceptions of self and can contribute to increased distress in motherhood. Women experience abrupt and significant changes to their lives with little preparation (Highet et al.). Western culture places high value and expectations for success on the mother role. Internalized expectations for control and mastery of the motherhood role lead to stressful challenges and unpredictability, which can increase a woman's struggle to cope with her new identity (Haga et al.) and heighten anxiety in her life. A woman's ability to incorporate the concept of motherhood into her self-identify is shown to act as a predictor of her postpartum mental health. If she cannot reconcile her new role and the expectations she perceives, then she is likely to experience distress (Seymour-Smith et al.).

New Mother's Identity and Loss

Periods of change, particularly life transitions such as motherhood, create stress because there is a loss of identity (Seymour-Smith et al.). As a new mother, a woman finds herself facing increased demands, responsibilities, fatigue, and environmental stressors (Seymour et al.). A woman often gives up her job, hobbies, and social engagements to become a mother, losing many parts of her daily life (Seymour-Smith et al.). The baby now dictates a mother's schedule, often resulting in a loss of self and a loss of time for things she enjoyed, which were part of her identity. Motherhood-related changes fuel feelings of loss and frustration and engender "the context in which mental health symptoms [are] developed" (Highet et al.182). Adding fuel to the fire, increased anxiety perpetuates self-doubt, loss of self, and diminished confidence as a new mother (Seymour et al.). Furthermore, anxiety lowers parental warmth, satisfaction, and self-efficacy, and increases parenting hostility.

Is This Normal?

Lack of general societal awareness about anxiety in the perinatal period increases a mother's experience of distress. Nichole Fairbrother and colleagues ("Perinatal") argue that PPA disorders receive very little attention in comparison to postpartum depression research and services. In fact, they hail their study as the first of its kind, which studies a representative sample of the prevalence and incidence of PPA. Similarly, other researchers have highlighted how new parents have insufficient awareness and understanding about perinatal anxiety, thus contributing to their vulnerability (Pilkington et al., "Enhancing").

Low societal awareness about anxiety disorders directly impacts women's mental health awareness and ability to access appropriate resources: "The lack of general awareness about anxiety disorders in the perinatal period when compared with depression supports the notion that perinatal anxiety is insufficiently recognized. This is likely to be not only delaying early recognition of symptoms, but also causing confusion amongst those with perinatal anxiety" (Highet et al. 183). Many women were unaware of the symptoms of anxiety disorders, and the available resources they accessed were insufficient in differentiating between symptoms of depression and symptoms of anxiety (Highet at al.). The women found themselves trying to fit their anxiety symptoms into a depression checklist that did not yield relevant or helpful information. Thus, unable to find information that fit their personal experience, they were filled with further confusion, angst, and frustration.

Stigma

Another consequence of the lack of societal awareness about PMADs is the stigma attached to mental health disorders. Fear of mental health problems and reluctance to accept the mental-health label can create an insurmountable obstacle for new mothers (Bilszta et al.). Society creates stereotypes for individuals suffering from mental illness—often labelling them as weak or attention seeking and blaming them for the disorder (Ruybal and Siegel). In a time when physical, mental, and emotional limitations make accessing help difficult enough, the additional hurdle of stigma and negative perceptions can be too much to contend with (Bilszta et al.). Changing perceptions that the woman is not at fault increases an individual's willingness to provide support and sympathy (Ruybal and Siegal) and increases mothers' help-seeking behaviors. Attribution-based campaigns creating awareness and reducing blame will serve to increase the social supports available to new mothers.

Support: What Do Mothers Need?

A significant gap exists in understanding the type of support a new mother may need. There are often deficiencies in the support new mothers receive, which exacerbate and increase the risk for PMADs.

Significance of Intimate Partner Support

Although we eschew the significance of intimate partner support, we recognize even more the increased challenge and potentially higher risk for PMADs that single mothers/parents may experience; we also acknowledge that many single parents fare very well and are not immediately disadvantaged because of their partner status. Researchers outline the importance of social support and emphasize how partner support, both practical and emotional, is foundational to the mother's wellbeing (Bina; Haga et al.; Pilkington et al., "A Review"). The addition of a baby affects the intimate partner relationship, including interpersonal dynamics and the balance of power. Mothers may find it overwhelming to care for their own needs, their baby's needs, and their partner's needs (Bilszta et al.). Additionally, insufficient partner support increases the demands placed on new mothers, creating feelings of frustration and disenchantment (Highet et al.). Kim Boland-Prom and Nancy MacMullen (2012) emphasize the centrality of the partner relationship as both supportive and stressful. Sherry Farr and colleagues attribute low social support and high stress as impacting a woman's self-confidence, thereby increasing her distress. Rena Bina argues that the "type of social support as well as its degree of significance … vary according to women's cultural backgrounds" (579). Indeed, cultural differences in support needs and resources and a multiplicity of factors affect a mother's mental health and wellness.

Researchers focusing on prevention of PMADs indicate partner support as an instrumental protective factor (Pilkington et al., "A Review"; Pilkington et al., "Enhancing"). New parents are more vulnerable to mood disorders because of their new roles and responsibilities and the physical, emotional, and mental demands of these changes (Pilkington et al., "A Review"; Seymour et al.). Additionally, there is inadequate information and preparation for the challenges and adjustments they may face in this transition (Pilkington et al., "Enhancing"). Targeting partner support to reduce the risk for postpartum mood disorders is ideal for many reasons: it is not gender specific, it can be long term, and it provides ongoing exposure so that changes can be noted (Pilkington et al., "A Review"). Adjusting to motherhood can be facilitated by providing adequate social support to new mothers and building their belief in their abilities (Leahy-Warren et al.).

Feeling Alone: Mothers Need Community

Psychosocial factors are among the biggest risk factors for postpartum women. A woman's social identity is just as important to her sense of self as her intimate and interpersonal relationships are (Seymour-Smith et al.). Many women lack community connections, which makes it difficult for them to normalize their experiences or to differentiate between normal and concerning psychological adjustments (Bilszta et al.; Seymour et al.). A sense of "us" provides belonging and connection in addition to providing meaning, coping, and resilience (Seymour-Smith et al.). Women suffering from depression or anxiety are more prone to isolate themselves and to withdraw from social situations further limiting their interactions with the outside world (Highet et al.). Having insufficient programs for new mothers means they do not have the opportunity to make connections with other mothers and to gain support, leaving them feeling disconnected and alone (Highet et al.).

Silje Haga and colleagues conducted a study to determine why some new mothers have a greater sense of wellbeing than others. One of the helpful influences promoting wellbeing was participation in an informal postpartum group, where women could normalize their experiences, network, and gain social support. P. Choi and colleagues reveal that women value and desire support from other mothers, and Haga and colleagues contend that involvement in a new mother's group offers a place to gather information, normalize, and gain a sense of control. The authors also recommend group counselling as a viable option, as it provides both professional help and fulfills a new mother's need for support from other mothers. Rena Bina's extensive 2008 study further underscores the importance of community support and its instrumental role in a mother's wellbeing. Involvement in a religious community or in another community structure was found to reduce a mother's risk for psychological distress, including depression (Seymour-Smith). Other researchers emphasize the necessity of community for creating important relationships and reciprocal learning from a variety of perspectives (Mollard).

Assessing Postpartum Anxiety

Screening and assessing perinatal anxiety are a challenge, given that both definitions and assessment measures for perinatal anxiety are inconsistent, inadequate, or underutilized (Grant et al.). Indeed, "screening instruments which have been validated for use in perinatal populations do not exist" (Fairbrother et al., "Perinatal" 50). Current diagnostic criteria used to assess postpartum mood disorders are the same as they are for nonreproductive periods, despite the suggestion that perinatal anxiety can have symptoms specific to motherhood. There is a need for assessment tools and criteria sensitive to the unique context and challenges of motherhood. Women are at

higher risk for developing anxiety symptoms in the first postnatal year, which highlights the necessity of screenings for the postnatal period (Seymour et al.). Increased use of screening tools—including specific postpartum/perinatal anxiety scales and items specific to new motherhood—would significantly influence the accurate diagnosis of postpartum mood disorders; the use of depression scales, namely the Edinburgh Postnatal Depression Scale (EPDS), is more widely used.

Anxiety is a significant condition for many new mothers, yet the depression modules for postpartum screenings are primarily used. These screenings assess depression and lump anxiety symptoms under the depression category rather than looking at them separately (Matthey et al.; Miller et al.; Chavis). Women are 60 percent more likely to be diagnosed with anxiety disorders in their lifetime than men (National Institute of Mental Health), and the postpartum period poses a time of increased risk. Yet the education, awareness, and interventions continue to focus heavily on postpartum depression, and give far less attention to anxiety (Chavis). In a recent study of eighty-six first-time mothers, Llena Chavis found that 68 percent of these mothers experienced moderate to severe anxiety. The study shows anxiety to be almost as prevalent as depression in first-time mothers. High scores of anxiety are typically associated with high scores on the EPDS (Cox et al.), and anxiety often presents as depressive symptomology (Pereira et al.). New mothers may be identified as depressed, yet it is the symptoms of anxiety causing them the most distress, and these are not being properly addressed.

The co-morbidity of anxiety and depression negatively impacts prognosis and increases treatment time for women suffering from anxiety disorders (Matthey et al.; Miller et al.; Pereira et al.). Depression left untreated poses considerable risk to mother and baby because of self-harm or harm to baby; therefore, it is the focus in postnatal checks (Chivas). Practitioners may be focused on a single diagnosis, and miss symptoms of other mood disorders, which may not present in postnatal depression screenings (Matthey et al.). Distinguishing between anxiety and depression is crucial so that treatments can be specific to the symptoms (Miller et al.). A woman may not screen for depression at her initial postpartum check, yet she may still be suffering from symptoms of anxiety. Not all anxious parents are depressed (Matthey et al.), but unaddressed anxiety leaves women vulnerable to depression (Matthey et al.; Miller et al.). In our haste to rule out depression, healthcare providers may miss symptoms of anxiety and distress, increasing the risk a new mother may become severely depressed.

The major life changes and transitions of motherhood place women at an increased risk of many mental health concerns, yet postpartum depression takes precedence in public health policies and assessment tools (Pereira et al.). The EDPS has been the standard for assessing postpartum depression for

decades, with only limited items specific to anxiety (Fairbrother et al; "Depression"; Miller et al.), but prenatal and postnatal anxiety are often missed during screening with EPDS (Farr et al.). Over a decade ago, Renée Miller and colleagues proposed broader screening tools and classifications to encompass depression, anxiety, and stress. In their study, they find that 29 percent of women had at least one classification of depression, anxiety, or stress. Initial use of only the EPDS had missed identifying 6 percent of the women in their study who were experiencing other symptoms of distress. Other research supports earlier findings that anxiety symptoms were grouped under depression modules, placing patients at risk of misdiagnosis and mistreatment, thereby exacerbating distress (Matthey et al.). The rates of affective disorders for women can nearly double when anxiety is included in the screening (Matthey et al.). In Carlo Marchesi and colleague's systematic review of perinatal anxiety disorders, all eighteen studies use the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, American Psychiatric Association, 2013) to diagnose anxiety disorders, which may not be used by all doctors screening postpartum women. Boland-Prom and MacMullen argue that limited time frame and mood states are problematic in the current medical models of postpartum depression. They advocate for models that support a broad variety of moods in addition to biopsychosocial and person-in-environment perspectives. Miller and colleagues propose broader screens of postnatal distress to include depression, anxiety, and stress for screenings in new mothers. They argue that depression as the standard for postnatal maladjustment neglects the anxiety and stress symptoms that many women with distress experience. Their recommendation was to use the Depression, Anxiety, and Stress Scale *(*DASS-21; Lovibond and Lovibond) because it more accurately measures broader affect states in postpartum women. Priscilla Pereira and colleagues support the need for lengthier postpartum care and for more extensive mood screenings. They argue that a gap in studies between the postpartum period and maternal adjustment increases the risk for new mothers. Despite the awareness that postpartum mood disorders have a significant effect on mothers and their children, there is very little known about the actual transition process of affected women to motherhood.

Identification of Postpartum Anxiety

The spectrum and scope of postpartum health models require a change. For decades, the biomedical approaches to postpartum mental health have influenced the discourses, assessments, and interventions of professionals. These approaches do not take into consideration the complexity of systemic influences and psychosocial factors during the postpartum period (Pereira et al.). Those working with new mothers would benefit from advocating for

models placing motherhood within broader social and environmental contexts (Boland-Prom and MacMullen). These models are more representative when they include existing social group networks and group memberships that can identify strengths and supports for alleviating anxiety (Seymour-Smith et al.). Understanding the mother within a system is necessary to both identifying and reducing anxiety (Chavis). Mental health advocates are called on to expand the standard postpartum screening tools to include broader criteria for postnatal distress. Researchers have found postpartum anxiety disorders to be more prevalent than depression, highlighting the need for both clinical and scientific attention (Fairbrother et al., "Depression"; Fairbrother et al., 2016; Seymour et al. "Perinatal").

Additionally, there is a need for perinatal research and literature that includes broader populations of women. Existing research data are primarily based on the experiences of married women (Clout and Brown; Martini et al.; Schmied, et al.). There is a dearth of postpartum research examining predictors of PMADs for single mothers (Clout and Brown). Cindy-Lee Dennis and colleagues echo this limitation and note that single mothers are underrepresented in their study of postpartum anxiety. Yet another gap in postpartum research exists for sexual minority women (lesbian, bisexual, or queer). There is little information on risk factors and protective factors for sexual minority mothers, and the differences in social variables for a queer mother could significantly contribute to the prevalence and determinants of perinatal mental health (Alang and Fomotar; Flanders et al.).

Psycho-Education

Education and information can be provided by healthcare practitioners to prepare and equip at-risk, expectant mothers and their supports. Psycho-education can set the stage for realistic expectations and explores the normal responses a mother could have throughout the transition to motherhood (Chavis; Seymour et al.). Mental health workers can identify at-risk expectant mothers by examining a mother's system, supports, and construction of self. Does she see herself as competent and confident? Is she willing to accept that the process may not be as she envisioned it? If not, providing skills and information on the wide range of infant behaviour as well as postpartum mood disorders can empower new mothers and build on their strengths (Chavis).

Psycho-education would work best if implemented throughout both antenatal and postnatal periods. Antenatal education should include postnatal emotional changes and information on seeking help. Establishing a relationship with healthcare providers and mental health professionals that continues throughout both periods can also increase the likelihood of early recognition

and intervention (Bilszta et al.). Continuing care also allows health practitioners to identify existing social group networks and group memberships by assessing a mother's group identification as low or high, which can predict the likelihood of mental health concerns. Interventions focused on existing networks have proven to be a protective factor for new mothers (Seymour-Smith et al.).

Alternative Motherhood Discourses

Advocates for mothers can help create alternative motherhood discourses that challenge the idealized perfect mother or good mother (Choi et al.). Cultural and societal myths perpetuating unrealistic standards for mothers need to be critiqued. Cultural constructions of motherhood can create false expectations that set a woman up to fail. Further dialogue around the maternal role can expose the faulty concept of motherhood as instant bliss, fulfillment, and satisfaction (Mollard). Advancing discourse normalizing a broad spectrum of moods and feelings in the postpartum period and the prevalence of PMADs can better prepare mothers and families. This discourse lets women know they are not alone in experiencing a less-than-perfect transition; anxiety is normal and to be expected (Chavis).

Being aware of the difficulties and the range of emotions around pregnancy can help new mothers cope (Pilkington et al., "Enhancing"). Silje Haga and colleagues offer the concept of "good enough parenting" to ease the pressure on new mothers. We need to challenge the discourse of mastery. Likewise, we need to support expectant mothers to know that a range of emotions and challenges are common. Recognizing that parenthood is stressful, we can encourage mothers to embrace a mindset of acceptance and flexibility (Pilkington et al., "Enhancing"). The transition to motherhood can be facilitated by strengthening a mother's belief in her abilities (Leahy-Warren et al.).

Helping the Partner

Motherhood has a steep learning curve and does not always come easily or naturally. We can use a mother's social supports and can strengthen the parenting couple's relationship as protective measures against anxiety (Leahy-Warren et al.; Seymour-Smith et al.). Researchers have demonstrated new parents prefer to receive support from one another, and several factors have been identified as enhancing the partner relationship. For example, positive communication, emotional closeness and support, practical support, and minimizing conflict enhance the relationship a new mother has with her partner and can help alleviate both depression and anxiety (Pilkington et al., "Enhancing"). Likewise, helping to recognize guilt and shame that may be

experienced by new mothers can assist in early recognition of postpartum mental health concerns.

Low social support and satisfaction with the spouse or partner have been associated with higher risk for PMADs (Martini et al.; Schmied, et al.). Although lesbian, bisexual, or queer mothers are reported to experience better partner support because of their deliberate and planned nature of parenthood and the, potentially, more equitable distribution of parenting duties (Ross), we suggest these protective factors to PMADs may be overshadowed by external social factors. Indeed, queer mothers are likely to experience increased feelings of isolation and barriers to effective social support because of homophobia, heterosexism, social stigma, and strained relationships with family of origin (Alang and Fomotar, 2015; Ross). In her discussion of queer mothering, Margaret Gibson indicates that "bisexual identities have been erased across parenting research" (355). She also says that fatherhood movements have admonished LGBTQ parenting as much as they denigrate single mothers with low socio-economic status, which further adds to the isolation and stigma likely to be experienced by queer or single mothers.

Conclusion

The postpartum period is when a woman is at greatest risk for mental health concerns (Seymour-Smith et al.). Thus, it is crucial that awareness and understanding of postnatal mental health become a priority for counsellors. New mothers may require extra support from healthcare providers and society in general to ease them into their new role and to help them reconcile their new identity. New mothers face incredible pressure to succeed, yet many lack the necessary structures and supports to help facilitate their transition into motherhood (Haga et al.). Society's stereotypes and attributions reinforce the perfect mother ideal creating feelings of shame and guilt, which also act as barriers for help seeking (Ruybal and Siegal). There is a need for improved education and awareness for women, their partners and loved ones, and healthcare providers (Fairbrother et al, "Perinatal"). Women and their support providers need to be aware of the risk factors, protective factors, and warning signs for anxiety disorders as well as postpartum depression. It is our duty to advocate for early identification and intervention.

Discussing and assessing anxiety prior to the postpartum period are also recommended, as antenatal anxiety is associated with increased risk of postpartum anxiety. Awareness and exploration of anxiety in a mother's adjustment to pregnancy and eventual motherhood could lead to early identification and interventions for women at risk (Grant et al.). Addressing the gaps and needs in postpartum mental health will positively affect mothers, fathers, their families, and our communities.

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JOSEPHINE L. SAVARESE

Marijoy[1] Tells Her Story While Sister Hildegard Sings Encouragement

I was in a dream like state during the "commission of the offence"

Glance at the Sun, Marijoy

They said I acted: Contrary to Section 243, Disposing of the Dead Body
With the intent to conceal the fact I was delivered of it.

Behold the Moon and Stars

Did not know I was pregnant

Now, think.

Shock when I woke up, did not know how to react,

All of creation is a song to the praise of God

During the birth, things were unreal

God hugs you.

They called it: "depersonalization and derealization"

A nightmare or a dream

You are encircled by . . .

Cried throughout the two hour interview

Especially when describing the birth.

And the blue aftermath, when I buried Baby

in a waste bin.

. . . God's
mystery.

This poem is written for a young mother, Marijoy, who disposed of her baby that died immediately after birth on 3 July 2015. She expressed profound remorse when interviewed by law enforcement. In this poem, details of the case are put alongside lines by Hildegard of Bingen (1098-1179), a well-known mystic prominent in the twelfth century.[2]

Endnotes

1 The details are drawn from *R v Geraldizo*, 2016 BCPC 484 (CanLII).

2 Quotes by Hildegard of Bingen are adapted from "Quotes by Hildegard of Bingen" healthyhildegard.com/hildegard-bingen-quotes. Accessed 22 August 2018.

LAURA MAJOR

"Music and Mensis" or the Deconstruction of the Pregnancy and Childbirth Metaphor in Ntozakae Shange's "oh—i'm 10 months pregnant"

To reimagine the pregnancy and childbirth metaphor, which, in general, perpetuates the mind-body split between creation and procreation, not only must the poet write about her personal experience of procreation but she must metapoetically confront the dichotomy separating this experience from her creativity. By doing so, she implies that procreativity is an experience to be related poetically and that a poem is the product of the mind and body creating and procreating. For the African American woman poet, the reckoning is even more fraught, for the Black woman's body has historically been divided "into two neat categories: Sexed and Unsexed" (Mahurin 330). Ntozake Shange attempts to resist the above binaries in her poem "oh—i'm 10 months pregnant." She insists both on the embodied mind, creating babies and poems, and on the impossibility of dividing women into sexed and unsexed by focusing on the very condition and action proving the existence of both: pregnancy and childbirth.

This article shows how throughout the poem, Shange defies conventional use of punctuation and language, and actually pokes fun at the notion that poetry and babies are analogous. She does so by critiquing medical discourse and playing with the limits of metaphor. Ultimately, because the resolution of the pregnancy and the production of the poem both depend on Shange's likening her baby to language, this paradoxically becomes an admission about the material and metaphorical connection between books and babies.

"A child is not a poem
a poem is not a child."
—Margaret Atwood, "Spelling."

The pregnancy and childbirth metaphor for creativity generally perpetuates the mind-body split between creation and procreation. To negate this binary, not only must the poet creatively represent her personal experience of procreation, she must metapoetically confront the dichotomy separating this experience from her creativity, thereby positing that procreativity is an experience to be related poetically and that a poem is the product of the mind and body creating and procreating. Ntozake Shange reckons with this binary in her poem "oh—i'm 10 months pregnant," but also attaches race to her resistance by playing with language and interrogating sexist ideas about Black women's bodies. Shange defies conventional use of punctuation and language, and actually pokes fun at the notion that poetry and babies are analogous. She does so by critiquing medical discourse and playing with the limits of metaphor. Ultimately, because the resolution of the pregnancy and the production of the poem both depend on Shange's likening her baby to language, this paradoxically becomes an admission about the material and metaphorical connection between books and babies

The Books-Babies Binary

In "Creativity and the Childbirth Metaphor: Gender Difference in Literary Discourse," Susan Stanford Friedman maps out the different ways in which men and women have used the childbirth metaphor for creativity. She notes that when men use the childbirth metaphor—whether negatively as in the Enlightenment era or positively as in the Romantic era—they overtly or covertly perpetuate the mind-body split between creation and procreation, even while attempting to transcend it (85). If a woman poet is to assert herself as both against the system "that conceives woman and writer, motherhood and authorhood, babies and books, as mutually exclusive" (Stanford Friedman 85), she must deconstruct this binary mode of thought.

To write poetry about pregnancy and birth is to take one step in this direction—the lyric poem about these experiences becomes a refutation of the premise that a woman cannot both create and procreate. In their attempt to recover and celebrate women's bodily experience and write from that experience (*l'ecriture feminine)*, second-wave feminism and French feminism promoted the conjunction between poetry and the body. Both of these movements, though, have been vulnerable to charges of essentialism and biological determinism. And instead of negating the Cartesian binary, this kind of writing can be seen as reducing mind to body.

Thus, a double deconstruction becomes necessary for reimagining this metaphor: not only must the poet write about her personal experience of procreation, but she must metapoetically confront the dichotomy separating this experience from her creativity. On one level, such a deconstruction links

the personal to the greater cultural realm, but on a deeper level, it implies that procreativity is an experience to be related poetically and that a poem is the product of the mind and body creating and procreating. The poet, thus, celebrates a gynocentric poetry written about, through, and by the embodied mind. Of course, not all female poets perform such a sophisticated deconstruction; some may accept the traditional opposition between procreativity and creativity, and others may defy it outright.

For the African American woman poet, the reckoning is even more fraught, for, in general, the whole discussion about the childbirth metaphor and the mind-body split, is about white bodies and white minds. In addition, by embracing body, the African American poet might perpetuate the division between ideas as lofty and bodies as "the debased side of nature" (Oyewumi 3). According to Oyewumi, "all those who qualified for the label of 'different' … have been considered to be the embodied [and] dominated therefore by instinct and affect, reason being beyond them. They are the Other, and the Other is a body" (3). In addition, the Black woman's body has been historically divided "into two neat categories: Sexed and Unsexed. The 'Sexed' is the Jezebel … a body so insistently sexualized that its sole purpose seems to lie in its capacity for producing ecstasy … Its alternative (the 'Unsexed') is the Mammy … a mother-to-all who is nonetheless completely divorced from the crude business by which one becomes a mother in the first place" (Mahurin 330). Neither is a subject; rather, each is a commodity "to be consumed" (330).

Ntozake Shange attempts to resist the above dichotomies in "oh—i'm 10 months pregnant." She insists both on the embodied mind, creating babies and poems, and on the impossibility of dividing women into sexed and unsexed by focusing on the very condition and action proving the existence of both: pregnancy and childbirth.

Race and Language

Ntozake Shange was born Paulette Williams, but in 1971, she shed her "slave name" becoming Ntozake, which translated from Xhosa means "she who brings her own things," Shange, translated from Xhosa as "one who walks with lions." Shange's best known theatrical piece, *for colored girls who have considered suicide/ when the rainbow is enuf,* was very well received, but Shange considers herself "a poet first and a playwright second" (Lester 718). Shange is a self-defined "woman centered person" (Lester 727) and "hard-line" (727) feminist who uses language in unexpected and unconventional ways as an expression of control and liberation She is strident in her feminism, so much so that *for colored girls* was almost universally conceived of, by black men, as an attack on them; however she is as opposed to racism as she is to sexism: "I have a vagina and skin at the same time so I don't have a dilemma…. I couldn't side

with a racist or a sexist…. I would side with whatever would be good for women and children of color" (qtd. in Brown).

Like many African American feminist writers, including Audre Lorde, Lucille Clifton and Toni Morrison, Shange defines herself in opposition to white men, white women, and black men. In the poem "oh, i'm 10 months pregnant," however, Shange speaks as a woman writer more than as specifically an African-American woman writer: her words are relevant to all women poets attempting to dislodge the books-babies binary.

Yet even if the content of the poem does not specifically address race, the form and language of the poem, of all Shange's poetry, display her identity as African American. Shange's poetry is discernable in its purposeful defiance of standard English and punctuation. Periods and commas are rare sights in her poems, and capital letters never appear. Gabriele Griffin suggests several reasons for Shange's use of the lowercase: it might reflect a sense of inferior status, and it might be used to erase hierarchy or power structures. Regarding the lower case "I," because it is physically divided in two, as opposed to the "rigid and immobile" uppercase "I" (Griffin 36), lowercase suggests "flexibility and possibilities of movement" (36). Instead of conventional punctuation, Shange uses slashes to punctuate her lines. The spelling in her poems is characterized by the omission of letters ("should" becomes "shd" and "your" becomes "yr") and by uncommon contractions ("between" is "tween" and "for" is "4"). Griffin suggests that "contractions" is "a word resonating strongly with women, as part of a menstrual/reproductive/creative cycle," and, thus, reflects "the way in which the body is used in speech" (35).

Shange has explained her motivations for this play with form and language in two ways. The first is formal and emanates from a desire to engage her readers in a struggle: "I need some visual stimulation, so that reading becomes not just a passive act and more than an intellectual activity, but demands rigorous participation" (qtd. in Tate 163). As Ania Spyra notes, "Since she sees standardization as limiting the creativity of language, Shange insists on linguistic experimentation in her poetry" (91).

Her spellings, Shange says, "reflect language as I hear it…. The structure is connected to the music I hear beneath the words" (qtd. Tate 163). This seems akin to "glossalalia" and "heteroglossia" described by Mae Gwendolyn Henderson, who, drawing on Bahktin's theories of discourse, characterizes black women's writing as "speaking in tongues." Glossolalia refers to the ability to "utter the mysteries of the spirit" (353) in an inspired mode of intimate communication, whereas heteroglossia refers to "polyphony, multivocality, and plurality of voices" (353). According to Henderson, since African American women "speak from a multiple and complex social, historical and cultural positionality" (351), their speech takes on an "interlocutory, or dialogic character, reflecting not only a relationship with the

'other(s),' but an internal dialogue with the plural aspects of self that constitute the matrix of black female subjectivity"(349). Mary O' Connor also uses Bahktin's dialogism to point out that "the more voices that are ferreted out, the more discourses that a woman can find herself an intersection of, the freer she is from one stereotypical and sexist position"(35).

There are, however, deeper political and psychological reasons for Shange's defiance of language and form. Shange aims, as a Black poet, "to attack deform n maim the language that i was taught to hate myself in. I have to take it apart to the bone" (Shange 1981). Shange refers to "the King's English" as "the enemy" and her subversive use of it as "a weapon" (Lester 728). By making the language "say what we want it to say" (Lester 727), Shange aims to "preserve the elements of our culture that need to be remembered and absolutely revered" (qtd. in "Shange, Ntozake"). Shange's use of language is not only a rebellion against the fiction that European art is the standard, but against her own upbringing in a Black, middle-class, conservative home. In 1976, Shange admitted that the inanity of that class perspective prompted her adoption of the idioms and dialect of the live-in maids who had cared for her as a child. A trace of that way of speaking remains in all her poetry, including "oh, i'm 10 months pregnant."

Interrogation of Medical Discourse

The title of the poem reveals much about what is inside. The "oh" hints at the poet's weariness and exasperation at being exceedingly pregnant. Her exclamation that she is "10 months pregnant" seemingly uses hyperbole to emphasize just how pregnant she is. This use of "10 months," however, is not only a foretaste of the joking tone of the poem, but the poet's first critical examination of medical discourse. Most people think of pregnancy as being nine months long, divided into three trimesters. But since we count pregnancy from the beginning of the woman's last menstrual period, pregnancy is really forty full weeks, or ten months. Shange's title then not only highlights the discrepancy between the true length of gestation and the popular view, but also marks her refusal to participate in any misleading discourse perpetuated by the medical community.

The poem opens with a dichotomy between the medical, observable aspects of pregnancy, and the realm of literary creation. The speaker speaks to her doctor, "tween the urine test & the internal exam/ when her fingers were circling my swollen cervix," attempting to proffer an explanation for her baby's late arrival:

i tried
to tell her the baby was confused
the baby doesn't know
she's not another poem.

The verb "tried" is repeated three times to emphasize the futility of convincing her empirically minded doctor that there is a non-medical reason for the delay of the birth. This emphasis draws attention to the distance between the mother and her physician. In her dated but seminal article "Pregnant Embodiment: Subjectivity and Alienation," Iris Marion Young discusses this distance, seeing it as a part of the alienation that a pregnant women feels vis-à-vis the medical community. Young explains some of the phenomena that seem to cause Shange's frustration: "Her [the pregnant woman's] condition tends to be defined as a disorder, because medical instruments objectify internal process in such a way that they devalue a women's experience of those processes, and because the social relations and instrumentation of the medical setting reduce her control of her experience from her" (55). Besides drawing attention to this alienation, Shange is also playing a humorous rhetorical trick; the speaker does not really believe that the "baby was confused," but is rather trying to establish the link between writing poems and having babies in a most material, tangible way. Shange plays with the childbirth metaphor; she simultaneously affirms and questions the link between these realms.

The Playful Deconstruction of the Childbirth Metaphor

Stanford Freidman, quoting Paul Ricoeur, discusses how contradiction is inherent in metaphor in that it presents "'an insight into likeness' seen "in spite of and through, the different'" (77). In metaphor, the reader must "complete the process of reconciliation" (77) by discerning the "figurative truth" through the "literal falsehood" (77). According to Stanford Freidman, readers of the childbirth metaphor know that babies are not books but can reconcile the contradictory elements of the metaphor because they recognize "that the author's analogy defies cultural prescription of separated creativities" (80). If we use the "blend" model of metaphor, reconciling contradictory elements becomes even easier, since the metaphor with its own "emergent structure" (Turner and Faucconier 113) does not have to fit perfectly with any of its inputs. Stanford Freidman seems to move toward this understanding in her own terms by claiming that in the female use of the childbirth metaphor "the intensification of collusion and congruity … allows the tenor and vehicle to mingle and fuse" (80).

In this poem, however, Shange challenges the reader in the reconciliation

process. Both because she uses a joking tone throughout and because she pushes the metaphor to an absurd point, her use of the childbirth metaphor becomes similar to the male use of the metaphor in that "collision drowns out collusion" (78). If, according to Stanford Freidman, the woman's birth metaphor "suggests that her procreative powers make her specially [sic] suited to her creative labors," then Shange's poking fun at that metaphor seems to undermine her commitment to the deconstruction of the books-babies binary. A close examination of the poem, however, reveals the poem's wit in setting up two extreme binaries and then exposing the silliness of each.

Shange's use of the childbirth metaphor is actually very different from the generic male poet's application. Whereas the male "gives birth" to poems from his "womblike mind" (Friedman 79), Shange's "i" has a very visible pregnant body. She wants to investigate whether the reverse of the male metaphor is true, whether one can give birth to poems from the body. The mention of urine tests, internal examinations, and swollen cervixes foregrounds this physicality, and emphasizes the less aesthetic aspects of the reproductive body to protest the idealization of reproduction and the ensuing metaphorical appropriation of this blooming, fertile, and ideal state. In "wow yr just like a man," Shange sets out the paradox of the lived female reproductive body: "bodies & blood & kids" or the "gooey gaw/female stuff" needs to be repressed for a woman to be considered a poet ("well & that ain't poetry"); yet "as a woman & a poet," these messy parts of the female body cannot be repressed. When Shange decides "to wear my ovaries on my sleeve" and "raise my poems on milk" she knows that she is entering "an arena of her own," where the "unclean" becomes poetry and "music and mensis" are inextricably connected aspects of her life and her poetry.

In stanza two of "oh, i'm 10 months pregnant," Shange explains to the doctor the reason for her baby's confusion. The baby's mother, the poet, was so absorbed in literary creation—"i was working on a major piece of fiction at the time of conception…had just sent 4 poems off to the *new yorker* & was copy-editing a collection of plays"—that it "altered the poor baby's amniotic bliss." The stanza closes with Shange exclaiming: "doctor/ the baby doesn't think she shd come out that way!" Shange indicates here that she was so engrossed in the creative processes and energy of literary creation that it affected the baby's conception and her "formative first twelve weeks," leading the baby to believe she is a poem. Through the glaring absurdity of this assertion, Shange questions the idea that a woman can only be a poet or a mother. How, she seems mockingly to ask, can the poet's preoccupation with literary matters cause her to damage her child?

Shange also subtly criticizes medical discourse. Indeed, the words "formative first twelve weeks" appear in inverted commas so that medical language is purposely differentiated from poetic language. Prevailing medical discourse

elevates the status of the fetus and demands that the mother, as a fetal container, maintain extremely high levels of vigilance and precaution while pregnant. Shange takes this tenet to its ridiculous limit: if the mother is occupied in the literary world—for example attending "numerous opening parties all of which involved *me*" (my emphasis)—she adversely affects the baby's wellbeing.

The third stanza expands on the differences between scientific and creative discourse through the poet's conception of how her baby regards this dichotomy. This is a clearly imaginary viewpoint emphasizing the rhetorical nature of the poem. The mother has a wholly detached relationship to her baby, who is always referred to as simply "the baby" or "this baby." The poem is not about the mother-daughter relationship; rather, the baby and the doctor represent perspectives that the poet wants to deconstruct. In stanza three, the poet explains her baby's rationale:

> i mean / she thinks she shd come up / not down
> into the ground / she thinks her mother makes up things
> nice things ugly things but made up things nonetheless
> unprovable irrational subjective fantastic things
> not subject to objective or clinical investigation

The baby has co-opted the Cartesian view that the cerebral is superior to the physical. She associates the mental faculty of creation with ascendancy—"she thinks she shd come up"—and the corporeal with the lower realm—"not down / into the ground."

This baby seems to anticipate George Lakoff and Mark Johnson's observation in *Metaphors We Live By* that most orientation metaphors in Western culture use up-down spatialization in a way that "up" has a positive connotation in contrast to the negative "down." In arguing that "most of our fundamental concepts are organized in terms of one or more spatialization metaphors (17), Lakoff and Johnson offer many examples: happy is up, sad is down; more is up, less is down; high status is up, low status is down; good is up, bad is down; virtue is up, depravity is down; rational is up, emotional is down; and having control or force is up while being subject to control or force is down (15-17). This baby who takes metaphors quite literally not surprisingly prefers up to down. Even if the made-up things are "ugly," they preside over a physicality that is "subject to objective or clinical investigation." The baby would rather be "subjective" than "subject to."

On one hand, the baby is a literalist; to be "made up" means to ascend from the mother—"to jump out of my mouth/ at a reading someplace"—and not descend in the way natural to babies. On the other, the baby thinks figuratively: "she believes the uterine cave is a metaphor." Both her literalism and her paradoxically metaphorical approach emanate from her denial of her mother's

(and thus her own) embodiment. The notion that her mother has a body, creates poems, and, moreover, creates "music and mensis" is foreign to this baby.

The mother poet then finds herself wedged between binaries. She is caught between her baby's imagined perception, according to which everything valuable is subjective or "made up," and the doctor's clinical and empirical mindset, according to which everything is objective and can be examined with a medical instrument. Neither the baby nor the doctor can deconstruct the creation-procreation bind or can accept that a woman can produce both babies and books. The mother cannot connect with the baby—"I have no way to reach her"—or with the doctor—"doctor/ are you listening?" Yet she yearns to explain to the baby, who "wants to come out a spoken word," that she is not a poem. Conversely, the poet wants the doctor to understand that poetry and the body are not unrelated.

The mother does not simply wish to inform her baby that she is not a poem, but rather that "she is no mere choice of words." The books-babies bind is not resolved with a simplistic platitude by which procreation and creation are made equivalent. By using the adjective "mere" to describe language and poetry, she clearly constructs a hierarchy in which a baby is a superior creation to a poem, which reverses the baby's denigration of physical birth and her elevation of poetry. That a baby, a human being, is more significant than a poem seems obvious; however, the Cartesian mindset privileging the mind, and even the mind's product, over corporeal production or reproduction leads to confusion. The imagined baby embodies this confusion.

The final stanza—in which the mother comes up with a way to convince the baby, "this literary die-hard of a child of mine," to "drop her head & take on the world like the rest of us"— is as witty as the rest of the poem. Having established that the baby precedes language in importance, Shange now equates the two in order to convince the baby to emerge. Thus, she addresses her baby, "you are an imperative my dear," and relies on the double use of the word. The baby is both a necessity, and she is compared to the part of speech that commands. Both connotations are empowering. Therefore, the baby responds: "& i felt her startle toward my left ovary." Only by acquiescing to the baby's belief that she is a figure of speech does the mother manage to persuade her daughter to present herself. This compliance, on a broader scale, indicates the poet's ambivalent agreement to use the childbirth metaphor. Throughout the poem, Shange pokes fun at the notion that poetry and babies are analogous. But the fact that the resolution of the pregnancy and the production of the poem both depend on her likening her baby to language is an admission about the material and metaphorical connection between books and babies.

This deceptively simple poem records, in oscillating viewpoints, the mother-poet's rather complex struggle with the different realms. She clearly disagrees

with her empirical doctor, who gives credence only to the physically observable aspects of the body. We feel the poet's frustration with her doctor in the refrain where, presenting the baby's point of view, she exhorts the doctor to understand. Her baby's perspective, however, is also unacceptable. By drawing attention to her material "swollen cervix" and "left ovary," Shange negates the baby's view that "the uterine cave is a metaphor."

The poet's bewilderment at both these perspectives pulls her in two directions. Shange's manifesto in "wow, yr just like a man" insists that a woman poet cannot repress her reproductive body; indeed, the very subject matter of the poem and the presence of the physical reproductive body seem to affirm this. Yet the exaggeration of the conceit to the point of ridiculousness reveals the poet's skepticism regarding the connection between literary production and reproduction. The tone of the poem indicates the wish to somewhat separate these realms: having babies and writing poems can be done at the same time, but should not be conflated.

The epigraph above, from Margaret Atwood's poem "Spelling," seems to agree: "a child is not a poem / a poem is not a child." And it continues "There is no either/or. However." Yet later in her poem, Atwood proclaims: "the body / itself becomes a mouth." The birthing body opens up like the mouth expressing language, and the mother expresses the baby. The baby is the language, the poetry, of the body, and in Shange, the poetry is the language of the embodied mind.

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ASTRID JOUTSENO

Cyber Labour: Birth Stories on Mommyblogs as Narrative Gateways into Maternal Thinking

This article deals with birth stories on mommyblogs as a narrative genre through which writers become participators in maternal thinking and practices. Grounded in the feminist new materialism, feminist literary studies and social media studies, this article investigates the positions of writing and reading birth stories as well as their effects and connectedness to discourses on mothering, difference, agency and digital subjectivity. Through examples from birth-story posts this article shows how birth stories construct mothering both online and offline. As I sketch out birth stories as gateways into mommyblogging and reading, I weave in an autoethnographical narrative of encountering birth stories while I was pregnant. In my close reading of birth story examples from mommyblogs, I focus on the concepts of relationality, the cyborg, as well as maternal agency, thinking and practice. I analyze norms, narration of difference, and the reflexive relationality these maternal narratives create. What I discover is a digital (m)other: a shifting maternal subjectivity of a cyber mother, who appears liminally in both digital and material condensations.

In this article, I discuss the role of birth stories on mommyblogs as gateways into thinking and writing about mothering while experiencing it. I show how birth stories construct mothering with the help of the concepts of relationality, the cyborg, maternal practice, and maternal thinking (Friedman; Ruddick). I suggest that the proliferation of birth stories on mommyblogs highlights the need for discourse on mothering: to question normative ideals and to make sense of the material transformations of becoming a mother. As I sketch out birth stories as gateways into mommyblogging and reading, I weave in an autoethnographical narrative encountering birth stories while pregnant (Jones et al.). In my close reading of birth-story examples from mommyblogs, I analyze norms, narration of difference, and the reflexive relationality these maternal narratives create.

In mommyblogging, digital representation, community, and communication all convene to meet the lived material mothering (Podnieks and O'Reilly) and maternal practice (Ruddick 2003). Sara Ruddick's maternal practice points to mothering not as a sticky or stable subjectivity (essentialism), but as the practices of preservation, nurturing for growth and enabling social acceptability (Ruddick 220). This understanding of mothering underlines its qualities as repeated action and work, and unties mothering from womanhood and subjectivity. In addition to Ruddick's conception of mothering as practice, I borrow her concept of "maternal thinking." She argues that practices necessitate a thoughtfulness, which leads to "a discipline of maternal thought" (Ruddick 225). This discipline is then shared and discussed with (m)others in the same situation—sharing "an identification and a discourse about the strengths required by their ongoing commitments to protect, nurture and train" (226). Ruddick states that critical dialogue becomes meaningful within the framework of shared discourse leading to discussion among those who "practice maternal work or living closely and sympathetically with those who do" (226). I will show that in the context of mommyblogs, Ruddick's maternal practice and thinking resonate.

Although within this article, I discuss birth stories as distinct narratives on mommyblogs, my project is steeped in a larger quest for grasping visions of how influences flow between digital mothering and the embodied, experiencing reader. I assume that the material and digital are separated through difference in temporality, but they are also entangled in a messy manner. This article is part of a developing argument for reading mommyblogs as maternal narratives that contribute to the creation of a "digital (m)other"—a shifting and changing maternal presence liminally existing in the digital and material. Theoretically, I ground my research in the framework of new materialism. Since embodied experiences, lived life, and their expressions as maternal narratives on mommyblogs—as well as our feminist understandings of them—are transforming, I contribute to the feminist body of work analyzing the slippages between subjectivity, materiality, and technology. Therefore, I am cautiously traipsing on the path opened by Donna Haraway's cyborg. I construe the nuances of slipping between digital, material, and narrated mother. May Friedman has argued that the "mamasphere" is a manifestation of being cyborg (Friedman 77). Therefore, without fully acknowledging the magnitude of the change, we are already living—and mothering—as cyborgs: interweaving material, biological, and affective embodiment with technology of communication and enhancement. Similarly, Diane Coole and Samantha Frost have argued that the emergent posthuman context is already transforming what it means to be human in our everyday lives (23).

Mommyblogs are a culturally defined digital and material border-crossing phenomenon, defined by the stylistic conventions of mommyblogging as a

genre (see Friedman). In 2014 there were 4.4 million mommyblogs in the USA alone ("How Many?"). I identify birth stories as a stylistic category of posts in this genre. Through the convergence of new mother's needs and the possibilities afforded by development of the Internet, a "mamasphere" has been born. It is a digital network of loosely linked life writing on mothering and motherhood (Friedman 9). Previous research has identified mommyblogs as empowering, community building, agency encouraging, rebellious, and as affective labour (Friedman, Cleaf). Blog researchers have delineated mommyblogs as a genre with shared characteristics (Friedman; Petersen). I follow May Friedman's suggestion to view the emergent mamasphere as relationality (81-84). She reads mommyblogs as a relational place where motherhood is contextualized and debated, not fixed and stable (81). Friedman underscores this relationality through the importance of sharing with others in "a networked intimacy" (77), while not arriving to fixed definitions and resisting sameness in celebration of differences (74-75). This understanding of mommyblogs allows for their inspection as complex, relational, unfinished, multidirectional negotiations. In the light of this relational approach, mothering appears as actions or practices and as maternal thinking processes, to evoke Sara Ruddick's terms (2003). This understanding counters the narration of mothering as an identity project or as something stable governed by medicine, law, and patriarchy.

Finally, before I delve into the birth stories on mommyblogs, I wish to refer to the title "Cyber Labour" by explaining that blogging is a form of affective work, just as mothering is. This notion points toward the awareness that although blogging and mothering are practiced from the intimacy of the home, they are interconnected with capitalism and the transformations of work. Mommyblogging, therefore, becomes a doubly layered case of affective work: both maternal care work and blogging are such practices (Cleaf 13-14).

Mothering While Reading Birth Narratives

In the late spring of 2011, I was in my body with a heightened awareness and a sense of pain, panic, curious expectation, and confusion. Where would I find answers? Nothing in my life had prepared me for pregnancy, so I turned to the Internet, searched, and found mommyblogs. To fill the silence, the gaps, and the holes, I poured over birth stories and their detailed laments and celebrations of time were yet unknown to me. What I navigated toward was narratives discussing more than the practicalities of parenting or the products necessary for survival. I was looking for the mirroring of a consuming ambivalence—feelings that did not match the expected motherhood narratives. By going from one blog to another, spending time reading, following links and discovering more, I found different women negotiating their pasts, their

passions, and futures, as well as their professional identities, feminism, expectations, disappointments, mental health, illness, loss, and more. Although some passages echoed the commercial representations of proper mothering, others were ripping things up word by word—saying what had not been said before. During the months of pregnancy, mommyblogs became my companions. They were a source of hope, information, communication, ideas, fear, ideals, and more.

Narratives about mothering have proliferated exponentially in the last twenty years (Podnieks and O'Reilly 205). In the literature, this phenomenon has been termed "mommy lit," and it is part of "intensive mothering" or "new momism"—concepts that illustrate the turn into de-privatizing motherhood and the intense idealization of the role of the mother (Podnieks and O'Reilly 205). Hallie Palladino and Kim Owens see the proliferation of birth stories online as a sign that women want to regain authority on their birth giving bodies to become active agents in motherhood (Palladino 117; Owens 354). Certainly, mommyblogs have intensified and facilitated sharing publically what was previously a matter of the domestic private sphere (Rich 13), thus breaking the cultural boundaries. Mothers writing about motherhood has certainly become a phenomenon, but this also entails that there is a readership and a yearning for dialogue: mothers reading about motherhood while mothering. The proliferation of birth stories online means it is possible to find different kinds of narratives reflecting different experiences and circumstances of mothering. Another effect of reading online is that each reader views the content differently, depending on the technologies used (computers, browsers, and Internet service) and the practices of posting and reading. Because of the digital style of organizing stories on blogs and the unfinished quality of the subject (mothering), an encounter with a mommyblog is always "limited and incomplete" (Friedman 74). This quality leads to birth stories on mommyblogs appearing as reflexive, in flux, and open for interpretation and dialogue.

Kim Owens has studied online birth stories through interviewing women who have published online. She views birth stories online as remediations: "in writing their stories, women mediate their experiences, enabling an intercession between memory and expression. Beyond mediation on the emotional level, however, these stories also qualify as remediations in that they are reformulations of birth itself and of birth stories told in other forms, through other media" (353). Whereas Owens manages to approach the layeredness of narration online with the concept of remediation, I try to view birth stories on mommyblogs as even more cyclical and multidirectional. If remediation suggests transference of an experience into a story on another medium, I want to reflect on birth stories on mommyblogs as their own performances and creative narratives capable of influencing material practices and their interpretations. Therefore, the interplay between material and digital may be more complex.

My feelings toward giving birth were disappointed, fearful and endangered. I was in pain, in awe and thankful for Western medicine all at the same time. I had to come to terms with the chasm between my own expectations and the very different unfolding of events. Mine was not a home birth in NYC or a natural birth in a pool. Mine did not resemble anything I had planned, let alone the narratives on the mommyblogs I was reading. Narrative had been a saviour in my personal and professional life prior to becoming a mother and through pregnancy and labour in its aftermath. Still, after giving birth, I experienced time and space as something that was not aligning linearly. Despite this shift in experiencing reality (or maybe because of it), I yearned to know what was happening in other mothers' lives. I returned to reading mommyblogs soon after going from expectancy to mothering a newborn. I found expressions of the silences that often surrounded my intense sense of living. I found a sense of belonging, even when I was merely reading while swaddling a sleeping baby.

Becoming a Mother While Narrating

If considered from the perspective of maternal agency (O'Reilly 697-99), birth stories are a narrative gateway into becoming a (cyborg) mother and into the practices of mothering. With the concept of maternal agency, it is possible to work with the feminist ideas of agency underlining maternal particularities as empowering, rather than treating them as examples of institutional motherhood overpowering the agency of a mother. Regarding birth stories online, Kim Owens has argued that sharing birth stories publically has an agency strengthening effect (355). Although there is plenty of important criticism about the uses of agency, subjectivity, and autonomy in feminist theory and in conjunction with mothering (Diquinzio; Smith and Watson; Podnieks and O'Reilly), in this article, I am reading the mommyblog narratives with the concept of empowered maternal agency.

Much of the cultural narrative on birth focuses on the newborn child as the main outcome, but mommyblogs make a case for the birth of a mother. Birth stories describe a function of the body that is simultaneously presumed typical (biology and notions of naturalness) yet continues to appear miraculous—such as a stretching of the boundaries of knowledge (both everyday knowledge and ontology). Usually, they also describe various levels of interference with medical tools, technology, knowledge, and beliefs. Maternal agency becomes the focus of these narratives, as mommyblogger Bella Savransky shows in her post "On Self-Love":

> In giving birth to my children, I, in a way, gave birth to myself, and it has reshaped my life and empowered me as a woman in ways I never expected. When you experience your own body wax and wane, stretch, ache, and toil through pregnancy and childbirth, you can't help but realize what an incredibly magical creature you are.

Savransky says birth stories are about the transformation into a mother. They are a narration of a material and psychological change so substantial that subjectivity is totally renewed, questioned, and re-experienced. The mother-in-becoming has the power to narrate this transformation, yet, until recently, these narratives have not been present in literature or elsewhere in the public. Savransky's words also highlight the material embeddedness of birth narratives. The story recounts an intense embodied moment. The attraction is in the details: the kind of writing, the kind of birthing method, and the style of conveying emotion and elements of danger and/or surprise. Birth stories are written in a semistructured style, and they usually construct a linear narrative signposted by the events of birth. Narratives that describe a successful birth of a child usually start with early labour, and explain when, how, and where first contractions started; they narrate false starts and stops and then the full labour. *Cup of Jo* blogger Joanna Goddard's birth story "Our Birth Story" from September 2010 recounts the events of the evening and night when she gave birth to her first son. The post incorporates text and images. Mommyblog birth stories nearly always incorporate photographs as part of their narration, and the published photographs of the birth narrative are a crucial element in the mommyblog narration. Visual story telling often foregrounds ideals in the contemporary mommyblogging narration, creating juxtaposition and tension between text and image. Judith Lakämper identifies the visual material of social media and mommyblogs as part of the processes of "new individualism." This kind of individualism relies on the new identity technologies in which one has to constantly recreate the self "physically, psychologically and professionally" through image making in order to exist (Lakämper 82).

The photographs on Joanne's birth story have been taken with a nonprofessional camera by Alex, her partner, and include unfocused shots and selfies. The photographs show Joanne, Alex, and the newborn in different locations as the birthing progresses. The narrative remains humorous in tone, and details early labour, focusing on the pragmatics of getting from home to hospital in NYC in the middle of the night. Joanne explains how they make their way:

> Alex grabbed our hospital suitcase, and we headed downstairs to catch a cab. We laughed at how obvious the scene must have looked to passersby: It was 2 in the morning, and a harried guy holding one

> small suitcase was flagging a cab, while his enormously pregnant wife clutched her belly beside him. What else would we possibly be doing? ("Our Birth Story")

The author keeps thinking about how the couple's experience appears to outsiders; it makes points about interactions interspersed with jokes. There is a limited amount of pain or fear imagery. As labour progresses, the narrative turns into a more urgent account:

> "No," I insisted, "I have to push now. Like really, really have to push. Like, I have this crazy huge urge to push and I just have to do it. Would you mind getting the doctor right away?"
>
> I could tell that the nurse didn't really believe me, but after some convincing, she called the doctor. When the doctor arrived, she also doubted that I could have dilated so quickly. (After all, they were expecting me to labour all day, and it was only noon.) But when she checked me, her eyes popped.
>
> "Oh, Joanna, you're fully dilated!" she said. "It's go time!" ("Our Birth Story")

The post ends with tears and with the overwhelming surprise, happiness, and relief of labour gone right and finally meeting the baby. *Cup of Jo*'s birth story is easy to follow and easily relatable. The writer addresses her audience directly. Thousands of comments follow the post, which have accumulated over the years. They are mostly written by mothers waiting to give birth or remembering their own experiences.

I begin with the *Cup of Jo* birth story to show how certain aspects can easily turn into normative narratives. In its form faithfulness, this kind of narrative may contribute to narrowing the experiencing and expression of birth and to the style of telling a birth story, as it is also a post on a very popular blog. Hallie Palladino suggests that birth stories "reflect the extent of their author's acceptance of, resistance to, or ambivalence towards mainstream social norms." (109). Still, I propose this birth story is valuable for its informative and encouraging tone. The post is vulnerable and in tune with its audience. It is well written, and it conveys both analytical sentences and descriptions of the author's emotional responses to her experiences. Birth stories can create pressure, expectations, and unrealistic hopes. Yet they may also broaden understanding of the material limitations, challenges, and surprises relating to labour and the narratives of birth. Next I expand on what a mommyblog birth story can be by bringing forward narratives that question norms and negotiate difference.

Birth Stories against the Grain

Mommyblogs engage in a discourse that resists norms by narrating trauma, fear, disability, loss, illness, and death. May Friedman argues the following: "Mothers write mommyblogs in the context of dominant discourses of motherhood, but also in constant conversation with one another and with commenters. As a result, the mamasphere can be viewed as a dynamic organism, bound by discourses of motherhood yet constantly emerging to both obey and resist these discourses in dialogue" (81). Birth stories on mommyblogs are, therefore, also the narratives of miscarriages, birthing of stillborn babies, failing expectations, and encountering unexpected difficulties. These kinds of narratives further complicate claims that birth stories narrate the birth of a baby and mother. By refusing to remain silent, these narratives counter normative constructions of mothering.

While birth stories on mommyblogs can have a normalizing effect on birth practices via stylistic repetition, dissenting narratives of giving birth disrupt this kind of development. They crack the norm through stylistic conventions and most of all through the kinds of births they describe. These counter narratives proliferate because there is a heightened awareness among writers about norms and a written negotiation is a useful, and often the only possible way to argue against them and to make sense of different experiences. Friedman argues that "one of the key functions of the cyborg mamasphere is the capacity for non-normative mothers to find connections and to shed light on aspects of identity or parenting practice that are generally ignored" (87). Also, the relationality of mommyblogs––their discursive and unending qualities—contribute to the potentiality of counter narratives. The mamasphere allows for (and thrives through) the different stories. Through these differences and variations, mothers write themselves into active agents in various positions and argue against prescriptions narrating labour or a birth story.

Mothers write birth stories against the expectation of a natural birth—a popular term for giving birth without medicated pain relief at home instead of hospital (see, for example, *Ina May's Guide to Childbirth*, 2003)—but they also write countering and questioning the norms of ablebodiedness, whiteness, heterosexuality, and healthiness. Crucially, these narratives are also examples of maternal practice and thinking. Birth stories have also been written while in mourning for loss (for example, "March 7, 2016." *Blog a la Cart*) and against the idea that a birth story has new life as its outcome. These narratives counter the construction of labour as a story without loss, death, and disability. They also expand the concept of maternal thinking. Narratives of stillbirth for example call for the recognition of the loss of a child; they show that carrying and birthing are meaningful experiences of mothering worth telling (see for example "Noah's Birth Story").

My next example comes from *Wheelchair Mommy*. The blog's narration follows the mommyblog style through posting conventions and breaking norms by describing birthing with disability. The blog's author, Priscilla, is a mother of three, and lives in Austin, Texas. She has been a paraplegic since a spinal cord injury in 1999 and has been blogging since 2000. She started blogging to make sense of her accident and the sudden change of direction in her young life. Priscilla has written two birth stories on her blog. In "Will's Birth Story," Priscilla recounts her evening before a scheduled C-section. There are no images; paragraphs are short, and the text has some spelling mistakes, making it difficult to follow. Priscilla is writing at home, a week after delivery. She recounts hospital procedures such as a failed spinal injection, and describes how she had to deliver while under anesthesia. Her narrative is not very emotional, and its details are scarce. In "My 'Birth' Story," she narrates the difficult birth of her second child:

> Apparently my uterus ruptured and i had placenta previa. Which means I probably won't be having any more babies of my own. It seperated [sic] from … the area where my first scar was. But that explains the SEVERE pain I was in.
>
> I haven't talked to MY OB about it but his partner who started my section told DH that. We'll see. It's probably not worth it though, especially since we are very open to adoption if we go with #3.

The post is very short in comparison to usual birth stories. Priscilla writes from the hospital, while still feeling unwell. The writing is fragmented and, at times, incoherent, which makes it impossible to understand what has taken place. The immediacy of the events weighs on the narration and the lack of. The birth story of her third child does not appear on the blog, although the children continue to be a large part of the blog.

Wheelchair Mommy's narration shows two things: how birth stories appear as genre necessities on mommyblogs and how they can go against norms while simultaneously adhering to them. Birth story narratives appear on Priscilla's blog twice, as if almost an expected part of the kind of blog she is writing. She publishes so close to the difficult birth (the second time) that her health appears to affect the construction of the narrative. These birth stories do not actively negotiate with norms, nor are they artful literary creations. Instead, they lay bare traumatic events about medical and emotional entanglements; they appear almost as monologues (rather than an invitation for dialogue) addressing issues such as possible childlessness in the future. Still, these birth stories transmit the voice of a mother steeped in maternal thinking, who through her presence and openness about disability and difficult birth becomes empowered through using her voice.

To Tell or Not to Tell? Renegotiating Cyber Labour

The last two example posts critically reflect on the meaning of birth stories in relation to blogging and mothering. Sometimes, the reflexive qualities and relationality of mommyblogs manifest in posts that explain why a birth story is not going to be published, or how the affective relations to blogs as self-defined spaces change both in sharing and in the style of writing. In these examples, the double meaning of cyber labour becomes evident. Latonya Yvette and Savransky are bloggers who have written extensively over many years. They have taken different stances on blog sharing, communities, narrating birth stories, or talking about racism, class, or fear of illness.

Shortly after giving birth to her third child, Latonya Yvette posted "Home Again: Thoughts on blogging." She reflects on the stages between sharing about her previous pregnancy and miscarriage, then needing space and having concerns about overexposing her children while choosing to continue as a commercial blogger:

> And there we were, at my sister in-laws wedding, where we all catch up and all of my supportive and astonishingly loving family that I inherited met me with love about this space. My honesty, and how it truly is *my* space, and how seeing bits of River and my life through fashion was a favorite topic. Our natural birth and wether [sic] or not I would share more about how awesome it was to birth without fear also came up quite a few times as well. I felt myself talking with confidence and yearning for that feeling I once had when I shared here when it was just River, when I ignored the negativity. I found myself eating my words in reference to no longer sharing parts of my kid's lives on here (I mentioned completely cutting them out of the blog on Instagram and it became a comment frenzy. The picture was later deleted.) I truly felt bad for those of you who followed along with my loss and subsequent pregnancy, and the amazing birth of Oak. In that moment I felt as if I cheated you all. As if I was dishonest. I let you in and then shut you out once I got what I wanted, my baby. For that I'm sorry, that was never my intention. (emphasis in original).

In this post, Latonya redefines her relationship to her readers through discursive border making, conversation, and memoir, which Friedman has identified as "cyborg mamasphere techniques" (87). Latonya acknowledges the negotiating and becoming qualities of mommyblogging and social media presence, which threaten any possibility of a stable subjectivity and generate new positions for the narrator and readers. She engages the reading community directly, and mentions the bad feelings she feels regarding her choices about sharing about baby loss and then not sharing. Her post is relational and

regenerating: she negotiates the ties to the reading audience, her relatives at the wedding, and her children and partner at home. She is regenerative toward her subjectivity as the mommyblogger governing her space and her narrative. Still, while relying on and negotiating her maternal agency throughout the post, she refuses to give the audience the expected birth story.

If Latonya Yvette's post shows how the self is reconstructed through cyborg negotiation, then Savransky underlines the interplay between "mother/other and conversation/memoir" (Friedman 87). Bella Savransky has been an advocate for home birthing and the empowering aspects of becoming a mother. During the years of blogging, Bella's activity on the blog has varied, as have her takes on monetizing. Savransky's fluctuating online presence brings to light just how complicated a mommyblogger's relationship to blogging can be. She has written extensively on the identity work of being a mommyblogger. Still, the *Petite Biet* blog seems to serve the purpose of building a community and allowing for thinking through writing and developing professional skills, while the tensions remain unresolved.

In January 2016, Savransky returned to posting after a break. She reflects on the evolvement of her blog since she started by sharing her first birth story in 2010:

> I shared my birth story and for the first time, I was met with reactions that were empowering and accepting rather than judgmental or sceptical. Instead of giving me a look of bewilderment or taking two steps back when they heard that we'd birthed our baby at home, women were emailing me and asking "What was it like?" or chiming in, "Me too!". It was the very beginning of an online community. MY online community. It was a glittery little lifeboat filled with new friends, and it was raw and honest and uplifting. I became passionate about telling my stories, and motherhood began to make sense.
>
> The words flowed and the blog grew. Online friends became real life friends. With the birth of my son, I became a mother of two. My world, and my days, became more and more full. Then came sponsorships and social media, and the blogging fortress that I'd built and which rested so near and dear to my heart became my actual job. I was so grateful. But I watched as the online worlds of many writers slowly became bigger and more powerful than their real-life worlds. I watched as online personas and branding overtook individuality and authenticity. ("Impassioned: A Story of Becoming")

This fragment shows how birth stories have acted as a gateway into blogging, mothering, and finding a likeminded community; it makes explicit claims for using narrative as a tool to make sense of new life experiences as a mother. The post also speaks to the continual crossing of material and digital, and shows

how through various stages, mommyblogging has become problematic labour for the author and how she has grown critical of the mamasphere.

Cyber Notes

In this article, I have presented birth stories on mommyblogs as a threshold into cyborg mothering, narrating while mothering, and reading while mothering. I have done this with the concepts of maternal agency, maternal thinking, and practice, and by close reading blog posts. Through my personal narrative as a reading mother, I approached the reading of birth stories as another facet of becoming a cyborg mother who exists in liminal crossings between the digital and material expressions of mothering. Through autoethnography, I discovered the yearning and loneliness accompanying the expectant mother; these embodied affects are some of the layers leading toward mommyblogs.

Birth stories act as gateways into mothering and mommyblogging both for writers and readers. Although popular mommyblog birth stories are often normative and restricting, counter narratives and alternative birth stories are proliferating. These narratives resist and counter the following norms: ablebodiedness, health, heterosexuality and ideas of nuclear family, whiteness, and class. Birth stories show how the narration on mommyblogs is always taking place with awareness about existing expectations, medical lines of thought, norms, and their deviant interpretations. They are examples of maternal practice and the maternal thinking behind it (Ruddick).

Finally, online birth stories are an unprecedented source of data about giving birth from the labouring person's perspective. Hallie Palladino proposes that they offer an insight into not only practices, expectations, and lived experiences, but also social and cultural expectations (109). I add that these same forces influence the narration of the birth story. Therefore, I suggest a strong connection between the agency making power of life writing (Smith and Watson) and the proliferation of birth stories. To conclude, mommyblog birth stories are interwoven in multiple ongoing discourses on maternal subjectivity, digital agency, and relationality. These aspects require further research, as their significance is only beginning to be recognized.

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HAILE ESHE COLE

Reproduction on Display: Black Maternal Mortality and the Newest Case for National Action

This essay critically examines the growing international attention given to Black maternal and infant health outcomes in the United States, and couches it within Black feminist theories of womanhood and motherhood. Existing Black feminist literature has acknowledged the ways in which Black women from the era of slavery have served as the embodiment of inhumanity and the calculating baton in which to measure against the personification of white virtue, womanhood, and motherhood. Moreover, these works have also significantly contributed to contextualizing and historicizing this problematic conception of the pathological Black mother. This piece highlights the ways in which current media depictions recreate problematic narratives of Black motherhood and uses the example of Black maternal mortality in the United States to 1) highlight the centrality of Black motherhood and reproduction within the narratives of Black pathology; 2) address the "spectacular" nature and fascination with Black suffering and death; and 3) underline the ways in which narratives around Black maternal and infant health align ideologically with normalized conceptualizations of the pathological Black body.

In February 2011, billboards were erected around the country asserting that "The most dangerous place for a Black American child is in the womb." This campaign initiated in New York City by a Texas-based organization called Life Always was an antiabortion promotion highlighting the high rates of abortion in the African-American community. The Radiance Foundation, another Black prolife organization, also erected billboards with statements such as "Black Children are an Endangered Species" as part of their "Too Many Aborted" campaign. These groups, among other active national organizations identifying as a part of broader National Black Prolife Coalition, directly engaged in what Ashley Hall calls anti-Black abortion rhetoric: "an ideological position in which a person believes that Black women should not

receive abortions and furthermore, that abstaining from abortion promotes Black unity and ensures the survival of the Black community" (1).

Members of the National Black Prolife Coalition also maintain that abortion is a leading cause of Black death and that Planned Parenthood has been instrumental in targeting minority communities with genocidal abortion services. Although the group's position against Planned Parenthood is rooted in an accurate yet complicated history around eugenics,[1] the billboard campaigns were met with significant opposition from demographically diverse groups as well as Planned Parenthood supporters. Some of the campaign's most vocal critics highlighted connections to growing conservative and anti-choice legislation across the country as well as the co-optation of ideas of racial progress and civil rights to support their causes (Jesudason and Baruch). Instead of depicting a firm stance against eugenics and genocide, the organization's chosen messaging failed to adequately contextualize the issue of abortion and also unsuccessfully directed the blame onto Planned Parenthood clinics. I argue that the most salient and damaging rhetoric in the billboard campaigns is the idea that being in a Black woman's womb is equivalent to the kiss of death and that Black women are to blame for the deaths of their children. Although this is a more contemporary example, public messaging around the Black reproductive body and its employment as a rhetorical and political tool are not new. More specifically, the ideology of Black female culpability, both generally and directly in relation to the wellbeing of Black children and families, is also not a new phenomenon. In fact, the ideological roots of the pathological and nonredeemable Black mother run deep.

Black feminist theorists have acknowledged the ways in which Black women from the era of slavery have served as the embodiment of inhumanity and the calculating baton in which to measure against the personification of white virtue, womanhood, and motherhood (Spillers, "Interstices"; Roberts). Other works have significantly contributed to contextualizing and historicizing this problematic conception of the pathological Black mother (Roberts; Collins; et al Hartman; Berry; Glenn). Although the depiction of the billboards highlights the controversy around abortion, a widely debated issue among a diversity of people, Black women have been susceptible to the judgments about their mothering capabilities. These judgments and historically rooted ideologies perpetuate ideas around Black women's inability to access true and legitimate womanhood and motherhood.

Acknowledging this, the following piece seeks to examine the growing international attention to Black maternal and infant health disparities in the U.S. to 1) highlight the centrality of Black motherhood and reproduction within the narratives of Black pathology; 2) address the "spectacular" nature and fascination with Black suffering and death; and 3) underline the ways in

which narratives around Black maternal and infant health align ideologically with normalized conceptualizations of the pathological Black body.

Furthermore, Black inferiority, inhumanity, and pathology have historically contributed to key narratives around health, the body, and illness. Illness and death become normalized and inextricably linked to the diseased African/Black body, which became, according anthropologist Jean Comaroff, "an object of European speculation … 'Africans' personified suffering and degeneracy, their environment a hothouse of fever and affliction" (1). The historical legacy of Marion J. Sims evidences the ways in which scientific interest, experimentation, and exploitation of the Black reproductive body has also served as the basis for modern day knowledge of women's reproductive health and the foundation of the field of obstetrics as we know it. In this way, the contemporary maternal health crisis and the growing cognizance and research interest in deciphering Black maternal and reproductive health has interesting, yet discounted, connections to a treacherous legacy.

Spectacular! Spectacular! Black Maternal and Infant Mortality

In 2010, the Office of Disease Prevention and Health Promotion identified maternal and infant mortality as a key health issue, which was the year after Amnesty International identified and acknowledged in their groundbreaking report *Deadly Delivery* the problematic racial disparities existing in the United States around the issue of women's health and birth. Although the United States spends more than other high-income countries on healthcare, it ranks far below other countries in both maternal and infant mortality rates. Despite the global trend of falling rates of maternal mortality, the U.S. was one of the few wealthy nations to experience an increase in rates (Grady). When broken down by race, Black women experienced a maternal mortality rate of 40.4 deaths for every 100,000 live births between 2011 and 2013. This is compared to 12.1 for white women and 16.4 for women of other races (Center for Disease Control and Prevention). Said another way, Black women are almost four times more likely to die from a pregnancy-related complication than their white counterparts. Texas, my home and primary field site for ethnographic research over the last six years, has been identified as having the highest maternal mortality rate among Black American women not only in the United States but in the developed world (Hoffman).

Although there have been significant improvements in infant health outcomes across the nation when broken down by race and ethnicity, the data reveal again the glaring disparities (Office of Disease Prevention and Health Promotion). Consequently, a significant amount of interest and research has started to be directed at investigating and ultimately creating interventions and solutions around infant and maternal mortality. More specifically, there

has been a rallying cry around the immensely disparate mortality rates for Black women around the country. While these disparities do reflect an important problem that deserves and requires this conferred attention, the incentivized nature and monetary components attached to the issue carries the potential to become problematic.

In her book *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, Dorothy Roberts exposes the ways in which drug policies targeting and criminalizing poor and particularly Black pregnant women were promoted under the pretext of concern for the wellbeing of the fetus. Nevertheless, corresponding policies surrounding abortion as a criminal sanction undercut and disproved those deceptive rationales (Roberts). In a similar way, the contemporary urgency around elucidating the dilemma of Black maternal and infant death, I argue, has in many ways become a means of capitalizing on the spectacle of Black suffering and death. Specifically, it has become efficacious and newsworthy to center research and programming on Black mortality. This is not to say that research or the attention surrounding this issue is injurious in itself. Nevertheless, this phenomenon manages to inhabit the aperture that is both the consumption and capitalization on enactments of Black life and suffering. It depicts a salient modern day example of the ways in which Black suffering and death becomes "spectacular" and, even more disturbing, the ways in which abhorrence and enjoyment become affixed around Black suffering.

In one of my most memorable accounts during fieldwork and while working for a local health department, a local doctor and researcher, both white and male, repeatedly exclaimed while discussing the high and disparate infant mortality rates for Black infants, "What are we supposed to do about all of these dead Black babies!" Taken aback by this painfully disconnected and quite frankly insensitive interjection, I later realized that it reeked of what Saidiya Hartman labeled as voyeuristic fascination with and yet repulsion by exhibitions of sufferance where the "spectacular character of Black suffering" becomes an historical normality (3). Hartman references a number of critical examples including Frederick Douglass's account of the beating of Aunt Hester, the sorrowful procession to the auction block, and the performance of Blackface and minstrelsy. There are others, of course, such as the widely held practice of exhibiting the Black body in freak shows and zoos as evidenced in the legacy of P.T. Barnum,[2] for example, and Sarah Baartman's display as the Hottentot Venus.[3] In the end, the "drama of Black life" as Hartman calls, it has been sustained as a form of hypervisible entertainment (3).

Spectacle, the Black body, and medicine also have a disturbing lineage. Harriet Washington's work in *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (2008) provides a number of salient examples of the usage of the Black body to serve

the objectives of medical discovery. Marion J. Sims, Sarah Baartman's posthumous dissection, and the notorious story of Henrietta Lacks[4] all show how experimenting on the Black body as well as its public exhibition has been a cornerstone of medical history and practice. Jean Comaroff again is useful here in further depicting the inspection and exhibition of the Black, and in particular female, body:

> Like others before them, Cuvier and his editors focused on the exotic, simian qualities of the reproductive organs of black women, legitimating as medical inquiry their barely suppressed fascination with such torrid eroticism. Travelers … had also written in this vein of the "genital aberrations" of Bushman and Hottentot women, and Mungo Park, if in somewhat different idiom, had reduced Africa to the body of a black female yielding herself to white male discovery. (311)

Returning to Hartman's work, she importantly highlights the simultaneous existence of violence, repulsion, and pleasure in these acts. Drawing on *Black's Law Dictionary*, she states that enjoyment is "to have, possess, and use with satisfaction; to occupy or have the benefit of " (23). Enjoyment, then, is rooted in the satisfaction and acquisition of benefit, profit, and/or income. While Black women and communities stand to gain from the garnered attention around this important issue, public health agencies, researchers, and medical professionals, among others, potentially profit—be it research funding, prestige, or recognition—from their engagement with this issue.

During my time working in public health, in the community, and conducting fieldwork, I could see firsthand the ways in which these circumstances played out. Millions of dollars were dispersed to create programming for Black women. Millions, of course, that were oftentimes inaccessible to many community organizations unable to adhere to corporate and organizational standards of operation or prove their institutional stability. Programming was developed to address Black American women's health as Black staff functioned while overworked, underpaid, and suffering from the same social ills that their programming sought to resolve. Medical institutions, clinics, and providers reached out with purportedly benevolent aims, but were oftentimes unable to divest from problematic and oppressive practices alongside various other community-identified anti-Black comportments. In this way, Black women, in contrast to already powerful institutions, have yet to see much concretized benefit as a result of the newfound attention to the issue of Black maternal mortality.

Motherhood and the Black Reproductive Body

As espoused in the examples of the exhibition and abuse of Sarah Baartman or the violent castration and mutilation so pervasive in the "horrible exhibitions" that were lynchings, the sexual permutations of Black life and their intersections with the spectacle are historically evident (Hartman 1)., Frederick Douglass describes the beating and stripping down of his Aunt Hester as well as the experience of being "awakened at the dawn of day by the most heart-rending shrieks of an own aunt of mine, whom he used to tie up to a joist, and whip upon her naked back till she was literally covered with blood" (5). Contrastingly, the connections between Black suffering as a spectacle, constructions of enjoyment/benefit, and the Black reproductive body may be less evident. Fred Moten's work is useful here, as it expounds on the connection between spectacle/performance, value (or for my purposes profit), and the Black maternal and reproductive body. In his introduction to the book *In the Break: The Aesthetics of the Black Radical Tradition* (2003), he states the following:

> Enslavement—and the resistance to enslavement that is the performative essence of blackness (or, perhaps less controversially, the essence of Black performance) is a *being maternal* that is indistinguishable from a *being material*. But it is also to say something more. And here the issue of reproduction (the "natural" production of natural children) emerges right on time as it has to do not only with the question of slavery, blackness, performance, and the ensemble of their ontologies but also with a contradiction at the heart of the question of value in its relation to personhood that could be said to come into closer focus against the backdrop of the ensemble of motherhood, blackness, and the bridge between slavery and freedom. (emphasis in original, 16)

Moten pinpoints the Black maternal body as the prototypical embodiment of inherent contradictions of value, which underscores what he calls "the essence of Black performance." He illuminates both the state of value and nonvalue that occupies the person of enslaved laborer when he references Leopoldina Fortunati who states that "the individual contains value and non-value … the commodity is contained within the individual. The presence of the commodity within the individual is an effect of reproduction—a trace of maternity" (17).

Within this analysis is a recognition of the ways in which, given the history of African chattel slavery, Black bodies house economic paradoxes around value and nonvalue. I argue that this can also be said regarding the ideological, social, and, ultimately, political understandings around Blackness and is evidenced specifically in constructions of Black gendered bodies as asexual/

hypersexual, visible/invisible, and servile/aggressive. Moten's analysis reestablishes the ways in which the Black reproductive body is used as a pecuniary means to not only produce but also reproduce capital. Just as Moten locates the Black "being maternal" as a critical juncture where Blackness, spectacle, and value collide, the emergent attention to Black maternal and infant mortality has also revealed the confluence of these same matters.

Since the Black reproductive body more broadly and the "being maternal" can be articulated as a central component to the establishment and reproduction of a system of capital built on the value of Black gendered and racialized bodies, it follows that the Black reproductive body would also bear a significant brunt of the ideological encumbrance. In keeping with the idea of spectacle but returning to notions of the diseased and pathological Black body, I argue the Black gendered reproductive body—or more pointedly in this piece, the Black mother—continues to occupy, in many ways, the original site for Black pathology.

Daniel Patrick Moynihan's 1965 report, "The Negro Family: A Case for National Action," identifies the declining Black family as an important national issue. The report was received controversially and met with intensely contrasting viewpoints and interpretations. Notably, it was critiqued for applying a white and male-centric lens in its study and for blaming Black female heads of households for recreating a culture of poverty and transmitting pathological behaviours to their children in the home (Spillers, "Mamas"). Although the stated critique of the report does hold some weight, I argue that neither proponents nor critics of the report can deny the centrality of Black mothers in Moynihan's analysis of Black American poverty and decline. This is even with the report's attempt to include an historical and social examination in its analysis.

The above example, as well as the opening description of the billboard campaign, recreates and maintains historical conceptions of Black women as the primary culprits for the decline of the Black community. Looking at the latest dialogues surrounding Black women's reproduction, birth disparities, and mortality, I wonder how much the media and newfound attention to this issue is unfortunately one of many manifestations of Black reproduction on display. Moreover, the current narratives, though framed with concern and benevolent interest, still fall in line not only with historical narratives of blackness, disease, and illness but also with the illegitimacy and pathology of Black motherhood—spectacular and chaotic but also customary and unredeemable.

Conclusion: Getting to the Roots

Generally, prenatal care, education, socioeconomic status and financial barriers, behavioural risks such as smoking, and even social support have been considered as factors that can significantly contribute to maternal and infant health outcomes. In contrast to this more clinical and behavioural approach, there has been an interesting shift regarding the particular outcomes of Black women and infants. For example, studies have shown that even when controlling for education, socioeconomic factors, and behaviour, Black women still experience higher rates of preterm birth, low birth weight, and maternal and infant mortality (Carty et al.; Giscombé and Lobel; Hogue and Bremner; Rich-Edwards and Grizzard; Rosenthal and Lobel). In other words, when compared to a white woman with the same education level, income, access to care, and behavioral practices, a Black woman is still more likely to have negative birth outcomes. An article in the *New York Times* has asserted that even highly educated Black women with a higher socioeconomic status were more likely to have worse birth outcomes than a lower income teenage white mother (Reeves and Matthew). Given this, practitioner, providers, and researchers have investigated other mechanisms by which the disparity is manifesting. After eliminating education, income, behavior, and socioeconomic status, for example, race becomes an apparent "last man standing."

One of the groundbreaking and heavily cited theories regarding race and maternal health is designated as the "weathering hypothesis." This theory, coined by Arline Geronimous, proposes that the health of African-American women may begin to "deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage" and may affect their maternal and infant health outcomes. (207). A similar notion is described within the concept of the allostatic load, regarding mortality generally:

> The cumulative exposure to socioeconomic disadvantage and racism/discrimination could have detrimental effects on health that may lead to premature death (i.e., death for those younger than 65 years of age). This cumulative effect may influence alio static load, which is defined as the cumulative effect of physiological instability across systems from repeated adaptation to stressors. This, in turn, may disturb the release of certain biomarker substances in the body (i.e., epinephrine, dehydroepiandrosterone sulfate, and cortisol). These hormones may cause increases in blood pressure, cholesterol levels, glycated hemoglobin, C-reactive protein, and waist-hip ratio, among other health indicators. (Borrell et al. 811)

Stated another way, "weathering," and its counterpart the allostatic load, describes a process in which extreme and unrelenting experiences of stress

over the life course physically deteriorates the body, resulting in a number of physical ailments negatively affecting health. These concepts offer important insights into the systemic and structural impacts on health. It is also useful for depicting the ongoing onslaught of detrimental variables that can erode physical, mental, and emotional elements of health. They are also particularly useful when describing the accumulation and impact of stress in the lives of Black American women.

The impact of stress and the weathering process on pregnancy contributes to negative birth outcomes including low birth weight (Hogue and Vasquez; Geronimous; Rich-Edwards and Grizzard). Research has also found the following: 1) Black women are more likely to experience stressful life events (Dominguez et al. "Stress"; Lu and Chen); 2) socioeconomic conditions, societal/institutional structures and pressures, neighborhood, intimate partner relations, and experiences of prejudice and discrimination are some of the sources of stress for Black women (Holland et al.; Rich-Edwards and Grizzard; Rosenthal and Lobel); and 3) higher instances of perceived stress has been linked to instances of LBW. Most important in these findings is the linkage between stress and experiences of racism and discrimination, which were found to be associated with instances of low birth weight particularly when introduced at a younger age (Carty et al.; Dominguez et al. "Racial"; Giscombé and Lobel; Hogue and Bremner; Rich-Edwards and Grizzard; Rosenthal and Lobel).

Evaluating health by looking at social determinants and pinpointing racism as a key contributor is becoming the norm when examining maternal and infant health disparities. Yet I wonder if even those dialogues only pay lip service to the historic, social, and cultural conditions creating the problem. As research points to racism as the primary culprit for racially disparate health outcomes, the inability to disentangle racial oppression and its impacts on the Black reproductive body from what has been accepted and normalized undercuts our ability to call out and challenge the aberrant and egregious roots of Black illness and death.

Although stories about Black maternal and infant mortality rates are rapidly circulating throughout the media and public discourse, these depictions continue to present for public consumption the diseased Black body and broken Black mother that needs saving—an image that easily fits into the American psyche. On the other hand, Ida B. Wells, in speaking of rape, once said that "What becomes a crime deserving capital punishment when the tables are turned is a matter of small moment when the negro woman is the accusing party." (7) In considering again this issue of culpability and responsibility, what if instead, we shifted the focus and called out the perpetrator? What if instead of headlines reading "Black Women Are Dying" or "Childbirth Is Killing Black Women,"—the latter a recent CNN article

title (Howard)—we saw headlines beginning with "Racism Is Killing Black Women"? Although this is a statement that Black communities know all too well, I wonder whether this public countering and calling out could create a more pointed and hopefully impactful discomfort that removes the "being maternal" and replaces America, its history, and residual culture as the pathology—the unrelenting and fatal disease.

Endnotes

[1] Margaret Sanger, one the foremothers of Planned Parenthood clinics, was also a large advocate of the American eugenics movement.

[2] Although known for his political career and the creation of the Barnum and Bailey Circus show, P.T. Barnum's career included blackface and minstrelsy as well as the exhibition of "exotic" individuals. This included an aged slave woman name Joice Heth that he passed for 161 years old and Madame Abomah, the "African Giantess," to name only a few. Heth's body was publicly dissected after her death (Washington, "Hugh Jackman's").

[3] Sarah Baartman, also known as the Hottentot Venus, was an African slave brought to Europe and put on display in a freak show exhibit where spectators could observe her large buttocks and genitals. After death, her body was dissected and placed on display. Her organs and body remained in France until they were finally returned to her place of birth in 2002 (Parkinson).

[4] Henrietta Lacks was a Black American woman who died of cervical cancer in 1951. Cells taken from her body without her consent were used posthumously in studies that revolutionized scientific and medical research (Hassan).

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MARIANNE DELAPORTE

Curse to Co-creation: Religious Models of Labour Pain

Until the nineteenth century when labour pain became a technical problem to be solved, such pain was given religious meaning. Christian understandings of labour pain have long been based in interpretations of key Biblical texts, beginning with Genesis 3:16 and continuing with New Testament texts, which are understood to be commentary to this primary text. This article examines the four major spiritual models of labour pain that stem from these interpretations— curse of Eve, salvific, growth and perfectionist—and charts their rise and fall. The models are not distinct but intertwine and affect each other over time. The curse model—labour pain as punishment for Eve's disobedience—was not used on its own but was most often paired with the salvation model or growth model so that the punishment of Eve was healing or generative. Salvation and growth intertwine as well in some understandings, as a woman's spiritual and emotional growth lead to her active role in salvation history. The perfectionist model turns the curse model on its head, as it strives for a prelapsarian state in which women will not suffer the curse of Eve. Perfectionism in this sense is a belief that one can return, in this world, to a perfect union with God, a form of divinization. In conclusion, the four models are seen to have adapted to the secular transformation of pregnancy and labour, offering a potential model comingling pain and pleasure, spirit and body.

Until the advent of anaesthetics in the delivery room in the nineteenth century, labour pain was assumed and given religious meaning. Anaesthetics, and later psychoprophylaxis, however, complicated the question of labour pain. Pain became a psychological or physiological issue rather than a religious one. Alternative methods of birthing outside the medicalized model initiated new religious models, particularly a perfectionist model that claimed women could return to a prelapsarian state in which pain was not part of labour. This article examines the four major spiritual models of labour pain—curse of Eve,

salvific, growth, and perfectionist—in the Western Christian context, with the aim of understanding how these interpretations intertwine and alter over time.

The medicalization of childbirth in the nineteenth century has been studied in depth, and I will not linger upon it here. Religious voices of the day did not fight much to keep the religious meaning of birth. The Catholic Church itself rejected the religious aspect of birth as it put in place prohibitions against sisters in nursing orders and grew suspicious of midwives, which left the field open to the secularizing influence of the medical profession (Martin). Protestants equally turned birth over to doctors and hospitals. The language of pain changed as it secularized; it was seen as a treatable dysfunction and a technical problem to be solved.

Curse of Eve

> "To the woman he said
> 'I will greatly increase your pangs in childbearing;
> in pain you will bring forth children.'"
> Genesis 3:16 (NRSV)

Western Christian understandings of pain in childbirth are tied primarily to readings of Genesis 3:16. This passage has been commonly understood to explain pain during birth as payment for original sin—Eve's punishment for disobeying God. Since Eve led Adam into sin, it was judged that her punishment would be worse than his, which was toiling in the fields ("cursed is the ground because of you / In toil you shall eat of it all the days of your life" [Genesis 3:17]). However, Biblical scholars have noted that the above translation of Genesis 3:16 is problematic. A better translation might be "I will greatly increase your toils and pregnancies / Along with travail shall you beget children" (Meyers 105 and 108). In this translation, the pain is not physical but psychological, and the suffering refers not to the act of childbirth itself but to the whole range of childbearing, from conception through parenting. This is the pain referred to throughout the Bible when the term "*issabon*" is used—one which Iaian Provan notes may also include economic hardship and worry. Biblical scholars have accepted this wider interpretation of Genesis, yet in popular belief, the pain of labour continues to be understood as payment for sin. Although the "Eve's curse" interpretation may seem purely negative at first glance, the punitive model has the advantage of removing guilt and fear of the afterlife. Pain is seen as just and retributive (Glucklich 17).

Throughout Western Christianity until the nineteenth century, most women accepted labour pains as part of Eve's curse, but added other, more positive, interpretations to this. Motherhood in the Early Church and Middle Ages

was centred on two characteristics: suffering and nurturing. The suffering was the ongoing emotional pain throughout the life of a mother, just as the above Biblical commentators emphasize. Pain in childbirth was not excluded, however, and the traditional curse interpretation of Genesis 3:16 is reflected in the medieval understanding of Mary's birthing Christ. Jesus's birth echoes the first birth, Eve from Adam; both are supernatural, painless and leave no mark. Jerome (420 CE), John Chrysostom (407 CE) and others believed that Mary did not suffer in childbirth because she was free of the original sin, which they read into Genesis 3:16. All other women must submit to this punishment, and in submitting, they can purify their souls.

It is indicative of the strength of the curse model that when Dr. James Simpson introduced chloroform into the delivery room in 1846, he felt the need to answer religious critics with his own interpretations of the Bible; he traded in the word "sorrow" in Genesis 3:16 for "labour" as we have seen done previously. Dr. Simpson published a pamphlet in 1847 on the subject of religious objections to chloroform, but no real debate ensued (Shoepflin). As the understanding of labour pain changed in the nineteenth century, the curse model has largely disappeared (Corretti and Desai 2018). Christian authors bring it up only to dismiss it. One Christian midwife I interviewed dismissed the interpretation to her clients; she replaced it with one of opportunity to trust in God and strengthen that relationship.

Salvific

> "When a woman is in labour, she has pain, because her hour has come. But when her child is born, she no longer remembers the anguish because of the joy of having brought a human being into the world." (John 16:21)

Labour pains can be understood as punitive and healing simultaneously, as we see with the mixing of Eve's curse and the salvation motif. Ariel Glucklich notes the following: "In religious literature, pain that is conceptualized as a problem (punishment) is experienced as a decentralizing threat to the telic center (ego). In contrast, pain that is conceptualized as a solution (medicine) assumes a higher telos than ego and is centralized or reinforced by the sacrifice of the ego" (61). Creative co-suffering with Christ, often linked to the John passage above, was a way for women to experience their labour pain as a solution. The salvation motif mixed the language of Eve's curse with co-suffering with Christ, as in this seventeenth century French prayer:

> In my confinement, strengthen my heart to endure the pains that come therewith, and let me accept them as the consequence of your judgment upon our sex, for the sin of the first woman. In view of that curse … may I suffer the cruelest pangs with joy, and may I join them with the suffering of your Son upon the cross … If it is your will that I die in my confinement, may I adore it, bless it and submit to it (qtd, in Gélis 155).

While many women related directly to Christ in his patient suffering for others, others related to Mary as a mother in pain. The fourteenth-century mystic, Birgitta of Sweden, experienced pain through multiple pregnancies and births, which she describes in her *Revelations*. In one mystical vision, in which she is granted the wish of seeing Mary give birth, Birgitta emphasizes the painlessness of the birth, and Mary reassures her of this. Even though Mary did not feel pain in childbirth, she relates Christ's death to that very pain, telling Birgitta: "I was like a woman giving birth who shakes in every limb of her body after delivery. Although she can scarcely breathe due to pain, she still rejoices inwardly as much as she can because she knows the child she has given birth to will never return to the same painful ordeal he has just left" (Book 7:21).

Mary may not have suffered in labour, but she understands the pain as she shared it in Christ's death, when she became the mother of salvation. This theology is not new to Birgitta; it is found as early as Rupert of Deutz (1135 CE). In one thirteenth-century English poem, Christ on the cross explicitly tells his mother that "now at last you must learn / what pain they suffer who bear children" (qtd in. Neff 268). Women, thus, could identify with Mary's birthing pains at the crucifixion, relying on Mary's understanding of their pain, and pray to her for an easy labour. Mary's birth pains at the crucifixion could then be linked to women identifying their own labour pains with Christ on the cross so that they share with him a role in salvation through suffering.

Over time, the curse motif was largely replaced with this salvific one. In the twentieth century, Catholic theology struggled with the meaning of labour pain in light of modern medicine. The curse of Eve argument was rejected and replaced with arguments reinforcing the role of mothers in the home and elevating their sacrifice. In a 1956 address on the subject of natural childbirth, Pope Pius XII argued for the benefits of psychoprophylaxis—a method of preparing women psychologically for anaesthetic-free labour. He tackled Genesis directly and argued that God did not forbid "mothers to make use of means which render childbirth easier and less painful" (44). He also distanced himself from the perfectionist position by noting that some pain was inevitable. The pope reminded his audience that suffering is not always negative and that mothers can "show that suffering can be a source of good, if she bears it with God and in obedience to His will." The meaning of suffering is not spelled out

here, but it is linked to the suffering of Christ and great heroes. That pain can have positive meaning is in line with a theology of vicarious or expiatory suffering which flourished between World War I and Vatican II council (1918-1962). This theology was popular in France and the United States, as theologians and mystics, in particular victim souls, struggled with the meaning of pain in light of the tragedies of the World Wars and growing scientific explanations for pain. The victim souls, who were believed to have been chosen by God to suffer terrible physical pain in order to save others' souls, were largely women. Women could offer up suffering, whether in illness or labour, as part of their nurturing roles.

The salvific motif has been problematized as sadomasochistic and antifeminist, yet it continues in many Christian circles. A new iteration of this motif is the co-creation motif. As women suffer in labour, they create with the suffering Christ, and birth a graced, divinized humanity (Cullinan 103). In less explicitly salvific language, women repeatedly speak of co-creating with God or of feeling at one with the creative powers of the universe.

Growth

> "Yet she will be saved through childbearing,
> provided they continue in faith and love and
> holiness, with modesty." (1 Timothy 2:15)

This confusing and pseudepigraphal Pauline text is one of the early references to Genesis 3. It is used to argue for salvific or expiatory pain, but it can also be used to argue for the growth model. There are three major interpretations of this text: theological (salvific), figurative, and physical (growth). In the theological or salvific interpretation, women are saved through childbearing and other maternal activity. The author of the pastoral epistles expands upon Genesis so that childbirth is not only punishment but also part of women's redemption—based on a vision of the world in which their activities are relegated to the household and centred on childbearing (Solevag). Related to this is the figurative interpretation: Mary has saved us through birthing Christ. This interpretation is found in Ambrose of Milan (397 CE) (Reuling 89), although it is considered a stretch by most Biblical scholars, as the rest of the passage pertains to actual women's activities. Christopher Hudson understands the passage to concern ethical growth, and relates it to Jewish commandments surrounding birth. I Timothy is a parallel call to gentile women to test their righteousness during this time of danger (406). This last interpretation can be linked to that of John Chrysostom for whom labour pain was a source of potential spiritual growth: to educate (Reuling 2006, 156).

Puritan authors also used pregnancy and birth as a metaphor for conversion

and growth in faith. Actual labour followed suit. In his 1710 sermon on pregnancy and childbirth, Cotton Mather, the great Puritan minister, emphasized the moral value of pregnancy and labour: "for your *preparation for Death* is the Most Reasonable and Most Seasonable thing to which you must Apply your self" (emphasis in original, Christy 6). Although he referred to Eve's sin, his major emphasis when it came to labour pains was shared suffering with Christ, acceptance of God's will, and spiritual education: "bear Afflictions and Abasements, with a CHRIST-like Patience, and are Crucified unto the World...Then you have a CHRIST formed in you" (emphasis in original, Christy 6). For Mather, pregnancy and the pain of labour are a form of spiritual exercise that a woman must take full advantage of, as they allow her to grow in faith in God, to focus on doing good, and to prepare for death.

This understanding of pain continued into the modern era and was an argument against medication. One gynecologist in 1872 argued that "this baptism of pain and privation has regenerated the individual's whole nature … by chastening made but a little lower than the angels" (qtd. in Pernick 47). Today, there is little discussion of labour preparing one for death, yet the pain of labour is still often linked to growth. Catherine Niven and Tricia Murphy-Black note that the consequences of recalling labour pain are beneficial for women in the vast majority of cases; they teach them coping strategies, increase their confidence, and give them a feeling of pride and a sense of achievement (251). Pamela Klassen, in her interviews with home-birthing mothers, shows that pain "is often invested with the power to grant women understanding of their gods, their intimate relationships, and themselves" (78). Often these women speak of growth in relationship to creation, God, and their partners through experiencing labour pain.

Perfectionism

> Painless child-bearing is a physiological problem;
> and 'the curse' has never born upon the woman whose
> life has been in strict accord with the laws of life.
> (Stanton, The Woman's Bible)

Attend any childbirth preparation class in any hospital today and the major point of the course will be pain management. Yet outside of the medical establishment, not everyone agrees that pain is part of birth. Women speak of orgasmic births. One Christian midwife I interviewed asserted that the feeling is more like an anxiety attack than pain, and Ina May Gaskin famously quipped: "Think of it as an interesting sensation that requires all of your attention" (*Spiritual Midwifery* 43). This understanding that labour pain is unnnatural is part of the perfectionist model of labour pain. Proponents of

this motif use Genesis but can also turn to Galatians 3:13—"Christ redeemed us from the curse of the law by becoming a curse for us" (Klassen 81-82)—in their arguments for pleasurable birth.

In the nineteenth century, many natural healing advocates in the United States and abroad used the language of nature rather than God to argue that childbirth should not be painful if a woman had lived a natural, healthy life. Preaching a form of perfectionism, these practitioners flipped the curse motif on its head: pain is a form of punishment, but the cause is civilization or the particular woman's habits. Yet perfectionism offered hope—it is possible to return to the prelapsarian state and to move to divinization if one acts and thinks in the proper manner (Pernick 52). The suffragist Elizabeth Cady Stanton favoured natural healing, and in her 1898 commentary on Timothy, she gives a perfectionist position: childbirth is not meant to be painful, she says; pain is the result of not living according to natural law.

In the mid-twentieth century, a new movement called "psychoprophylaxis," or "natural childbirth," continued this perfectionist argument; it claimed that if women educated themselves they would not need anaesthetics during labour. Grantly Dick-Read, an English physician, was the most spiritually inclined of the natural childbirth advocates, and, thus, the most tuned to perfectionism. He was not a true perfectionist, however, since he sometimes saw the need for a doctor to intervene. Dick-Read argued that pain is rooted in fear and that doctors could soothe and calm a woman out of her fear of pain and out of pain itself. It is culture and civilization, including the Bible, that make women assume they must suffer. In a Rousseauian passage, Dick-Read cites watching an Indigenous woman give birth with ease before moving on with her work. The image of the "primitive woman" in the early United States served different purposes for different authors. As Richard Wertz and Dorothy Wertz point out, this image could be used by men to imply that civilization had "unsexed" women, making them aggressive and unfeminine and that their natural role was one of domesticity and passivity—roles promising a less painful birth (113-14). Women, on the other hand, often used the image to symbolize purity and pride. Stanton once exclaimed "Am I not almost a savage?" after a relatively painless labour (qtd. in Caton 122).

Wertz and Wertz call Dick-Read's text the most religious work on childbirth since Cotton Mather's sermon on Elizabeth. Dick-Read combined arguments about biology and nature with essentialist arguments focusing on childbirth as the spiritual fulfillment in women's lives. Childbirth should be pleasurable—a spiritual experience as well as a physical achievement. His writings emphasize that birth is a "spiritual manifestations of the underlying forces of her existence" and a "physical manifestation of a spiritual experience" (123 and 107). This language made him particularly popular with Catholics, as he brought social value back to childbirth, using psychological and biological

terms to reinforce the theology.

The perfectionist model was strengthened in the 1970s with the arrival of *Spiritual Midwifery*, a foundational home birthing text written by Ina May Gaskin and the other midwives of The Farm, a religious commune in Tennessee. Gaskin's understanding of pain stems from Dick-Read, from her experience as a midwife, and from the religious beliefs of the commune. Just as doctors had named the pains of labour "contractions" to distance women from the pain, Gaskin renamed them "rushes"—a term that "describes better how to flow with the birthing energy" (*Spiritual Midwifery* 19). The term "rushes" is linked to "what a rush!" which is slang for an exciting, mind-altering experience; thus, the language of pain or stress was replaced with that of a mystical, pleasurable experience. An integral part of the rewriting of childbirth was this emphasis on the ecstasy of birth. As one woman, Cara, said "It felt ecstatic. Everything that happened in my body felt really natural" (qtd. in Gaskin, *Spiritual Midwifery* 37) (See Delaporte 2018 for more detailed discussion of The Farm's theology of birth).

The Farmies, as the commune dwellers were called, embedded Christian beliefs into their religious system, but their understanding of suffering was opposed to the traditional Christian understandings of maternity. Suffering was not a sign of good motherhood, or a way to be granted prestige by society; rather, it was a sign of weakness and, more importantly, of ego. If one lets go of one's' ego, ones let go of pain. Nonmedicalized childbirth was seen as heroic and spiritual but not because it was considered painful or because the birthing mother was a sort of selfless martyr or sacrifice. Instead, the birth process was seen as a locus of pleasure. Unlike prior authors—who had acknowledged the sexual aspect of childbirth but had attempted to protect women from its confusion—Ina May embraced this connection. One Farmie recounts the following: "at the start of a heavy contraction, I found his [her husband's] mouth. We French kissed. Whew! Here comes another! We kissed again, from the start to the finish of the contraction…. I was testing the midwives' adage: 'It's that loving, sexy vibe that puts the baby in there in the first place, and the same loving, sexy vibe will get the baby out' (qtd. in Gaskin, *Spiritual Midwiery,*186). Gaskin's later work addressed the possibility of orgasmic birth directly, as women narrated their orgasmic birth stories. One mother, Margaret, links orgasmic birth to the mystical: "I had a cosmic union orgasm, a bliss-enhanced state. In a way, this has had a permanent effect" (qtd. in Gaskin, *Ina May's Guide* 158). Orgasm, here, is not hedonistic or self-centred; rather, it has long-term effects on couples and the woman's relationship to the world.

The Farm's theology also included the Buddhist belief that suffering is simply wrong thinking. Since all people are linked together in an energy web, this wrong thinking affects those around us. Gaskin's quip—"Don't think of

it as pain. Think of it as an interesting sensation that requires all your attention"—reflects this belief in pain as wrong thinking which affects others as well as the self.

Gaskin's theology of childbirth pain was part of a larger perfectionist tendency on The Farm. Although the theology and rules changed over time, there was an underlying belief in the perfectibility of human nature, as evidenced by the period when Farmies stopped wearing glasses, believing they could perfect their sight through proper thought. This experiment ended rather quickly as Farmies stumbled around, but is indicative of their perfectionist underpinnings.

Perfectionism moved the locus of blame for pain from the universal image of Eve to the individual woman while it offered a possible utopian future in which birth would not only be painless but a source of spiritual enlightenment for the whole community. Although Gaskin's work has been tremendously influential, her understanding of pain is still in the minority. Perfectionist interpretations of labour pains continue with discussions of pleasurable and orgasmic births, although they are now largely nuanced to emphasize the malleability between pleasure and pain.

Conclusion

This brief journey through Christian interpretations of labour pain indicates a movement toward an understanding of pain centred not on passive stoicism, individual pleasure (the orgasmic birth for the sake of orgasm), or a secular-medical fear of pain, but on a growing awareness that labour pain, with its particular waves and its proximity to pleasure, is a prime location for co-creation and growth. This model links pain not only to individual growth but also to the potential for growth in the community and cosmos. Although the new interpretation is generally no longer fully perfectionist, it is touched by utopian possibilities—that is, a private moment can have a wider impact on society or even the cosmos. The use of the Biblical texts noted with each model reinforces this greater meaning of pain to move and create. As the curse model has receded, the phantoms of Eden and Eve have not. Embedded into the perfectionist model is the hope for a return to a renewed relationship with God, a possibility of "*tikkun olam*"(improving the world in Jewish theology) or a co-creation of sorts. The salvific model, in which women suffer actively with Christ or Mary, gives the route to this return to wholeness. Finally, the growth model is expanded through this theological lens to include the maturing of the woman herself to become a force for healing growth in the world. Pain and pleasure, the body and the soul, are integrated into one narrative about birth and spiritual renewal—the body is the site for a microcosm of salvation history from Eden to human divinization with Christ.

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NANÉ JORDAN

Placental Thinking for Mother-Centred Birth

This essay forwards the notion of "mother-centred" birth by engaging with contemporary placenta practices in a North American context, as grown from the revival of midwifery-based care. As a midwifery advocate and birth scholar, I want to reevaluate "birth" as a central category for social philosophy and human thriving. I want to see respectful, compassionate care for mothers' wellbeing and quality of experience become central to the birth-giving and postpartum period. Enacting social philosophy through placental thinking, I extend the literal and metaphoric power of placentas toward the empowerment of mothers. Placentas have a tree-like structure and relational design that is a literal and metaphorical tree of life—nourishing roots that gestate the earliest gifts of mothering. Placental thinking for mother-centred birth considers mothers to be at the centre of birth, and seeks to empower mothers by highlighting the importance of the lived qualities of mothers' birth and postpartum experiences.

I love placentas. But I was not looking for them in my early years of birth work. Yet the placenta—that amazing blood-pie born soon after baby is from its mother—has a stage of labour all its own. As a birth keeper and once apprentice midwife, I support sacred, humane birth practices for women, babies, and families. As a midwifery advocate and birth scholar, the placenta has patiently called out to me to listen to and learn from its many gifts—if only I, and others, will listen.

I am truly inspired by the placenta and what it does to nourish and support new life. Once seen as the left overs of birth through medical procedures, the placenta is having its day, as more and more mothers, midwives, families, birth workers, and others are connecting to its wisdom ways (Jordan). Across North America and elsewhere, placentas are being reclaimed after birth by mothers and families through such practices as burial planting, ceremony, lotus birth, encapsulation, and other forms of therapeutic use. The placenta

and umbilical cord are perhaps our first sacred tree of life, as the placenta nourishes the baby in utero from the mother until birth. With its treelike design, the placenta is symbolically connected to extended networks of life on Mother Earth, upon which we depend for ongoing nourishment after birth. I love the placenta for being a body-, birth-, and earth-based metaphor for relationship, communication, and interconnection. Placentas highlight the centrality of body knowledge in modern societies that are loosing connection to the "birthy" mother fabric of our earthy origins.

Treelike, Relational Design

The round, cakelike shape of the placenta has a mother and a baby side. The mother's side appears brainlike with intersecting lobes attaching to the inside of the mother's womb/uterus during pregnancy. The baby's side holds the umbilical cord and extends into a long, winding tree trunk anchoring the floating baby in utero. Babies are the fruits and flowers on this human tree of life. The cord, or trunk, connects the baby's life force to rooted networks of blood vessels in the placental mass, which look exactly like tree roots. These vessel roots reach into the nourishing soil or life force of the mother. Capillaries in the placental mass diffuse all necessary nutrients, oxygen, and wastes between mother and baby while maintaining the separate vascular and circulatory systems of each. The bodies of mother and baby are, thus, completely unique, yet they are bound to the other through the placenta's relational design.

This amazing placental morphology is the first human experience of relationship. Thinking on it all, I am drawn into the poetic mysteries of our maternal origins—mysteries of birth and gifts of life itself. Throughout my years of teaching about midwifery and mother-centred birth, I found that reconnecting people to the wonders of placental design holds a compelling thread to the primacy of birth-based origins, bringing awareness to the maternal roots of our lives. With its rich blood-red, rooted, treelike design, the placenta embodies the necessity of nourishing relationships—as the birth rite (and rights) of our lives.

Mother-Centred Birth

In thinking about placentas and birth, I extend the oft-used term "woman-centred birth" to "mother-centred birth" in order to acknowledge mothers themselves. I want to highlight mothering as a central facet of human existence that supports the regeneration and development of human culture and society at large. Biological, cultural, and social wellbeing surely begins at birth and in the qualities of both the mother's and baby's experience during the precious,

intimate early moments of giving birth and being born. The qualities of sensation and feeling of birth are central to mother's and baby's experience at this intense, transformative time of life. "Sensation" means "being of the senses," and is related to sensual, embodied experience. Thus, concern for positive qualities of sensual experience is true for mother and baby and, by extension, for partners and families into which the new mother-baby unit is born. Mother-centred birth extends relational, respectful, and empathic care and guidance toward mothers giving birth; the mother's experience is considered central to the birth process itself. Mothers are thus empowered to give birth from the powers of their bodies and from their holistic self-capacities of mind, emotions, and spirit as they navigate the sensations of pain, pressure, relief, or ecstasy of birth giving. Mothers are at the centre, and are cared for and held by those around them.

Midwives have long been considered to be "with woman" in this regard, where "with" denotes coming alongside the mother as a sacred, whole person. The midwife can be a knowledgeable companion to the mother's experience, rather then acting to control, manipulate, or abuse her body and birth giving. The literature on midwifery (Gaskin; Koehler; Johnson and Daviss) demonstrates how women are highly satisfied with the wellbeing midwives provide during and after birth. Midwifery is, thus, a central component of care for mother-centred birth.

I myself was an avid student of the lay midwifery movement in Canada since attending a homebirth in 1980s Toronto. The word "lay" denoted North American midwives who practised homebirth midwifery since at least the 1970s onward. Without legal status, lay midwives—those brave feminist foremothers of the social movement for woman-centred, caring, and positive birth experience—trained themselves in the art and science of midwifery through various means (Gaskin). This included studying obstetrical texts, working with doctors, travelling to birth clinics, apprenticing with experienced midwives, and learning from birth itself. Having grown alongside the women's rights movement and witnessing the overmedicalization of birth with its often paternalistic control of women's bodies (van Teijlingen et al.) midwifery as a social movement restored natural, physiologic, low-tech birth giving to mothers and families at home and in clinic where possible.

As a mother-centred philosophy of care, midwifery supports mothers' powers, rights, choices and self-sufficiency, and honours mothers themselves as the keepers of birth. Pregnancy and birth-giving are understood to be normal life-cycle events that can be experienced in positive, life-affirming ways. I became an early promoter of midwifery, home and natural childbirth, and the amazing physiology of birth. I witnessed the courage of mothers, and the empowering, transformative and even ecstatic and spiritual potentials of birth giving (Buckley; Young). Currently, a new generation of legal,

professional Canadian midwives appears to be as dedicated to these early values of midwifery as their foremothers. These midwives will continue to inspire, I hope, ongoing shifts in social policy and to restore understanding of the centrality of mothers and birth giving to human life and culture. I aim to continue to explore how midwifery can impact social philosophy, while increasing positive, love-centred qualities for early human experience. I believe we can become a more socially just and loving world by empowering the rights, agency, and experiences of mothers themselves and by restoring awe, honour, and "joyousness" (Yoshimura) to the life-giving power of birth.

In the early days of lay midwifery, North American mothers and midwives were recovering from intervention-focused, paternalistic, and hierarchical limitations of the medical system, including the mistreatment of women giving birth (Arms). One limitation—realized after critiquing the overuse of episiotomies, the lithotomy position (lying on the back), and the strapping of mothers' limbs—was the lack of connection between birthing mothers and their babies' placentas. In hospitals, standard practice was, and still is, to cut the umbilical cord quickly. Once born, the placenta is often removed from mother and baby only to be disposed. Many mothers may not be aware of how this bloody-looking organ was an integral part of the growth of their own baby. The placenta as a physical and meaningful aspect of pregnancy and birth is still undervalued within the medicalization of birth.

As theorized by anthropologist Robbie David-Floyd, birth practices are a form of ritual. Ritual can be any action or sociocultural practice that establishes and regulates human thoughts, materials, or services. In this case, the medical ritual quickly disconnects mothers and babies after birth from each other, and from placentas. Yet in the midwifery and homebirth movement, mothers and midwives have rediscovered and learned about placentas; they have given value to this venerable organ of gestation and birth.

As a young midwife's assistant, I became used to handling placentas after birth, when new mothers had time to look at and learn about their babies' placentas. I especially remember the first time I saw a placenta up close, when a midwife mentor brought one from a recent birth in all its blood-red glory. I peered curiously at its bright red form, and through close instruction, I began to discern the placenta's shape and function. I was soon in awe of its sacred design, as many mothers are when they learn about placentas for themselves. The placenta is like a grand communicator; placenta and umbilical cord define the paradox of connection and separation of two bodies. The placenta facilitates a continual dialogue of blood nourishment from mother to baby. Thus, our first language is truly one of maternal nourishment, where resources flow from mother to child in an abundant mother stream, which ensures the baby's growth and survival.

Attending to placentas and cords during and after birth was an outgrowth

of grassroots midwifery and homebirth practices. Midwives and mothers followed body wisdom in allowing birth to unfold—reclaiming what I now call "mother-centred" healing traditions in which mothers are respected and honoured as life givers. Women's knowledge and respect for birth itself has been invariably lost, hidden, or suppressed especially in Western societies through patriarchy. Disconnection from, and dishonouring of, actual female- and birth-based origins has become the norm, which has culminated in "disrespectful and abusive care during childbirth" worldwide (Bohren et al. 3; WHO), including "obstetrical violence" that can result in "birth trauma" (Alcorn; Creedy). Trauma is experienced by mothers who have been hurt, mistreated, or submitted to medical procedures they are powerless to stop during birth giving. The historical effects of the European witch hunts on midwifery, women's healing practices, and wisdom (Spretnak), the colonization and oppression of Indigenous cultures and birthing traditions (Shiva), and the medicalization of birth (van Teijlingen et al.) have all greatly limited how modern society understands and approaches care for women's sexual and reproductive health, bodies, and birth itself.

Thus, it is imperative to expand understanding and social philosophy from birth-based perspectives. Birth is a truly missing facet of the Western philosophical tradition, which has been dominated by hierarchical male-centred thinking that does not take birth experience into account. Birth and birth giving have been devalued and accorded low status as if birth giving were not connected to social, cultural, and spiritual production (O'Brien). As maternal philosopher Sarah Ruddick contends, "It is necessary for feminist philosophers to tell the story of birth again, reconnecting the work of mothering to the female labour in which it begins" (197). As a foundational experience for all of human life, I believe that revisioning birth in mother-centred ways provides socially transformative values. This is not about essentializing women as birth givers only, but recentring mothers to restore and re-story the power of birth for mothers' social meaning and leadership.

Placenta Practices

Much of what I learned in those lay midwifery years has flowered into mother-centred practices and uses of placentas—including not cutting the cord until it has stopped pulsing so that all of the baby's blood flows from the placenta back to its own body, also known as "placental transfusion" (Garnaoui). Not cutting the cord too soon also means mothers and babies stay connected to each other, as they truly belong together after birth. Key to mother-centred birth is keeping the baby in the mother's arms, which means not whisking the baby to the other side of the room away from the mother. The mother-baby, who are a "dyad" (a body of two), can then take these precious early moments to feel and

discover each other earthside, as the mother's hormones of love prevail. After the placenta is born, mothers are given time to see its form up close and to understand its function. They may choose to keep the placenta and later bury it—perhaps under a tree, in a yard, or somewhere close to where the baby was born. Families can create rituals and ceremonies with the placenta; they can give thanks for this gift of life. Placenta planting and ceremonies are filled with individual and cultural meanings highlighting the deep significance of birth and all mothers' gifting of life (Chawla; Burns; Mann).

Another use for placentas is to prepare, cook, or dry them for consumption by the mother (Link-Troen; Myers; Wood), just as many mammals consume placentas after birth. Placentas are hormone and nutrient rich so that consumption is thought to support mothers' vitality and to ease postpartum depression; across North America placentas are now anecdotally known to have these therapeutic values during the challenges of early mothering and beyond (Enning; Selander). Drying the placenta and making capsules from it—known as "placental encapsulation"—is one such consumption practice. Placenta consumption, also called "placentophagy," is being researched to better understand maternal uses, risks, benefits, and outcomes. Daniel Benyshek et al. found no adverse neonatal outcomes from mothers' placenta consumption. But they did not provide evidence of this practice alleviating mothers' postpartum depression, and suggested that maternity care providers discuss with mothers the full "range of options available" to prevent and treat postpartum depression (1). Further studies of placentophagy found incremental benefits for mothers regarding increased mood, hormonal levels, and less fatigue as compared to placebo groups, but there were no "robust differences" (Young et al.), so more research is warranted.

Placenta encapsulation has been developed in North America with a focus on pills, yet other methods exist. I have heard of the preparation of a special placenta broth for mothers by midwives in a region of China, as well as having cooked safely stored placenta myself for mothers in the hours and days after birth. German midwife Cornelia Enning recommends making a homeopathic "mother tincture" of placenta for the baby to use in future life to treat various ailments (46). It seems it is the stem calls in the placenta (and umbilical cord blood) that contribute to the healing magic of placentas as a regenerative medicine (Parolini). Concerning placenta uses and remedies, I caution that practices be done safely through the desire of the mother herself in consultation with experienced caregivers.

Other mother-centred practices focus on keeping the umbilical cord, which is the original thread of life and a potent energetic metaphor of placental relations. Mothers can keep their babies' umbilical cords and then dry them in spiral or other shapes. The cord takes days or weeks to shrink in size, and can become a sacred keepsake for mothers and children as life goes on. There is

also the "lotus birth" practice, in which mothers keep the baby, cord, and placenta intact for several days until the cord naturally dries up and falls away from the baby's belly button. Lotus birth allows the placenta to be released in its own time; it is thought to be gentle and peaceful for the baby (Lim).

There are also placenta prints to make, which involve printing each side of the placenta directly onto white paper and leaving blood outlines as inky keepsakes on the page. Of course, there are many more cultural placenta practices, histories, and stories to tell and rediscover at home and worldwide. I love how placenta uses, ceremonies, remedies, stories, and art nourish mothers' and babies' wellbeing, honour mothers' birth giving, and celebrate the arrival of new life. My aim for placental thinking is not to point to one placenta use or practice over another; rather, I highlight that through caring about placentas and finding meaning in their uses for mothers and babies, placentas become acknowledged for their life-giving and metaphoric value in and beyond the birth room. The social-, spiritual-, and meaning-based significance of placental relations between mother and baby are hard to measure through quantitative or clinical research studies alone. The ways in which placentas are being revealed and revalued show how mother-centred birth can transform mothers' individual lives and increase social wellbeing for all. I see mother-centred birth as deeply connected to the placental gift of our collective maternal roots.

Placental Thinking

The idea of "placental thinking" makes a creative nod toward philosopher Sara Ruddick's *Maternal Thinking*.[1] Maternal thinking recognizes the compelling practical and intellectual work of mothering; it is social act in which "daily, mothers think out strategies of protection, nurturance, and training" (23). Ruddick acknowledges how the powers of mothers' minds and actions nourish children's growth and safety. Maternal thinking dispels the notion that motherhood is only biologically determined or some kind of instinctual occupation. In relation to this, placental thinking creatively forwards placentas as being of great value beyond purely biological notions of birth, which is meant to empower mothers and the work they do. Placental thinking extends the metaphor of placentas alongside mother-centred birth and birth-based social philosophies—understanding mothers to be social and cultural creators at every step. As such, birth giving is an act of profound agency and wisdom, a key moment of human endeavour.

Through placental thinking, we can imagine the heartbeat of the primal mother-baby dyad expressed through placental relations. In current medical practice, placentas are literally thrown out after birth. If garbage is "refuse," then placentas are refused. Placentas are considered to be medical blood waste

and incinerated as such. Yet throwing out placentas may be an amplified metaphor of our social understandings of the maternal gift of life as being literally worthless. This is especially so in the context of mothers not knowing about, or having access to, their babies' placentas after birth. The association of birth blood as garbage is equally related to the taboos and shame associated with menstrual blood in Western cultures (Grahn). Rather than honouring the sacred function of the female body's life-giving powers, mainstream North American culture prefers displaying human violence and war in the media and movies. In contrast, the mother blood of life and birth is left unseen and unacknowledged. But this life blood can be reclaimed and celebrated for its creative, primal powers (Wood).

Separation rituals at birth, as with too early umbilical cord clamping and cutting—and removing the baby from its mother at the moment of birth—disrupt intimate processes of mother-baby bonding. These kinds of procedures interrupt the physiological and oxytocin hormonal peak of a mother's key experience of relief and even pleasure in the moments after her baby's birth, which are an integral part of early bonding (Buckley). Keeping the umbilical cord intact means the baby must be left attached to the mother, in her arms or on her chest, where the mother can connect with, hold, touch, feel, see, smell, hear, and talk to her newborn. This sense-based contact allows the mother and baby time to explore each other after birth; it also gives the placenta its direct hormonal signal to be born through the sensuality of mother-baby contact. Protecting the sensual nature of birth is surely placental thinking.

Additionally, directing kind, respectful, and compassionate attention toward birthing mothers is a component of placental thinking for mother-centred birth, which is a common philosophy and practice of midwives and doulas. But this need not be only so, as birth attendants everywhere can adopt a kind and respectful attitude toward mothers—including the ability and commitment to support, focus upon, listen to, and empathize with mothers. In a diagrammatic perspective, this form of care looks like a circle, where supportive caregivers hold space for the mother who is at the care circle's centre. Within this holistic birth circle, the mother can retain and direct her own energies for giving birth, physical and psychic, to herself and her baby. She has the birth power; she is the birth power with her baby—held in trusting relationships with her attendants, who direct their energies toward her as needed. Attendants in this birth circle have the ability to step back completely if unneeded. They can let themselves be invisible rather than command the centre of attention.

Attendants who demand mothers' energies for themselves often drain the life force from mothers. Birth giving is obviously very physical, but like running a marathon, giving birth is deeply mindful as the mother moves her consciousness inwards to focus on the huge task at hand. In authoritarian and

hierarchical systems of birth care, the birth energy is directed up and away from the mother and baby, as attendants often take "charge" of the birth. This is not a circle of care, but an appropriation of birth power so that birth-giving agency is delivered away from the mother. It is as if attendants were giving birth and not the mother. Attention focuses on the birth attendants themselves or on the machines working to keep track of mothers' progress. Attendants then dictate directions for birth experience by implementing their expertise and interventions, perhaps without regard to the mothers' wishes or even in communication with them. Mothers can end up feeling depleted and traumatized from giving birth under systems that appropriate their birth powers without regard for the quality and centrality of their experiences.

Although medical interventions are useful when absolutely needed, the mode of their delivery can get complicated by authoritarian and paternalistic (rather than "matristic," meaning "of the mother") practices of care. A fear of death exists, at times, during birth to contend with, and modern medicine has developed some useful techniques to deal with birth emergencies. Yet authoritative birth systems have often lost knowledge about or experience with low-tech, mother-centred birth—how to be with mothers and their birthing powers at the centre of birth giving. It is most often midwives and doulas who have experience with the long hours of mothers' natural labours from working at home and in community settings.

In placental thinking for mother-centred birth, mothers can feel safe to surrender into their own birth-giving processes, however this unfolds for them. As mothers navigate intense sensations, they exude a unique hormonal cocktail—an energy generated by mother and baby. This energy can instill a sense of grace in all attending the birth of a baby. Thus, placental thinking is enacted in holistic, empowered models of mother-centred birth, which value mothers' integrity, feelings, sensuality and wellbeing. Mothers are ideally educated about and prepared for the intense realities of birth giving, and have access to compassionate caregivers who can help them navigate birth terrain. At home, or in the clinic, birth centre, or hospital, mother-centred birth seems always advisable, no matter the interventions or procedures needed. This form of care involves a socially just, culturally informed, and mother-honouring attitude, and depends on the people, philosophies, and practices in various places. Placental thinking moves beyond patriarchal, authoritarian, and abusive practices of birth care toward valuing mothers and the experiential gifts of birth and life.

Thus, by reclaiming placentas, I hope to transform understandings of birth and to return birth-giving power to mothers themselves. Placental thinking acknowledges the arts, science, and understandings of birth arising from birth-based social and midwifery movements, from mothers' direct birth-giving experiences, and from the wisdom embodied in humans being born.

We would not be here without the ages of birthing relations that have come before us. Placental thinking speaks to the fundamental necessity of caring well for mothers—those who carry human regeneration. I feel gratitude toward the humble placenta, as I behold its nourishing roots of life that gestate the earliest gifts of mothering. I honour this sacred gift of life born from so many mothers, and I reclaim mother-centred birth from our collective placental roots.

Endnote

[1] Ideas about placental thinking and mother-centred birth are also developed in the context of the maternal gift economy in my book chapter entitled, "Placental Thinking: The Gift of Maternal Roots," from my edited anthology *Placenta Wit: Mother Stories, Rituals, and Research*, Demeter Press, 2017.

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BRIDGET BOLAND

Lost and Found

"Lost and Found" explores themes related to miscarriage and the loss of a pregnancy. My husband and I were elated when I became pregnant quickly and easily. That elation turned to despair when I woke on April Fools' Day to what felt like a cruel joke: I was bleeding at ten-weeks gestation. A sonogram confirmed that the fetus had no heartbeat.

I went home and miscarried naturally, without having a dilation and curettage (D&C). We had shared our happy news with family and some friends. Reactions to the miscarriage ranged from helpful support to trite assurances that we could try again. One friend sent a packet of seeds to plant in memory of the baby we'd lost. My mother-in-law, a writer, suggested I see the pregnancy I'd lost as a throwaway "first draft."

Overcome with grief, I first used food to numb my pain. Healing finally came from an encounter with another pregnant mother who had also been through several miscarriages. Her support and shared experience allowed me the opportunity to work through my grief.

I turned to tools I'd learned from my yoga practice and my therapist. I created a safe space in which to express my feelings as I hit a pillow with a tennis racket. This somatic expression allowed me to process my emotions instead of sugarcoating them.

Despite the pain of my miscarriage, our story had a happy ending when I conceived again, and later gave birth to a healthy baby boy.

After several months of trying to make a baby, my husband and I were elated to see a definitive blue line in the pregnancy test window one bright February morning. We were going to be parents! We were excited about realizing this dream and starting our family. My labour began in a typical way, with cramping and some mild spotting. But the timing was off. Way off. I woke on Sunday 1 April, and went to use the bathroom. Dark red blood bloomed on the toilet paper. I wiped a second time. More blood. I went back to bed. As

soon as I lay down, the cramps started. They came on slowly but built steadily over the next several hours. I got up to use the bathroom a second time. Blood again. More than the first time. Brighter red.

Timing is everything. Had they come six months later, these signs might have set off a thrill of eager anticipation that we would soon meet the child I'd been carrying inside me for over nine months. But I was only twelve-weeks pregnant. Instead of delight, terror coursed through me, along with the painful awareness that I was powerless to stop whatever might happen next.

It seemed a cruel April Fools' joke to lose my child on such a vibrant spring day. I went into shock, disbelief, and denial. Around 8:30 a.m. my husband woke up. The cramping was still intermittent, the bleeding light. I didn't mention the ominous symptoms. We dressed and got in the car to go to church. When he asked if I wanted to stop for coffee on the way, I snapped at him that we didn't have time. He recoiled from my harsh tone, and then asked if I was in a bad mood. I wanted him to know what was happening, but I resented that he couldn't just see how terribly wrong everything was. I resented having to say out loud that I was losing our baby. I fervently hoped that if I ignored my body's signs to the contrary, the baby would be fine.

I withdrew deeper into myself as the day went on, fitfully sleeping for a few hours until the contractions grew more insistent. Our first sonogram had been scheduled for the following morning. Around 4:00 a.m., I woke up with a yelp. My startled husband reached a reassuring arm out, mumbled, "Do you need anything?", then rolled over, and started snoring again. I lurched doubled-over to the bathroom, panting in an effort to manage the searing pain gripping my belly. When I called the midwife she said I should come in for my scheduled appointment so they could take a look, although she was pretty sure I was miscarrying.

"There's the uterus," the sonographer pointed to the image on the screen when we arrived for our appointment. "And at the bottom there, that's the fetus.

"And… no heartbeat."

All my life I've wrangled with words. "Button your lip!" my father bellowed when one of us kids talked back**.** I learned early on how to choke down what I felt, putting on a good front for survival's sake. But words took on a stark new importance when I miscarried, beginning with my plea to the bean of a baby growing inside me: please stay.

Even the word "fetus" took on a heightened importance: up until the twelfth week of pregnancy, the baby is called an "embryo." It graduates to fetus status at the twelfth week, making it feel a larger loss to miscarry then.

There was nothing the midwife could do, other than counsel me about letting the baby pass naturally or seeing my obstetrician for a D&C—a therapeutic gynecological procedure used to clear the uterine lining after

miscarriage. I opted to let nature take its course. By the time we arrived back home, I was moaning and rocking in the passenger seat of the car. My insides howled, and my mind was wracked with a different but equally awful pain.

Throughout the morning as my body expelled blood and tissue, I sat on my birth ball breathing through the contractions. I rested when I could, and walked or moved on the ball when the pain got too intense to endure lying down.

I insisted that my husband go to work; there was nothing he could do to make me feel better, and I wanted to be alone. By late afternoon, the bleeding and cramping had eased again. It was still there, but not as urgent as earlier. I felt antsy. I didn't want to sleep, and I couldn't sit still.

A bag of maternity clothing I had bought just a few days ago caught my eye. Another pain ripped through me, this one in my heart. The clothes had to go. I grabbed the bag and headed downtown. I was anxious. The pent up energy of my grief fuelled a kind of manic need to keep moving.

I walked into the maternity store, hoping to return the clothing and get out as quickly as possible. But the sweet salesclerk who had helped me pick out the numerous items I had purchased was at the register again. She remembered me, called me by name, and asked how I was doing. When I explained what had happened and why I was back, her smile melted and tears ran down her cheeks. I hastened her through the return, and averted my gaze from the pity in her eyes.

I walked out of the store clutching the return receipt. I felt so still inside. But emotions rumbled beneath that veneer of quiet. They threatened to erupt if I allowed them. I should have gone home, should have taken to my bed and wailed for my loss. Instead, I reverted to a coping behaviour that had gotten me through my childhood. I drove to the nearest Dairy Queen and ordered the largest malt on the menu. Twenty-one ounces of chocolate sugarcoated every bit of sadness and loss until I couldn't have felt it if I'd wanted to.

I'd started stuffing my fear about miscarrying two days earlier, as if on some unconscious level I'd already known the baby was dead. I'd been walking home from the grocery store when a friend drove by. She stopped the car then jumped out and walked over to me; a big grin lighted up her face.

"Guess what?" she asked coyly.

I guessed at her news immediately: she was pregnant, too. They were expecting their second child in October.

"Our kids will be playmates." She grinned again.

I was thrilled for her, but an ominous thought scuttled through my mind: *Too bad my baby won't be alive.*

I pushed the unsettling thought out of my mind and walked the rest of the way home. The eerie premonition didn't return that night, but when I got home, I did an odd thing. I walked into the kitchen, pulled open the refrigerator

door, and removed a quarter of a carrot cake left over from a dinner party we'd had earlier in the week. I removed the plastic lid, grabbed a fork, and stood at the kitchen counter shovelling forkfuls of cake into my mouth until it was all gone. I recall wondering vaguely why I felt compelled to eat the entire thing when I wasn't even hungry. I seemed to be in a trance. I couldn't get the fork from the platter to my mouth fast enough.

The next morning, I'd started miscarrying.

The words of my writing teacher at the University of Chicago rang in my ears over the next days as my body continued to expel my hopes and dreams of being a mommy along with the "products of conception," a ghastly way to refer to a baby. My grandmother had passed away while I was in school, and I'd never forgotten my professor's instruction when I requested permission to miss class to attend the funeral. "Take notes," she'd directed. "Take lots and lots of notes."

I'd found her suggestion crass at the time, as if observing the events of my beloved grandmother's funeral and burial would lessen my participation in mourning. But after my miscarriage, I found comfort in my teacher's wisdom. If I didn't write down what was happening, there was a possibility I would eventually forget—perhaps not the miscarriage itself, but the nuggets of valuable insights I was meant to glean and hold onto after the pain of the loss subsided.

The words of others also felt imbued with heightened value, like my playwright mother-in-law's feeble attempt to remind me that we could try to get pregnant again soon. "Consider it a first draft, a throw-away." She'd meant well, but this was far from a balm to my sorrows.

My own mother's words were disturbing for different reasons. After offering placating platitudes slightly less offensive than those of my mother-in-law's, she went on to remind me that she had endured two miscarriages in the midst of carrying five healthy children to term.

"Do you remember?" she prodded. "You had to go down and get me a container to put the parts in during the first one."

I remembered all too well that initiation into womanhood the summer I turned twelve. It had made me dread getting my period, a rite of passage that prior to her miscarriage I'd been anxiously awaiting. What I didn't point out to my mother was that she had misrepresented herself. Her second "miscarriage" was an elective abortion my father and a doctor had talked her into due to her advanced age and an increased risk of having a child with Down syndrome. I hadn't known the truth at the time she underwent the abortion, only that my mother went to the doctor's office one afternoon then came home and took to her bed for nearly six months. Some years later, she confided in me about the source of the depression that had led her into a dark hole full of anxiety attacks and agoraphobia, which left my father, siblings, and me floundering in the

habits and routines of running the household my mother had abdicated.

I didn't have the emotional strength during my miscarriage to call my mother out on her subterfuge about the abortion. Her ability to shapeshift the truth to meet some standard of acceptability in her mind infuriated and panicked me. Had she not sworn me to secrecy when she divulged her abortion to me, I might not have taken on her mixed emotions of shame and longing, emotions that led me to terminate my own surprise pregnancy in my twenties.

For most of my early life, I had no strong sense of self-identity. I knew who I was expected to be—who my parents, siblings, teachers and friends saw me as —but I moved through the world amorphous as an amoeba, in constant undulation to meet the expectations of those around me. I was the good daughter, the oldest child; to my father, I was his "big girl." I'd been standing in for my mother, playing the role of an adult, since childhood. All along, I'd been holding my breath and waiting for the day when someone would see through me and call me out as the fake I sensed I was deep inside.

After my miscarriage, I had no time or inclination for making nice or acting as someone I wasn't to make others comfortable. When my siblings called to encourage me, one more cheerful and upbeat than the next, I answered their phone messages with a group email telling them that if they couldn't be comfortable with my sadness they should not call again. I needed time. I needed to grieve.

The miscarriage had occurred just before my husband and I were to travel to my in-laws' for Easter—being away from home offered a distraction from the loss. For nearly five days, I acted as though everything was fine, nearly convincing myself that was the truth. No one brought up what had happened or asked how I was doing, for which I felt not angry but relieved.

But back at home the Monday morning after our trip, an earthquake of sorrow rumbled deep in my pelvis. There was an achy full feeling around my left ovary, as if something was lodged up against it. Although the pain was physical, I felt certain the source was emotional.

I went to teach a prenatal yoga class, something I normally loved but now felt like a cruel slap in the face by the hand of Fate. My facade held up pretty well in class. I moved into competent, professional teacher mode when I entered the studio. My students knew I was pregnant—or had been—but no one asked how I was feeling, and I made it through the class with my composure intact. We were gathering our things to leave when Callie, a sweet, out-to-here-pregnant blonde, turned toward me and unwittingly chirped, "So did you get to see the baby on the sonogram? How many weeks along are you?"

Five first-time moms turned toward me expectantly. They were always eager to share in one another's good news, and my pregnancy had elevated my status from teacher to the ranks of the initiated.

I choked out the news that I'd miscarried the week before. Some girls looked away, fearful that my misfortune might be contagious. A few gasped with shock and dismay as they ran their hands reassuringly over their protruding abdomens. But Callie lumbered as quickly as she could across the room, swept me into her arms, and held on like she would never let me go. The nearly full-term baby in her belly made it impossible for us to get close, but she did her best to pull me into a fierce mama bear hug. I wanted so badly to melt into the warmth of her embrace, but if I had started crying, I might never have stopped. Callie whispered in my ear that she had endured two miscarriages. She knew it hurt so bad you just wanted to die.

Finally, here was someone brave enough to speak to the pain I felt. I wanted to wail in Callie's arms while she rocked me gently back and forth. I didn't give in to that instinct, though. I wrenched myself away from her, mumbled senseless words of thanks for her compassion, and fled the studio. But I knew what I had to do. I had to give my grief a voice.

I went home on a mission. No more overeating. No more sugar. No more pretending I was okay. It was time to face the sorrow threatening to drown me. I'd been practising bioenergetics—a psychotherapeutic modality that works with the body and mind to resolve emotional issues and create more pleasure and joy. Down went the yoga mat with a chair on top of it, a pillow on the seat of the chair. I picked up a tennis racket and a small wooden dowel, preparing myself like a surgeon before an operation. I was doing a kind of healing, an excision. I rolled my feet on the dowel to open up my body the way my dear therapist had taught me, and leaned all my weight into the sole of the foot on the wooden rod until the pain was so sharp it brought the tears I hadn't been able to cry since the sonogram.

I rolled my hips as if I had an invisible hula hoop around my middle to awaken the remaining energy of the miscarriage lingering in my pelvis. I shut the windows and drew the drapes. The last thing I needed was the neighbours calling the police over the noise I was about to make. At last I was ready. I raised the racket up over my head and brought it down onto the pillow as hard as I could. The stuck feeling around my left ovary unclogged. Something drained out—grief. Black and gooey, toxic as tar if left unchecked. The wail that burst forth from me was primitive and raw, the sound of a wounded animal keening. Over and over for the better part of an hour, I raised and lowered the racket onto the pillow until my arms ached and my throat was raw from weeping.

Afterward I rested on the couch, more peaceful than I'd felt in weeks. I was empty but clear, open again. I'd lost my baby but found my voice. I could feel something more than anger and sorrow again. It felt safe to hold great expectations for a happy future.

Postscript

Although my miscarriage was a painful loss, the way I dealt with my grief made the experience much cleaner. The sadness didn't linger long. For the first time, I chose to feel my feelings and express them instead of covering them up or numbing them with food. For a few weeks after I did the bioenergetics exercises, I poked gingerly at the memory of the miscarriage the way one probes the tongue into the hole of a missing tooth to see if the nerve is still raw and throbbing. But each time I went after the memory, I felt only a sense of closure. The miscarriage had happened, and I was sad, but it wasn't going to take over my life or ruin the deeper sense of happiness that was my foundation. The loss brought with it a tremendous lesson about the value of grieving, and how it ultimately allows us to let go with grace.

Three and a half months later, my husband and I learned that I was pregnant again. Fearful that I would miscarry a second time, I used the fourteen weeks of early pregnancy to sit with my mixed feelings of delight and terror, to learn how to hold steady in all the uncertainty arising when there is simply nothing left to do but wait and hope. Our beautiful son Liam was born in our home on 29 April 2008.

NOREEN ANNE CAULEY

Trauma and Mothering: An Autoethnography

Sexual violence and mothering are prevalent events in women's lives. However, they are not often studied together from a feminist perspective. This essay uses autoethnography to explore the parallels between sexual violence and mothering. Specifically, this essay examines the medical models of trauma and childbirth, Maushart's "mask of motherhood," rape myths, patriarchal mothering, and empowered mothering. I argue that more vigorous interrogations of the commonalities and differences of mothering and rape will open strategic avenues for female growth, learning, and empowerment.

Sexual violence and motherhood are at first glance strange bedfellows. However, given that for women the statistical probability of experiencing sexual violence and becoming a mother is high, their intersections warrant attention. Estimates indicate that one in three Canadian women will experience sexual assault in their adult life (Statistics Canada, *Measuring Violence* 24). Additionally, a 2017 report compiled by Statistics Canada calculated that in 2011, more than 9.8 million women in Canada were mothers ("Mother's Day"). Thus, trauma and mothering are potential, underresearched, allies. I believe more vigorous interrogations of the commonalities and differences between mothering and rape will open strategic avenues for female growth, learning, and empowerment. As I emphasize the relationship between mothering and sexual violence, my hopes are two-fold—that this article be a site of healing for sexual assault survivors and mothers and that this article encourage discussion and connection within the worlds of trauma, pregnancy, and childbirth

Trauma's medical model obfuscates the importance of community in the healing journey. Although society acknowledges that sexual abuse damages an individual, there is rarely an accompanying societal responsibility reflected in actual community support. Similarly, lip service is paid to the importance

of mothers, although medical models of pregnancy, by design, disempower mothers. Nor are mothers supported under patriarchal assertions of ideal motherhood. In fact, myths of motherhood resemble myths of the perfect rape victim. Both silence women.

Rape, sexual violence, and motherhood are feminized, even though not all survivors of rape and/or sexual abuse are women and not all women are mothers. I do not support the gender binary, nor do I support the essentialization of motherhood and femininity. However, as Donna Haraway suggests in her *Cyborg Manifesto*, I will speak of "affinity". Haraway argued that feminists should create coalitions based on affinities rather than identity. As feminization enforces "extreme vulnerability" on people (Haraway 38), I argue both motherhood and rape render a person vulnerable. Thus, an association between motherhood and rape survivors need not be based solely in their gender categorization; rather, it can be based on a recognition—an affinity—of the similarities between these two life experiences and vulnerabilities creates possibilities for allyship.

Sara Ruddick argues against the essentialization of mothering and instead positions mothering as a disciplined, intellectually-driven endeavour (96-97). The essentialization of motherhood diminishes the labour that goes into mothering; it relegates this work to an instinct or to a "natural ability" that women inherently possess. This devalues mothering. Similarly, society often feminizes crimes such as rape and sexual abuse in order to dismiss and/or ignore them (Herman 30). The overlap between seemingly disparate topics—motherhood typically associated with joy and rape typically associated with terror—presents potential for healing through the creation of strong support systems. These are communities that seek to empower mothers and survivors and to dispute harmful myths surrounding motherhood and trauma.

Pregnancy and childbirth can be empowering, embodied experiences. Yet these experiences can also isolate women. The medicalization of childbirth, lack of agency, and myths of ideal mothers and the perfect childbirth enforce the social exclusion of mothers (Block; O'Reilly, "Labour Signs"). The absence of support systems, narratives of the "perfect" victim, and medical models of trauma can cause similar isolation and shame to a survivor of sexual trauma, and can severely limit the survivor's ability to heal and thrive. Nevertheless, healing from sexual abuse as well as from pregnancy and childbirth are potentially transformative sources of strength.

1. Trauma

My abuse occurred throughout my early teenager years. As Judith Herman notes,

> adolescent girls are particularly vulnerable to the trauma of rape. The experience of terror and disempowerment during adolescence effectively compromises the three normal adaptive tasks of this stage of life: the formation of identity, the gradual separation from the family of origin, and the exploration of a wider social world. (61)

Many of my symptoms—self-harm, an eating disorder, intrusive flashbacks, disruptions of consciousness, and nightmares—are typical of trauma survivors. Yet the plethora of medical professionals I saw through my later teen years and into my early-to-mid-twenties rarely broached trauma as a possibility for these symptoms. I was ignored when I mentioned suspicions of rape. Instead, an array of pharmaceuticals was prescribed.

Initially, medication kept me afloat. My first prescription helped me cope when I entered a hospital treatment program for eating disorders (ED). The prescription helped. It made eating more tolerable by decreasing obsessive thoughts around food. I benefitted from the hospital's cognitive-behavioural therapy (CBT). After nine weeks in the hospital, I re-entered the world. I had a strong support system. I recovered from ED with the help of my family, friends, therapy, and medication. All of these softened the emotional edge around food preparation and meal times.

Unfortunately, pharmaceuticals concurrently facilitated a disconnect with myself. My mind felt dull, swathed in cotton, and slow like molasses. I loved the first few weeks—a mind free from ED-associated thoughts—but I hated that as the initial relief faded away, my razor-sharp mental speed also vanished. Bessel Van Der Kolk noticed similar effects in military veterans "the powerful drugs we prescribed often left the men in such a fog that they could barely function" (19). Enmeshed in cyclical, inescapable struggle, I would take medication for weeks and months on end. I rode a roller-coaster of feeling better and feeling worse. Stop the medication, feel better then feel worse. Start, stop, ad nauseam.

All the while, as I continued recovering from ED, I noticed something lurking in the back of my mind. I voiced these concerns to my psychiatrist (who specialized in ED treatment), but he ignored me and instead redirected the focus to maintaining my weight gain. Flashbacks began to haunt me; my doctor ignored this and merely prescribed more medication.

Van Der Kolk suggests widespread prescription of pharmaceuticals to treat posttraumatic stress disorder may "in the end have done as much harm as good…. In many places drugs have displaced therapy and enabled patients to

suppress their problems without addressing the underlying issues" (36). I know from experience that posttraumatic stress does not exist "all in one's head" and that "the symptoms have their origin in the entire body's response to the original trauma" (11). Attempting to locate mental illness "primarily by chemical imbalances in the brain that can be corrected by specific drugs" (Van Der Kolk 35) has overshadowed fundamental aspects of trauma. Pharmaceuticals are helpful. However, when they mask, suppress, and silence trauma's pain—absent the discussion of medication as a strategy for the survivor to navigate trauma—their prescription becomes complicit in the dismissal of sexual abuse.

Furthermore, Peter Levine asserts that posttraumatic stress is not a disease, and it is not a disorder; it is the way the body copes with overwhelm, with terror, with trauma. Levine argues that trauma is an injury to both body and mind. He further stipulates the posttraumatic stress injury is an emotional wound, amenable to healing (34). Both Levine and Herman argue for therapists and doctors to empower survivors, instead of traditional top-down relationships; not doing so creates further suffering for the survivor and is counterproductive to healing (Herman 133; Levine 34).

Unfortunately, as my eating disorder behaviours and symptoms decreased, I began to experience terror. My perception of surrounding sounds would increase, my vision would darken, and I would lose consciousness. Repeatedly, I awakened to the feeling of my body crumpled on the ground. Ethologists call this "tonic immobility": "When any organism perceives overwhelming mortal danger (with little or no chance for escape) the *biological* response is a global one of paralysis and shutdown" (emphasis in original, Levine 23). According to Levine, humans experience this as a state of panic. It's not meant to operate permanently. For survivors of chronic abuse, this tonic immobility—rather than as a last-ditch effort to flee an inescapable threat—becomes the default reaction to a variety of situations in which emotional states are highly aroused (Levine 24).

My family doctor ordered an electroencephalogram (EEG) to monitor the electrical activity in my brain—to check for epilepsy. Over the years, I wore halter monitors to measure the electrical activity of my heart over twenty-four-hour periods. Eventually, I was diagnosed with depression, with anxiety, and was given more medication. None of it helped.

One of the medications I was prescribed was a powerful antipsychotic. Before a flashback would begin, I'd take a pill and fall asleep for nearly twenty-four hours. Still, the flashbacks persisted. I tried alcohol. I tried marijuana. Nothing really helped. The prescription drugs, the legal drugs, the street drugs—they all kept me in a kind of fog, a numbness. After several sexual experiences that I now categorize as rape,[1] the flashbacks intensified. It was no longer possible to start and stop taking medication as I had done earlier. Given

the increased number of prescriptions, abrupt cessation caused withdrawal symptoms.

As my struggles with treatment escalated, I increasingly questioned the medication, but I was unsure how to proceed. Ultimately, someone else made the decision about my prescriptions for me. The administrator at my psychiatrist's office told me I could not get an appointment for three weeks. I explained that in three weeks my prescriptions would be gone; I was not sure what state of mind I would be in to make it to an appointment. I asked if I could come in briefly to renew my prescriptions. Although I don't remember their exact words, I do remember that their tone was shaming, and they implied I was a drug addict. These were prescriptions I did not want; if I was an addict, it was by their design.

I decided that I did not want any more medication. I was not sick. I was not depressed. I was not anxious. No, I was someone who had been raped—many times—and wanted, *needed*, to talk about rape, about trauma, about dissociation, about flashbacks. I looked up the half-life of my medications, and planned to wean myself off the medication. Not that the medications were addictive, but to stop taking any of the medications abruptly resulted in feelings and sensations I was not sure I could tolerate—heightened emotional arousal, greater suicidal ideation, and floating out-of-body detachedness. I also decided to seek a therapist willing to discuss rape. I grew determined to air the festering traumatic wound buried deep in my psyche, which increasingly burst from my subconscious. Despite feeling trepidation, I was ready to confront rather than ignore my traumatic past.

As I began to search for help, I remembered how previous doctors refused to countenance discussions of trauma. Visibly uncomfortable when I did so, they were perhaps unequipped to discuss sexual violence. I would tentatively broach the subject, asking if all these symptoms could be related to rape. But those entrusted with my healing would ignore, gloss over, and shut down these conversations. The harm this caused is incalculable, and reverberates in my life today.

When I went to Homewood Health Centre in Guelph, Ontario, for their posttraumatic stress recovery program, one of the program's psychiatrists wanted to prescribe an antianxiety medication that also caused drowsiness; the medication helped others with posttraumatic stress disorder sleep at night. Although it had been a year-and-a-half since I'd taken any medication, as the doctor told me, "you won't get very much benefit out of being here, if you're not sleeping at night." Thus, I agreed to trial the medication for a week, after which we would evaluate its usefulness.

A week later we met, I told him sleep remained elusive, and my mouth felt dry as dust. He said, "well you know what the solution is?" and at the same time I said "stop taking it," he said, "increase the dosage." We laughed. I told

him I'd been down the road of increasing medication dosages before, and I was not interested.

For me, medication as a strategy failed. A doctor respected my choice, and it felt great. We discussed different sleep routines. It was collaboration between two people, instead of a top-down relationship in which the power dynamic rested heavily with the doctor.

2. Pregnancy and Trauma

Discovering I was pregnant emboldened me to find an empowering, patient-centred medical team. Lorna Turnbull's concern that "the medical model removes the power of women with respect to their pregnancies and places it in the hands of doctors or, in some cases, the state" rang in my ears (129). Feeling respected, maintaining agency, and working with my birth team to support my health and the birth of my child were all necessities. Healing from trauma gave me the confidence to demand my place as an active participant in my pregnancy.

Emily Martin laments how "obstetrical literature … describes the birthing woman as a machine, her labour as a form of factory production that must be supervised, managed, and controlled" (qtd. in O'Reilly, "Labour Signs" 219). Andrea O'Reilly argues the medical discourse erases birthing women as active subjects. Obstetrical policies and procedures are a tangible example of the objectification of labouring mothers: "the complex process of birth that interrelates physical, emotional, and mental experience is treated as if it could be broken down and managed like other forms of production" ("Labour Signs" 219). These policies articulate a top-down relationship. Furthermore, they deny mothers agency in their own birthing experience.

Trauma and birth are complex. In conceptualizing this, I acknowledge the manifest, tangible ways that Western medicine does help; medicalized interventions can be helpful in some circumstances.[2] Yet they become deeply harmful when misused to ignore trauma symptoms. The problem with medicalized interventions is when they are used to ignore and/or dismiss the real circumstances and agency of traumatized and/or pregnant woman.

I stipulate that societal shaming of survivors and pregnant and labouring mothers seeking medication and medical interventions is detrimental to their wellbeing. This societal shaming functions similarly to the medical model: they both attempt to limit women's choices. O'Reilly argues that for pregnancy, women must be allowed self-determination, access to information, economic resources, allegiances across race and class, and to participate in decision making about reproduction ("Labour Signs" 222). This is similar to Van Der Kolk's argument for trauma treatment. He urges his readers to remember what is forgotten in the brain-disease model: restoring community and

relationships is central to healing, self-determination, and creating social conditions where children and adults feel safe to thrive (38). Actively participating in healing trauma, in pregnancy, and in birthing a child instead of being simply a patient is profoundly empowering

Sexual abuse is a violation; there is no choice. During pregnancy—in a time when I was most vulnerable—I would again be subject to someone else's will. I worried my agency would be lost. This was intensely frightening. I was particularly wary of childbirth with a stranger. My closest hospital has thirteen obstetricians on call, giving me a twelve in thirteen chance that my labour would be overseen by an unfamiliar doctor. I absolutely did not want some random obstetrician— regardless of their expertise—having authority over my body or my birth.

Diane Speier argues that 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" (11). As a survivor, the potential loss of choice, agency, and vulnerability to a stranger—particularly in circumstances where I'd be totally exposed and at the mercy of someone else's decisions about my body—was frightening. Plus the horror stories I heard from friends, television, and movies about the difficulties of labour were terrifying—tales of forced episiotomies, botched epidurals, and mothers being denied access to their babies on delivery. Foremost in my mind was ensuring an empowering birth experience.

There is a particular insanity in forcing someone who has already experienced a violation and a loss of bodily autonomy to unwillingly cede control to anyone else. Speier's essay "Becoming a Mother" reinforces the importance of past life experience in childbirth:

> 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…. Since women always give birth in accordance with the way they live 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 the matters, as their approach to birth is often holistic. (10-11)

Given my apprehension of birth in a hospital,[3] my partner and I found a supportive midwifery practice sensitive to the issues I might face as a survivor

of childhood sexual abuse. In particular, my two primary midwives took care to empower me during my pregnancy and delivery. They offered emotional support as I grappled with the shifting internal landscape of hormones and a changing body.

Ultimately, when I voiced my concerns, my birthing team treated me with respect. This empowered me. Conversely, my initial disclosures of rape were dismissed and/or outright ignored by my healthcare providers. The effect of these strikingly different reactions highlights the supporting role connection with others plays in trauma and mothering.

In fact, a strong support network is integral to healing trauma. According to Herman,

> A secure sense of connection with caring people is the foundation of personality development. When this connection is shattered, the traumatized person loses her basic sense of self … because traumatic life events invariably cause damage to relationships, people in the survivor's social world have the power to influence the eventual outcome of the trauma. (52, 61)

It is, therefore, no surprise that absent this assistance, like many survivors of sexual trauma, I struggled with self-doubt, guilt, and shame. I coped with years of suppressing memories of rape through prescribed pharmaceuticals, self-medication, and dissociation.

Although I did not outright deny what happened, I suspended belief. My support system mirrored my glossing over of trauma. Those charged with caring for me ignored my attempts to discuss rape. For many years, I convinced myself that the flashbacks and the memories were powerful constructs of my imagination.

Yet, as I healed, I craved connection. Herman explains:

> Sharing the traumatic experience with others is a precondition for the recitation of a sense of a meaningful world. In this process, the survivor seeks assistance not only from those closes to her but also from the wider community. The response of the community has a powerful influence on the ultimate resolution of the trauma. (70)

The inability and/or unwillingness of my closest friends and family to support me throughout the turmoil of remembering isolated me further. My spirit and body felt as though they were filled with concrete after flashbacks. But my support system was noticeably absent. When after days and nights of flashbacks, all I wanted to do was sleep and watch Netflix, where was my community of people? I needed friends and family to express their love by bringing me food, giving me hugs, and quietly sitting nearby while I cried.

Yet when I became a mother, people did connect with me. They brought me

food and held my baby so I could nap. Simultaneously, others disappeared from my life. To put it another way: "mothering is not supposed to be a solo mission. The real mission involves pulling into your circle of life all those with something to willingly offer. You are the gatekeeper, but you were never meant to be the whole world to your child" (qtd. in Thomas 62). In the same way, the trauma part of me is like my baby—I need to be the gatekeeper—but healing never was (nor should it be) entirely on my shoulders. This realization that trauma, along the same lines as mothering, is not an individual responsibility helped me acknowledge the profound loss I felt as a result of the alienation from my community. The aloneness of bearing the full weight of my trauma nearly crushed me. There were times I did not think I would survive.

3. Masks and Myths

Admittedly, patriarchal motherhood is also soul crushing. Just as trauma causes sequestration, patriarchal motherhood similarly attempts to disempower women. Patriarchal motherhood isolates mothers and enforces the belief they must raise their children alone (O'Reilly, *Matricentric Feminism* 19). Motherhood and healing from trauma, as sites of potential empowerment, rely on strong support systems. Compounding the difficulties in healing from trauma are the profound silences surrounding sexual violence. The disappearance of many close friends as I navigated the world of sexual trauma and litigation further damaged my wellbeing. Yet motherhood is Janus-faced: providing experiences of isolation and empowerment.

The isolation of motherhood is corroborated in Susan Maushart's idea of the mask of motherhood. Like the dissociation and tonic immobility of trauma, the mask of motherhood ultimately "diminish[es] our knowledge, our power, our spirit as women…we no longer *make* a life—we *fake* a life" (emphasis in original, Maushart 463). Maushart's work has clear applications to trauma and mothering. According to Maushart, motherhood's mask exists to suppress the complexity of women's lives; the mask silences women and keeps them from trusting themselves (460-61). Other scholars, including Trudelle Thomas, build on Maushart's theories of masks and motherhood. Thomas deplores the divide the mask of motherhood creates between mothers and their communities. Thomas argues that the mask "prevents our society from realistically preparing prospective mothers … [for the] huge trauma of re-organization" involved in becoming a mother (63).

Similarly, we do not realistically prepare women and girls for the possibility of sexual violence. This lack of preparation reinforces silence around sexual abuse. For years, I struggled to communicate my truth, much less find someone willing to listen. Society is uncomfortable when a woman names her experience of rape:

> Husbands, lovers, friends, and family all have preconceived notions of what constitutes rape and how victims ought to respond. The issue of doubt becomes central for many survivors because of the immense gulf between their actual experience and the commonly held beliefs regarding rape. (Herman 67)

Like the mask of motherhood, society holds unrealistic, preconceived notions of rape and victims. The assumptions around so-called proper victimhood resemble society's misconstruction of mothering. Both misunderstandings produce harmful consequences that leave trauma survivors and mothers to cope in silence.

Thomas critiques the isolation many American mothers face as they assume full responsibility for domestic and childcare responsibilities. Furthermore, Thomas warns "the lack of fit between the expectations and realities of mothering may be experienced as a personal crisis, but it is ultimately a social tragedy" (63). A greater effort to prepare mothers for the realities of motherhood is needed. Communities cannot afford to support the mask of motherhood. The cost to mothers' mental health is too high.

The parallels between motherhood and trauma are further emphasized when I consider masks and dissociation. In terms of trauma, my capacity to dissociate saved my life. But years later, it cursed me and prevented me from confronting the violence I had endured. For mothers, masks impose a similar outcome. Maushart's evaluation of masks could replace my description of dissociation. Maushart acknowledges "the capacity for emotional make-believe, for pretense, for the construction of situationally appropriate masks, is perhaps our most enduring evolutionary advantage. It is also our greatest curse" (460). I maintain the silences mothers and trauma survivors face cause debilitating loneliness. The curse is the isolation from community. Society's lack of acknowledgment of women's lived experiences leads to the inability to share a common reality.

Society also enforces women's silence through the myths surrounding rape and motherhood. The parallels between the idealization of the perfect rape victim and the myth of the ideal mother are striking. Claire L'Heureux-Dubé, former justice of the Supreme Court of Canada, outlines the rape myths and stereotypes that political, social, and economic leaders use to uphold the status quo:

> Sexually experienced women and those who transgress stereotypes of appropriate female behaviour by their sexual orientation, choice of occupation, ethnicity, poverty, intoxication, mental health, previous sexual assault complaints, by walking alone at night or accepting a ride home, fail to qualify as deserving victims and seldom have their cases processed through the criminal justice system. (Johnson and Dawson 104)

Another prevalent myth is that of the "good" rape victim. A good rape victim is a woman who is attacked and raped by a stranger in a dark alley. The perfect victim is sober, white, heterosexual, and able-bodied; she takes her rapist to court, she is a credible witness, and she clearly articulates "no" (Johnson and Dawson 105). According to Herman, the legal system only recognizes a crime as rape if the perpetrator uses extreme force, which is even more disturbing, "since most rapes are in fact committed by acquaintances or intimates, most rapes are not recognized in law" (Herman 72). The criminal justice system and the wider community rarely acknowledge the lived experiences of rape survivors. Rape myths effectively work to silence survivors from seeking any type of legal recourse—thus, masking the realities of rape.

Similarly, O'Reilly distinguishes between the oppressive patriarchal institution of motherhood and the act of mothering. Mothering is rooted in women's actual lived experiences of mothering children, and has the potential to act as a source of empowerment (O'Reilly, "Feminist Mothering" 794). To that end, O'Reilly defines the "ten ideological assumptions of patriarchal motherhood," one of which is the idealization of mothers (*Matricentric Feminism* 14). Under this assumption, only a "white, heterosexual, able-bodied, married" woman who is also middle-class and a full-time mother is bestowed the title of good mother (O'Reilly, *Matricentric Feminism* 12-13, "Feminist Mothering" 802).

Since women are not prepared for the realities of motherhood or of rape, both events, if or when they occur, do not align with the ideals and myths society espouses. Initially, the survivor of rape and the mother are mired in guilt—guilt for not meeting unreal ideals. In the case of rape, these myths interfere with healing. In the case of motherhood, they disrupt the empowering aspects of being a mother. Both survivors and mothers are forced to wear masks. Through its ability to define and challenge these myths, feminism unmasks the realities of rape and motherhood.

4. Empowered Intersections

Many women, including mothers, are survivors of sexual abuse. The literature urgently needs additional discussion on the intersection of motherhood and surviving sexual abuse. Existing references to this intersection tend to reference the damage an abused mother will supposedly cause her child (Cannon et al.; Carolan et al.; Cross). However, Herman reassures survivors that:

> Contrary to the popular notion of a "generational cycle of abuse," however, the great majority of survivors neither abuse nor neglect their children. Many survivors are terribly afraid that their children will suffer a fate similar to their own, and they go to great lengths to

> prevent this from happening. For the sake of their children, survivors are often able to mobilize caring and protective capacities that they have never been able to extend to themselves. (Herman 114)

The birth of my child reaffirmed my commitment to life. This is not to say that having a child is the answer to healing sexual trauma. However, after years of hard work, the place that remained the most fragile and fragmented in me—the place where my connection to humanity was frayed—is the place that is filled by the love I feel for my child. To be clear, this is not my baby filling an emptiness or a wound to my soul and psyche. Rather, the love I feel for my baby spurs me to choose aliveness. Whereas once there was listlessness, tiredness, and ambivalence toward humanity, now there is a fierce desire and dedication to change.

My experience powerfully demonstrates motherhood's empowering potential. Raising my child outside "the dictates of patriarchal motherhood" (O'Reilly, "Feminist Mothering" 798) encourages me to value the knowledge I carry in my body. Before my baby, I desperately wished for acceptance from a community that often failed to recognize and support me in the ways I needed. Mothering freed me from this longing and emboldened me to stand outside the norms of healing and mothering. Most importantly, mothering emboldened me to accept myself.

Trauma is complex, as is pregnancy. The trauma of childhood sexual abuse stems from its pernicious nature. Injuring the body, mind, and soul of a person leaves a gaping, invisible wound. Pregnancy is the growth of a new life within another living person. A chemical imbalance in the brain and a mechanical process do not adequately convey the realities of trauma and pregnancy. Trauma and mothering are potential, though underresearched, allies. I believe through more nuanced explorations, survivors, mothers, and their communities can shed false premises surrounding trauma, pregnancy, and mothering. They can disambiguate the realities of rape and motherhood. They can unmask false myths and ideals of trauma and birth. This may also lessen the occurrences of rape, as we mother our children with the full knowledge of our bodies, minds, and hearts.

Endnotes

[1] I knew that if you said no, someone shouldn't force you to have sex. What wasn't clear was that the absence of consent does not equal consent. I had a tremendous capacity to dissociate.

[2] Pharmaceuticals can be helpful for traumatized people, especially when overwhelmed by their emotions (Van Der Kolk 36). Caesarean sections and epidurals save labouring women's lives.

[3] I knew that despite planning for my ideal childbirth, I should have contingency plans. My partner and I visited the hospital to assuage some of my fears, lest our home birth plans go awry. Later, I spent six hours at the hospital, at week thirty-seven of my pregnancy, when I started having contractions that did not progress to labour. I am grateful for experiencing a quiet hospital with my midwife and partner nearby. It was rehearsal for my actual labour and lessened my fear of hospitals.

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CHRISTIANA MACDOUGALL

"Oh, Get Over It. I Do This Every Day": How Ignoring the Specialness of Childbirth Contributes to Experiences of Emotional Distress

Childbirth is a daily event, making it a routine and predictable part of social life. For many people, childbirth is also a profound life-changing experience, as it incorporates previous life experiences, creates new identities, and alters relationships in significant ways. However, the nuance required to see childbirth as not only a regular event but also a special life experience is missing in many considerations of childbirth. Ignoring the specialness of childbirth contributes to experiences of emotional distress in childbirth. This article shares excerpts of four women's birth stories and demonstrates the need for more nuanced understandings of birth to from those involved in assisting women in childbirth. This article draws on data from a study of fifteen women in Atlantic Canada who gave birth in hospitals and who identified as having experienced emotional distress in childbirth. Feminist narrative inquiry and analysis were used to interview and analyze the birth stories shared by the participants. The stories shared demonstrate that women understand the daily and routinized approach to birth dominant in healthcare settings, yet they did not experience childbirth as a routine event. The rupture between the mundane routinization of birth and the transformative and unique experience of giving birth contributed to the distress the participants experienced during childbirth. The women interviewed for this research called on those who work with women during childbirth to be more appreciative of the unique space childbirth claims as both a regular and special experience.

Childbirth is a daily event, making it a routine and predictable part of social life, and for many people, childbirth is also a profound life-changing experience (Bachman and Lind; Lundgren; Thomson). However, the nuance required to see childbirth as not only a regular event but also a special life experience is missing in many considerations of childbirth. Additionally, there is a growing

body of evidence suggesting many women experience childbirth as a significantly distressing (Beck et al.; Czarnocka and Slade; Creedy et al.). This study demonstrates how ignoring the specialness of childbirth experiences contributes to emotional distress in birth. It draws on data from a study of fifteen women in Atlantic Canada who identified as having experienced emotional distress in childbirth, and shares excerpts from four women's birth stories. The article demonstrates the need for more nuanced understandings of birth from those involved in assisting women in childbirth.

Distress in Childbirth

Research often represents distress in childbirth as trauma, posttraumatic stress disorder (PTSD), or posttraumatic stress symptoms; it typically focuses on individual factors associated with birth. These factors include (1) descriptions of the woman giving birth, such as being poor (Fottrell et al.), having a preexisting mental illness (Czarnocka and Slade; Söderquist et al.), and personal coping style (Van Bussel et al.); (2) qualities of the birth experience itself, such as emergency procedures (Adewuya et al.; Söderquist et al.); and (3) the woman's internal experiences during childbirth, such as her thoughts, emotions, and interpretations about childbirth (Beck, "Birth Trauma"; Dale-Hewitt et al.). The dominance of an individualized and psychological view of distress, and its conflation with trauma and with PTSD, is evident in the focus of many research papers. Much effort is spent assessing the credibility of subjective experiences of distress—reducing women's experiences to symptom checklists and matching these against the diagnostic criteria for PTSD (Ayers et al.; Czarnocka and Slade; Soet et al.; Wijma et al.). Although there is agreement that one third to over one half of women report subjective experiences of trauma and/or distress in childbirth (Alcorn et al.; Beck et al.; Creedy et al.; Czarnocka and Slade), the accepted rate for childbirth-related trauma falls between 1.5 and 5.6 percent (Ayers et al.; Creedy et al.; Czarnocka and Slade; Fairbrother and Woody; Ford et al.; Söderquist et al.; Zaers et al.).

Some diagnostically oriented research relies on women's subjective reports of distress as a deliberate countering to the way in which women's experiences are silenced in the general childbirth literature; such research argues for better treatment of women in childbirth and for postpartum psychological treatment. See for example, Beck's "Birth Trauma" and "A Metaethnography"). Other studies have taken a different approach to examining experiences of distress in childbirth by deliberately centring the subjective experiences of the participants without filtering women's voices through the mesh of psychological language and diagnostic categories and by focusing on experiences of distress in childbirth (For example, Chadwick et al.; Moyzakitis). This project falls

within this category of interest and analysis, and thus centres distress rather than trauma as a core concept.

Distress

Because of the dominance of psychological and medical discourses, the concept of trauma is readily understood (and used) by people in their everyday lives in a such a way that distress is medicalized and individualized, and comes to be understood as individual dysfunction (Burstow; Lafrance and McKenzie-Mohr). Additionally, this conceptualization of trauma comes from a white, Western, and settler perspective, which erases the historical and current trauma of Indigenous peoples, displaced people, and racialized people (Banner; McKenzie-Mohr). This individualized construction of trauma ignores the important political, cultural, and social aspects of experiences and effects of trauma, and also removes the inducement for action ameliorating and eliminating trauma beyond simply symptom reduction (Burstow; McKenzie-Mohr).

Distress was a useful concept for this project; it carries the possibly of incorporating a broader range of experiences than the concept of trauma allows, and in doing so, it denies medical dominance and the resulting pathologization and marginalization. The women who participated in this study did not define or explain their emotional distress as limited to one event or interaction, or one thing gone wrong. Nor did they understand their distress as one diagnosis or set of symptoms or pathology. The participants in this study discussed the distress associated with their childbirth experiences in the context of the entire pregnancy, previous life experiences, thoughts and emotions about potential futures, and various and interlocking aspects of care (or lack of care). Thus, in these childbirth stories, distress was not caused by some thing resulting in feeling some thing. Stories of childbirth distress represented a complex interweaving of events, experiences, interactions, and internal experiences of thoughts and affect.

The Body

Giving birth is an embodied experience; thus, this project is grounded in a material-discursive view of the body, reflecting curiosity about "the day-to-day impact of the discursive construction of experience on material life" (Ussher, "Body Talk" 7). Capturing embodied experiences through research is rife with difficulty. Participants in most research approaches (including this one) must still rely on language—text and talk—to convey their bodily experiences, and a focus on discourse risks removing the body from consideration even in such an embodied experience as childbirth (Chadwick).

In this research, this understanding of embodied telling is reflected in how the text of the stories is shared with the reader. The poetic form of the excerpts represents the embodied storytelling of the participants. The lines of the stories may erupt only to die mid-sentence—sentences may not end but seep into each other, and ideas bleed into each other during the telling. It is important to represent these embodied stories in a way reflecting the subjective action taken in sharing stories, even if this means that the reader is left without tidy sentence structure and neat beginnings and endings (Chadwick). Indeed, this messiness in representation mirrors the messiness of experiences of birth and the way in which birth acts as a site of rupture in neat understandings of body and discourse.

Methodology

Participants for this study were recruited over a one-year period from November 2015 to October 2016. Participants were recruited who had given birth within the last year, were at least sixteen years of age at the time of conception, spoke English, and were able to provide their own consent. Rrecruitment was undertaken from various formal and informal community organizations (such as healthcare services, family resource centres, community groups representing specific racial and ethnic communities, and local parent and infant play groups) and from word of mouth referrals among participants and among those who became aware of my research through other means.

Fifteen women participated in this research project. Their ages ranged from eighteen to forty-three years old. The women came from a variety of regions across Atlantic Canada, including rural communities, small towns, suburban communities, and urban centres. All women gave birth in hospitals. Participants chose their own pseudonyms to be used with their narratives. Five participants had a preexisting mental health diagnosis (depression or anxiety) that they disclosed to me during the interviews. Nine participants had had older children and/or pregnancies that they mentioned, and six participants were involved with this project as a result of their first pregnancy. All participants were in coupled relationships. Fourteen were in heterosexual relationships, and one participant was in a same-sex marriage. Participants described themselves as ranging from poor to middleclass. All participants identified as white. Excerpts from four of the fifteen participants' narratives are included below.

The lack of racial diversity among participants is a shortcoming of this study. Although I recruited broadly and included many agencies providing services to racialized groups, only white women responded to call for participants, which may be associated with the very nature of this project's focus and of who was doing the research. As a white woman social worker doing research

regarding childbirth, this project and I may represent risk associated with the historical and ongoing oppression of racialized women, including the particular oppression racialized women experience in their reproductive lives. Whereas white women have a history of being viewed as idealized objects who are the weak and passive vessels that need to be "delivered of" their babies—and who now perhaps want to be seen as central and express agency in "delivering" their babies—the history of reproduction and research into reproduction has been different for racialized women (Ross and Solinger). It may be fair to assume racialized women have been more aware of the surveillance and control upon their bodies and the pathologizing of reproduction through violent social process, such as eugenics, forced sterilization, and the removal of their children (Ross and Solinger). Perhaps many women of colour want (especially white) researchers to leave them alone. Perhaps more attention from researchers and medical practitioners and social workers is not seen as likely to be helpful given the specific histories of their communities. Thus, although this research represents diversity across many types of birth experiences, and across various social locations, it is a study that will not represent racial diversity.

Feminist narrative inquiry and analysis were used during the interview and analysis phase of the research. They enable the co-constructions of knowledges as the researcher moves between data collection and analysis (Brown; Wilson). Researchers using feminist narrative inquiry and analysis as a methodology seek to change power relationships, reject ideas of neutrality and objectivity, and incorporate reflexivity (Morris). A feminist narrative approach allowed for the discovery of the messages and assumptions participants had about childbirth, both dominant understandings as well as challenges to dominant ideas about childbirth and distress in childbirth to surface (Arvay; Barbour; Hydén; Riessman, "Analysis of Personal Narratives"; Squire).

Guided interviews were carried out using general, open-ended questions and prompts. Interviews occurred at the location of the participant's choosing, often in their own homes, and lasted between forty-five and ninety minutes. Interviews were transcribed, and the resulting written narratives were analyzed for subjugated knowledge as well as for reflections of dominant narratives, with an interest in how participants navigated these realities (Stone-Mediatore). The findings below emerged organically in the interviews and/or after being prompted with the question: "Do you have any advice or messages you would give to those who are going to experience labour and delivery?" and are related to the theme "recognize that childbirth is a regular event that is special."

Findings and Discussion

Many participants shared that some of their emotional distress was related to feeling as if the specialness of childbirth was ignored by the medical staff involved in their care. The routinization of care associated with the regular medical event of birth felt cruel and inhumane to many of the women who shared their stories. Many births are considered unremarkable and are routine in hospital-based care, but even beyond this, medical emergencies are also regular events in healthcare. The excerpts shared below are taken from the narratives of four of the participants in this study—Morgan, Charlie, Sarah George, and Nella—who experienced birth as a medicalized event. All had unanticipated complications during their deliveries that risked either their lives and/or the lives of their babies. They required intensive medical interventions, for which they were grateful, yet all felt the specialness of their birth experience was subsumed under the routinized medical management of their care. Morgan, Charlie, Sarah George, and Nella reflected on the importance of having their birth experiences treated as special despite (or perhaps in addition to) the specialized medical interventions they received.

Morgan highlighted this thinking, and had advised staff to treat childbirth as a special experience—a special day. She linked the invisibility of the importance of a positive birth experience to gender:

> It is just expected, you know, for women to just be, this is part of what you do.
> It is part of what you do.
> Men can't give birth but it would be nice if there was just a little bit more,
> I don't know what the word is, something.
> It should be a little bit more important, a little bit more talked about.
> My first birth, one of the nurses literally yawned the whole time.
>
> I totally felt like a number.
> I thought about reporting her afterwards
> because I thought, "You just don't do that!"

Morgan's birth experience was associated with a life-threatening complication, and perhaps because Morgan believed she was going to die in childbirth, she linked the importance of empathetic attending to birth as similar to behaving empathically when dealing with death:

> And you know, you are lucky to be part of these people's lives in these important times,
> whether it is dying, birthing, sickness.
> You know, you are lucky to be part of that.

Feel blessed to be part of that and focus on that.
It is also to be influencing in a positive way even if someone is dying
then any medical professional that comes into that situation
should be impacting it in a positive way.

Charlie also experienced life-threatening complications during her delivery, and also linked birth and death. She is a veterinarian, and as such, she spoke about the importance of staff being sensitive to the needs of people undergoing routine yet emotionally challenging life events:

And I know that when you do something every day,
it becomes normal to you
but like, I would never go in to a client where I was euthanizing their animal.
…
And be like, "Oh get over it, I do this every day."
…
I would never even dream of…
Because it is part of their family and they are saying goodbye and it is like,
just because it is something I go through every day and have to deal with,
it doesn't make it any less important.
You've chosen, you've chosen a profession where this is what you are doing.

Charlie had advice for those caring for birthing women as she combined both the concern for women with the recognition of childbirth as a meaningful experience:

I want people to recognize
that it is a pretty huge experience for every woman that is going through childbirth
and everybody might have different needs [pause]
and to really talk to them and see what they need in that situation.
You know what I mean?
And be there for them.
It is like, don't just stick them in a room and you know,
You know, don't tell them that they are not technically in labour,
we don't want to hear technicalities.
You know what I mean?
Like reassure them what they are going through is normal yet it is still huge.
Do you know what I mean?

In this story, Charlie searched for some synthesis between the polar views of the childbirth as a routine yet special experience. Her frequent use of "you know what I mean" indicates that what she was trying to express is not easily put into words because it disrupts the binaries that have come to define childbirth (Devault). Charlie's comments reflect her view of birth as a medical event (which was Charlie's experience as she developed HELLP syndrome[1]). They reflect her search for a way in which she could maintain her status as person rather than patient and for a way in which staff could resist the neoliberal pressures to treat birthing women as objects on a healthcare assembly line (McCabe).

Similarly, Sarah George experienced medical complications during birth, and her baby required specialized care in the NICU. She also experienced distress as a result of having the specialness of her birth experience invalidated by the medical team's behaviour. She experienced being repeatedly ignored despite having been in one of the most vulnerable positions a person can be in—spread-eagled with feet in stirrups. The medical staff then took her baby to the NICU and dealt with other labouring women on the unit. Her advice mirrored Morgan's; she begged staff to remember the woman is an important person in need of care:

> To that person that is delivering [the babies], it's like another [day]
> and that made me so mad.
> "You are like the twelfth woman to deliver tonight."
> I'm like, "I don't care if I'm the twelfth person to deliver.
> This is your job.
> I am just as important as the first person that delivered and you need
> to make an effort."
> I can't believe they left me on that table, and she was like,
> "If you need anything call, push the buzzer."
> I am like, "I'm bleeding to death here and I am not going to be able to
> push the buzzer lady."

The anger is Sarah George's story demonstrates the indignities and inhumanity she experienced as she was forgotten and abandoned on the delivery table.

Finally, Nella had similarly reasonable advice for those working with women during childbirth: find a way to treat women and childbirth like they are special and important.

> I think for practitioners,
> I think people who have been doing it for a very long time
> are very comfortable with what they are doing
> and sometimes I think this with a lot of different professions,

but what they are doing might be the first time for the person who is laying on the bed having the baby and it is a very, like you said, special experience.
To them, it is just, you know, one more delivery but to,
I don't know, I don't know how to say it,
like, don't forget about that part of it.
Their part of it, yes, definitely, is to deliver the baby
and maybe that is where a doula comes in to play.
You know, maybe I should have a doula.

Nella spoke to the importance of attending to the woman in the room who is living through a very physically and emotionally overwhelming and challenging experience. It is helpful to have someone in the room dedicated to telling the labouring woman what is happening to her body and to the baby:

Yeah, or just like so that somebody could, even one of the nurses,
if they weren't all really busy to stand there and say,
"Okay, the baby is out, the baby is good,
we are going to take him over and clean him up."
You know.
…
Yeah, that's all. I don't need a lot. Just a little bit. Right?
…
That's it.

It seems as if Nella has given up on the idea that women can be cared for and that birth can be viewed as special in the hospital-based system she experienced, which suggests that caring for a labouring woman's emotional needs is outside the duties of the physician (belonging instead to the doula). Indeed, Nella wondered if the way to ensure women and birth are seen as special is to hire a doula to care for them while the medical team cares for their baby. She was seemingly resigned to the idea that caring for birthing people is not the role of medical professionals.

Okay, it is not the doctor's job to console me.
Right? The doctor is here purely for his or her job of delivery this baby,
that is not their job to make me feel happy inside.

The excerpts above point to the vulnerability women experience during birth. The highly emotional nature of birth combines with physical vulnerability to position women as needing care and sensitivity as they navigate this important life event and experience.

Conclusion

Narratives are stories told by people that reflect perspective (who is telling the story), context (the larger environment in which the story is told and the storyteller is situated), and frame (the outlook of the storyteller, including ideas related to culture and background) (Andrews; Riessman, "Narrative Analysis"). The childbirth narratives shared by the participants reflect an experienced-based view of narrative, which allows for shared creation of meaning through the act and interaction of telling and hearing stories (Squire et al.). In their stories, narratives move beyond serving as a way to disseminate knowledge about birth, and become a way of making meaning and creating new knowledges about birth as a special experience. Feminist approaches to research, including feminist interviewing and analysis, recentre subjugated knowledges and experiences. The feminist approach to narrative inquiry and analysis used in this project allowed the powerfully disruptive messages in women's birth stories to surface; these messages interrupted and talked back to the public narratives about birth and about childbirth distress. This methodology and the narratives produced encourage us to see those who give birth as more than simply birthing bodies—as full people who should also have rights, access to services that meet their needs, and choices in how they have their pregnancies and deliveries. It also allows us to see the importance of reconceptualizing birth as both a regular event and a special experience.

The childbirth stories told by Morgan, Charlie, Sarah George and Nella allow us to show how the individualized, pathological, and event-based views of birth and distress lead to an insufficient framing of distress in childbirth. These women all had serious, sometimes life-threatening, complications during their birth experiences, yet it was not these complications per se that caused them the greatest distress; equally troubling was the erasure of birth as a special and transformative experience. Some women wondered if the lack of awareness of birth as a special experience is linked to the more general and gendered invisibility of women, their work, and their needs in society. Morgan illustrated this analysis when she said "it's just expected … this is part of what you do." Participants' birth narratives also indicate how the routinization of care feeding into this decentring of women was a source of distress for participants. Charlie was made to feel that because birth is a routine and routinized event in healthcare, her birth experience was no longer important. In sharing her story, her phrasing of this attitude—"Oh get over it. I do this every day"—highlights how her sense of birth as important was dismissed. Sarah George's story calls attention to the way in which understanding birth as a time-limit event contributes to the mistreatment of women during this special experience. Once she had delivered her baby, the hospital care team seemed to treat birth as over; they left Sarah George alone, exposed, bleeding,

and vulnerable while they attended to her baby and other birthing women. Nella could also see the routinization of care, as she saw the demands this placed on healthcare teams. In a pragmatic and forgiving way, she advocated for women to be treated with just a little bit of respect and care: "I don't need a lot. Just a little bit. Right?" She recommended that doulas should provide women/mother-centred care if the medical care team cannot. Understanding the demands placed on medical teams, she sees this as a reasonably accommodating middle ground.

As others have argued, (Callister; Palladino; Schiller) listening to and learning from birth stories from the perspective of those giving birth are necessary to understand where the flaws in the current system lie and how to mitigate the harm done within the current system. Paying attention to the experiences of those who have given birth is part of the movement to expand reproductive-rights discourse beyond simply the right to not give birth (through contraception and abortion). It extends concerns to the right to have children and to have reproductive needs and concerns addressed in a more all-encompassing framework (Hayes-Klein; Ladd-Taylor; Schiller; Smith).

Ignoring the needs of women to have the specialness of their childbirth experiences recognized contributes to their emotional distress in childbirth. Participants experienced childbirth differently and outside of the polarized understandings of birth as regular or special. The women interviewed wanted to be seen as deserving of medical care and personal attention in their birth experiences; they also wanted their experience of giving birth to be seen and treated as a special and transformative part of life.

Endnote

[1] "HELLP syndrome is a life-threatening pregnancy complication usually considered to be a variant of preeclampsia. Both conditions usually occur during the later stages of pregnancy, or sometimes after childbirth" (Preeclampsia Foundation).

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ELENA SKOKO

How Did You Do It? Shared Experiences of Birth Activism on the Issue of Obstetric Violence: Interview with Ibone Olza

Ibone Olza is a Spanish mother activist, psychiatrist, and author involved in childbirth advocacy and research at the national and international level. In the present interview, she talks about her experiences within Spanish mothers' movement, specifically in relation to the phenomenon and the concept of "obstetric violence"—a form of gender-based violence exercised on women within maternity healthcare. The interviewer Elena Skoko is a fellow mother activist operating in Italy. The conversation herein represents a milestone for the Italian mothers' movement because it has influenced the use of the term "obstetric violence" in Italy, which has resulted in the creation of a new public awareness and a new national movement of mothers.

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Introduction

Ibone Olza is mother activist and perinatal psychiatrist, and is co-founder of the associations *Apoyo Cesáreas* (Caesarean Support) and *El parto es nuestro* (The Birth Is Ours, www.elpartoesnuestro.es) in Spain. She is author of several books on pregnancy, childbirth, breastfeeding, and advocacy, including the latest one, *Parir* (*Giving Birth*), which addresses the issue of obstetric violence. She is currently associate professor at the Faculty of Medicine of the University of Alcalà and director of the European Institute for Perinatal Mental Health. As a researcher, she explores the impact of contemporary childbirth practices on maternal and children's mental and physical wellbeing. Her engagement in birth activism has shaped both her personal life and her professional career, as she states in the present interview, and it has affected Spanish politics and policies of maternity health care.

I met Ibone at my first meeting of the COST Action BIRTH in Lancaster (UK) in 2015, as part of this European research project where researchers, policymakers, and activists work together to produce and disseminate scientific literature on the topic of normal or physiological birth. At one of the coffee breaks, she agreed to give me an interview, and we talked about the concept and the implications of the use of the term "obstetric violence" (Sadler et al.)—the phenomenon of inappropriate and abusive healthcare practices routinely used in modern maternity care that negatively affect women's lives. Our conversation influenced my decision to use this term in Italy for the purpose of influencing Italian maternity policies, which have not been addressing the consequences of inappropriate maternity care on women and newborns. Together with Alessandra Battisti, lawyer and mother activist, we drafted a law proposal "Norms for the Protection of the Rights of Women and Newborns in Childbirth and Regulation for the Promotion of Physiological Birth," lodged at the Italian Parliament in March 2016, followed by a viral national campaign—"*#bastatacere: le madri hanno voce*" ("#breakthesilence: mothers have voice")—and the foundation of the Italian Observatory on Obstetric Violence (www.ovoitalia.wordpress.com) (Skoko and Battisti). Our advocacy work continued with the publication of the first nationally representative data on the phenomenon in 2017, which were published in international scientific journals in 2018 (Ravaldi et al.).

Women worldwide have been reporting abusive and disrespectful care for decades, yet both high- and low-income countries have been ignoring the women's voices on this issue (WHO). To advance the state of things, mothers activists around the world introduced the term "obstetric violence" (legally framed for the first time in 2007 in Venezuela). The use of the term in Europe started in Spain, and soon expanded to Italy, France, and other European countries—resulting in controversy with obstetricians (Villarmea et al.)—and helped to build an international childbirth movement guided by mothers.

Interview

ES: Ibone, how did you start with birth activism?

Ibone: I was in training as a psychiatrist when I had my two births; both were emergency Caesareans, traumatic. After the second one, I spent ten days in an intensive care unit. I was only allowed to touch my son after a week; I could hold him only after a week. The months following that, I became very upset with the type of care he had in the ICU, where they had been taking care of his lungs. I became very worried, very active to open the doors of the ICU. For my third birth, I was trying to have a vaginal birth after two caesareans. I read all the studies. It was like doing another PhD thesis [laughs]. But most doctors would say, "no, you're crazy, you have the risk of the uterine rupture; you have to plan a Caesarean, and so on" … But I had read all the literature; I knew it was safer to go for a trial of labour. I ended up having a third Caesarean, very traumatic, after I dilated at term at home with the midwife. I went into the hospital fully dilated and ready to push my daughter. They treated me really very badly; it was very violent, very traumatic for myself. After that, I joined ICAN, the International Caesarean Awareness Network, an American association dedicated to lowering Caesarean rates and to supporting women who had traumatic Caesareans. After joining the ICAN, I started the Spanish support group for women who had traumatic Caesareans (*Apoyo Cesáreas*). That was in 2001. Soon we had women who had had Caesareans, and those who had a very traumatic vaginal birth. We had to learn from them because the ones who had Caesareans, we thought we had experienced the worst. I was jealous of any woman who had a vaginal birth, but when these women came to our group, they told us their horror stories. We realized this was not a competition for the worst birth, but rather a very serious problem. So we decided to start an association. At first, we wanted to do it with people of South America because in the group, there were many Argentinians. But we realized it was difficult to work in different countries, so we started an association in Spain in 2003. It's called *El parto es nuestro*. It all started as a need to heal myself, to understand. Rage is an important issue; you have this need to do as much as you can to avoid other women going through the same experience.

ES: At what point is the association now?

Ibone: It's been a beautiful process. Most of us were very traumatized women; we were very upset the first years. We were going to talk to the institutions and to the newspapers asking them to bring light to this problem to make it socially known. And we succeeded at that. Finally, in 2007, the Ministry of Health of Spain listened to us and decided to launch a strategy, a national strategy to improve childbirth. At that moment, we started to collaborate a lot

with other associations and with the Ministry of Health. For a few years, things seemed to get much better, but now we have a problem with a situation that we deem to be worse. It only seems like things are different. It looks like gynaecologists, midwives, and everybody else started to be more respectful in birth, but they have just incorporated our discourse. It is make-believe; it is not true. They say they are respectful and they won't insult the woman anymore but they will play the "dead baby card" [Author's note: when healthcare providers tell the childbearing mother that her unborn baby's life is in danger even if this is not true, in order to induce here, to comply to their wishes]; they will not tell her all the science. So I'm a bit worried. Certainly, we did get a lot; things are better, yet every day in our association we still receive many women who tell us horror stories. The association is big now; we are eight hundred members. There are even midwifes, doctors, and nurses, but most of us are there because we are mothers. We've done a lot of campaigns. I think lot of good things came out of our activism. But we think there is still a lot of work to be done.

ES: What were your most successful arguments? What did trigger the change? What triggered the communication with the institutions and with the medical system?

Ibone: I don't know. I think we found receptive people at the Ministry of Health. We went with the data. We told them: "Listen, you can't be proud of the data when there is 25 percent of Caesarean rate, both in the private and public hospitals." We told them about our pain; we told them our stories. We were very good in making women's stories heard.

ES: How did you make them hear those stories? I mean, you used data, but stories are not obvious in the data.

Ibone: We wrote many stories to the newspapers, we went to the TV, and we got good people to make good documentaries on national TV. We wrote a lot, a lot of letters, to journals; every woman did it. And then we started to form a support group in each town. We did a lot of Internet campaigns. One of the first ones was about episiotomy. We translated into Spanish a French web page dedicated to the information on episiotomy. We did another campaign that was called ¡*Que no los separen!* (Do not let them separate you) to inform families that they have the right to stay with their newborns, especially in the intensive care units. We made posters and we sent them to all the hospitals in the country. We created a group for professionals, where they could talk about their experiences. We also did a campaign about the Kristeller manoeuvre. We started the Observatory on Obstetric Violence because now we are really using the term of "obstetric violence" to denounce the abuse and the mistreatment of women and newborns in childbirth.

ES: What is your feeling about the concept of "obstetric violence"?

Ibone: Obstetric violence is any abuse to women and babies during childbirth. It can be anything— from doing things to the woman without informed consent, doing things that are not evidence based, and not offering the right information to the women. Venezuelan law says obstetric violence is not attending properly to obstetric emergencies, doing a Caesarean when there are ways to do a vaginal birth, separating the newborn from the mother for no good medical reason, telling a woman to give birth lying on her back, which is still used in most hospitals, even if it is totally against scientific evidence. All of this can be obstetric violence.

ES: How do you feel now about the concept? What reactions did you have? How did you use it as an activist's tool?

Ibone: At first, we were very reluctant to use it as a term because we thought it was going to cause us trouble. To our surprise, everybody understands it. Although professionals were at first very offended, many of them totally understood what we were talking about. We thought this concept would put us into trouble, but it turned out it was the opposite. It is very easy for most people, even for professionals, to understand that doing a Caesarean for no good reason or taking away a newborn from a mother for no good reason is a form of violence. The Latin American activists have shown this to us. They have started the Venezuelan law on obstetric violence. I think it came out in 2007, so did the Argentinians and the Mexicans who also had their own laws on obstetric violence. In Spain, we thought the concept was too strong. But now we realize it is very helpful instead. People understand it.

ES: Is it producing change? When did you start using it?

Ibone: I think we started in 2014. It's been helpful because it created a debate. At first, the professionals felt offended. They were saying: "You are not going to tell me I'm being violent!?!" We were saying: "We are not telling you that you are being violent; we are telling you it is violent to take away a baby from the mother." Or, it is violent to do a Caesarean. We asked them: "How do you feel about this? Is this something you would like to be done to you or to your daughter?" They know how it is. I think it's helping. It also puts light on the gender issues surrounding birth. Obstetric violence is a type of gender violence that is only experienced by women or babies. Birth is a very specific and vulnerable time. It creates the potential for great damage; the impact of this violence is so important. When we talk about obstetric violence, many husbands quickly understand it as well because they have been witnessing it; they have felt it.

ES: How do you sustain your activity?

Ibone: My personal or the association's?

ES: Actually, your personal and the association's.

Ibone: Personally, my activism has been causing me a lot of trouble. It was something I could not stop. It caused trouble with my family, with my colleagues, with my work. That lasted for a few years, then it became the opposite. And that kind of situation has happened to many of the women in our association. In our association, there were architects that were very traumatized by birth so they became activists. Now these architects are specialized in designing maternity hospitals. We have philosophers who were traumatized by the Caesarean, and now they are experts in the philosophy of birth. We have lawyers who are now experts in human rights in childbirth. Myself, I was a child psychiatrist but because of the activism, I ended up listening to so many women and became an expert in birth trauma. I ended up becoming a perinatal psychiatrist in my hospital. There was almost nobody doing perinatal psychiatry in Spain, except for a small group in Barcelona. It's funny for me to say this, but I'm probably one of the biggest experts on perinatal psychiatry in Spain because there was nobody else, not because I knew much. For many of us, our activism ended up also combining very well with our profession. We have teachers who also became activists, and they ended up publishing beautiful books for children and natural childbirth. Each one of us ended up getting something back professionally from the activism, which we never expected. And we never did it for that reason. We ended up getting a lot out of every word.

ES: You gained an expertise that is recognized in your community, also on the scientific level?

Ibone: Yes… this is interesting. And then there were other women who wanted to become doulas. They had not thought of being doulas; they were engineers. There was a time when many of us felt as if our activism was like a disease, like an addiction, you know. Our husbands, our parents would tell us: "Can you stop doing that?" There's a moment you can't stop; you feel you have to save all the women. I think that's a very difficult moment, but then in the long term, it all settles down. You understand many things. We say in our association that it's a feminist issue. We think our grandmothers had to battle to vote. Our figurative grandmothers, I mean. They had to battle for the women's vote, and they had to hear many of the things we hear now. Then our mothers had to battle to work, for the right to work. And now, it's our turn to battle for the right to give birth as women want, and safely. We were born in the seventies, in the eighties, and in the nineties, and now it is our time to do this.

ES: How is the association sustained?

Ibone: It's very easy. Women join us. Unfortunately, many women join us because of the bad birth experience. Basically, the association is very open. If you have any idea, we tell you: "OK, you go and do it [laughs]. We support you; you tell us what you need. If you want to start a campaign, we give you this. If you want to start a subgroup, you need to be in the association for a year, and to have a support from other members." But it's very easy; you set up a group in your town. We do most of the work through the Internet. When you join the association, you find out everything that's been done; you can choose to join the Caesarean support email list, or you can choose to support the lawyers, or you can choose to be in the scientific translation committee. There are many different groups.

ES: How does your association sustain itself economically?

Ibone: It's mostly from members' quotas. We get very little public money.

ES: Is there a core group? Is it centralized or does it work more as a network?

Ibone: It's more a network of groups, self-sustaining.

ES: As a leader of the association, is this work sustainable for you?

Ibone: There was never one leader. When we founded the association, there were twenty-one of us. I think because the way we see motherhood, we were very much against the association being associated with only one leader. We are a community. One day, one woman is the president and the next day, it's another woman. And if somebody has to go to talk on the TV, we ask: "Who wants to go?"; it's the same when somebody wants to publish a book. I think that this is the biggest treasure we have. We have a really good support network. Some of us may leave the association; some may come back. Some may be very active for two years and then forget about it. But there's never been much of a problem. The good thing now is that the association is not related to one person or two. Maybe there are five or ten people, like me, that might be a bit more known because we were there at the beginning. But even then, there are many of us. There is no person that can take the credit and say "I did this." No. It was always mothers working together. And we made sure this was clear; it was not for personal benefit or for being famous [laughs]. I think that's beautiful. It's the way mothers work. Many women were very active until they were pregnant and halfway through their pregnancy, they said: "I need to leave this." Fine.

ES: How do you make decisions in the group?

Ibone: There is an annual meeting, an assembly of the association, and it lasts for two days. In these two days, the most intense moment is a round of

presentations. We can take up to seven hours to listen to every woman; every member who is at the meeting tells us her story. We all end up crying because there are women who come to tell us about their stillbirth loss or about their successful vaginal birth after two or three Caesareans. This is very intense. Our strength is that we always listen to each other's birth stories. After that, we vote on the decisions. The president position is always held by a group of four women, sometimes there's been a man, but most of the time it's women. The four of them make the main decisions through the year, but they always communicate very well with the rest, and then there are different subgroups. The subgroups make their own decisions in communication with the presidency, but it has never been a big problem, really. Things always flew. We do vote on the main decisions at the general assembly of the year. But I don't remember a decision that was very difficult. There might have been some, but right now I can't think of any.

ES: How did your profession as a psychiatrist influence your activism as a mother? How did the profession combine with the motherhood and issues about birth?

Ibone: I learned a lot from this process. I gave so many talks. I learned how to deal better with health professionals. You asked me how my profession affected me as a mother?

ES: How is this connection working? How is it balancing?

Ibone: I have a lot of problems … with medicine. I love medicine. At the same time, I'm very upset by the way medicine is these days. This created a lot of conflict within myself, both as a mother and as a psychiatrist. It created a lot of tension. The more I learned from other mothers, whether it was about breastfeeding or about birth, the less I liked medicine. I went through a personal process of trying to get to the roots. I like medicine. I believe in evidence-based medicine. But at the same time, I think there are many problems with modern medicine. The biggest one, I think, is that medicine has to now listen to mothers. I don't know how to say this. It's very difficult; it's a strong tension. Then, as a psychiatrist, when I had a serious posttraumatic stress disorder (PTSD) after my last Caesarean, nobody diagnosed it, not even myself. It took me years to understand what I had gone through. I have to say this in Spanish: "*En casa del herrero, cuchillo de palo*" ("The shoemaker's son always goes barefoot"). The fact that I was a psychiatrist made it much more difficult for me to get help for my own PTSD, or even to understand what was happening. Now I teach many students, but I'm very critical about medicine. Yet, I love medicine. It's very contradictory.

ES: You can probably improve medicine this way.

Ibone: I hope I can humanize medicine. Our association *El Parto Es Nuestro* is a fabulous support network for me and for many of us. I have a very good support network from women, from different professionals whom I totally trust, and who can give me the best advice in various situations. Many members of the association say this is one of the most valuable things, belonging to this association, the fact that we have this network. If someone needs help in Barcelona or in Canary Islands, they can always find help. It can be help for a mother; it can be help for a divorce, what diet to have, how to manage your money or how to focus your professional goals. You get support for things that are not related to birth because of this big network of activism; it's a big network of women helping other women with a common trust. That's a gift coming from the activism.

ES: Did you ever have to choose the role you wanted to assume to give authority to your words, acting at times as a mother, at times as a psychiatrist?

Ibone: At first, it helped. Because I was a psychiatrist, I had the opportunity to make doctors, psychiatrists, or others listen to women's experiences of childbirth. I did that a lot. But many times, I would be rejected. The more I healed my own traumas, the better I was able to do that. Now that I feel I have healed, I can talk to doctors, and I can make them listen to women's experiences without getting upset anymore. I think that before they could feel my rage [laughs]. I feel I'm lucky to have the opportunity, because of my degree, to make them listen to me. I wish they could listen to me, and that they could listen to mothers, but this is the world. Now, I have this platform to talk to them, so I take it.

Conclusion

The experience of childbirth affects women in many ways, resulting in a radical change in women's life; women realize that becoming a mother means reorganizing their own identity and its relation to society. As Andrea O'Reilly puts it, "motherhood is the unfinished business of feminism", and many women realize that statement's truth the moment they give birth to their first child. The conversation between Ibone Olza and me reveals the struggles women face when they realize feminism has left them behind as mothers and has handed them over to an oppressive patriarchal system—disguised as medical and technological advancement—that completely devalues them as women and as human beings (Cohen Shabot and Korem). For some women, this awareness triggers a desire for action, and they invest energy and personal resources to change the state of things for other women. These acts of empowered motherhood, in O'Reilly's words, are powerful agents of change,

which may result in shifting of social paradigms, in community building, and in new careers for women who practice them. Yet they also come with consequences, such as exhaustion, post-traumatic stress disorders and others (Barry and Djordjevic).

Current practices of empowered motherhood focused on childbirth are using what has been called "evidence-based activism" (Rabeharisoa et al.); scientific knowledge and data are used together with experiential and embodied knowledge to make the desired changes within the system, rather than acting outside of it. In case of obstetric violence, this approach shall be considered as a successful one, even if the outcomes are debates and controversies. At least now, there is a reaction, whereas for decades, there was complete indifference. Marketing strategies, such as media campaigns and the press, are additional tools that the motherhood movement has learned to apply for major social and political impact.

Though criticized for "sensationalizing the data" (as expressed by an executive of the Italian Ministry of Health in a personal conversation), mothers activists are financially investing in the production and dissemination of scientific data related to the issues that concern them, and they demand accountability to the system financed by citizen contributions. It is only by showing their financial and political (socially influential) strength that mothers' voices are heard and acknowledged by the system; they can challenge stagnating relations of power, such as the power of obstetricians in the domain of maternity healthcare.

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Folio

Editor's Notes

It's a great pleasure to feature Adrianne Kalfopoulou in this issue of *Folio*.

Adrianne Kalfopoulou lives and teaches in Athens, Greece, and serves as a faculty mentor in Regis University's low residency MFA program. She is the author of three poetry collections, most recently, *A History of Too Much* (Red Hen 2018). Her publications include two essay collections, and several chapbooks, with featured or anthologized work in UK, Canadian, American, Polish, and Greek online and print venues. Recent or forthcoming appearances in *HOTEL*, *The Common, Inverted Syntax*, *Slag Glass City*, and *Writers and Their Mothers*.

Kalfopoulou's verse is widely admired for its matchless fusion of sensuous beauty and historical perspective. Poet and essayist Debra Marquart has praised Kalfopoulou's unique ability to "navigate[s] themes of exile, war, perpetual homesickness and the complex histories of family and country." Reflecting on Kalfopoulou's most recent collection, *A History of Too Much* (Red Hen, 2018) which centers on the Greek financial crisis, poet and critic Cynthia Hogue finds a "powerful lyric testimony to the courage, humor, and brave resistance with which ordinary people faced augurs of loss in Greece." In this selection, readers will encounter poems of formal rigor and expressive lyricism: a body of verse that reveals this poet's affinity with literary mother Sylvia Plath as well as her kinship with the specifically female tradition of politically committed vision embodied in Muriel Rukeyser's oeuvre.

Kalfopoulou's poems are deeply grounded in domestic settings; these familiar spaces of dailiness open onto broader vistas and reveal complex histories. In "My Daughter's Eyes," the speaker contemplates the right words to answer her child's questions about parental separation. Within her daughter's gaze, the speaker locates the richly colored reflections of the familial heritage that shape her child's life—one that crosses global terrain from "deep Aegean velvets that lap/the jagged shorelines of so much discord, so much/

fevered history" to her "father's orphaned, barefoot escape,/a Smyrnian memory." Here, as elsewhere, the poet turns an unflinching eye on the challenges of motherhood, noting the distances that accrue in the language a mother and her child share: a daughter will "ask for the world whole," while her mother "can only translate so much." Kalfopoulou's poems are particularly revelatory for the unsentimental descriptions of exile and the attendant desire to belong; they probe connections between lived reality and myth ("Refusing to be Demeter").

The links between personal and broader cultural history are vividly documented in "'Are You Listening?'" where a family's traumatic history of exile and escape is set against the larger cultural backdrop of international conflict ("Saigon. Phnom Penh. Jakarta./Countries of emerald leaves, the breadfruit trees. . . "). As conversation between the speaker and her mother unfolds, it becomes clear that the father's work in "dangerous places" and his wife's efforts to shield her children from the violence of war have left a dark legacy. As past and present intertwine, the poet is transported from the inconveniences of the current moment to "the bullet-marked walls, inside/the back bedroom where war was not meant to reach."

Writing about trauma is never simple; it requires writers to achieve an emotional balance and to construct a clear narrative of troubling and chaotic events. Kalfopoulou's poems frequently adopt formal structures to accomplish these goals. "Mute as Lawns Nobody Dares to Walk Across" showcases her technical mastery and keen awareness of intergenerational communication. The interlocking lines that define the form here recreate the uncanny logic of trauma, tracing the circular nature of conversation between the speaker and the mother—one that accommodates a range of characters as well as frequent shifts in time and place. The poem is a powerful testament to the discomforting truth known to generations of mothers and daughters: a painful heritage will make ordinary conversation fraught; healing may be a lifetime's work.

Kalfopoulou pays special attention to the challenges faced by mothers raising children on their own as they negotiate the competing demands of maternal duties and the desire for personal fulfillment. The speaker of "Growing" merges poetic composition with her daily chores, admitting:

> . . . it will take all of my strength
> to get through the bath hour, reading Babar,
> the talk of hair and how and if we will braid it,
> tomorrow's homework review.…

"A White Horse," meanwhile, portrays obstacles in love as the speaker's partner "struggles with the idea of my child/the difficulty of loving me with her." At the same time, the poet is drawn to moments of joy, as in "Cherries,"

where a mother and daughter share a bowl of fruit, eating them "pits and all":

> as if these fat-skinned jewels came
> straight from God, as if
> no other berry matched this
> sun-filled sweetness.

Poet and translator Aliki Barnstone observes that Kalfopoulou's writing "takes us beyond the whitewash into the heart of Greek culture . . . and creates a map of the contradictory Greek psyche." Kalfopoulou's verse lovingly charts the contradictions implicit in mothering; her comments offer a lively glimpse into her artistic process and I'm glad to include them below.

—Jane Satterfield

A Lineage of Silence

"As I put these poems together I saw themes, obsessions, repetitions: a tension between yearnings, the demands of parenthood, in my case single-parenthood, and overriding circumstances. But there were inheritances, too, a lineage of silence, subjects avoided, left unvoiced as in "Mother Tongue", "Mute As Lawns Nobody Dares Walk Across" and "'Are you Listening?'" — in the silences were the complications, of unrequited nurture most obviously, for what feeds/constructs a self or fails to. In this the violences of the patriarchy are implicated. I think of Hélène Cixous' words from "The Laugh of the Medusa": "Muffled throughout their history, they have lived in dreams, in bodies (though muted), in silences, in aphonic revolts." Many of the poems engage with loss, all speak to a conflicted response to motherhood — themes include *eros*, absence, sacrifice, failure. "The Border" conflates the idea of the body as permeable and so vulnerable, to the circumstances of an economic migrant, a young mother forced to leave her children behind, the border suggestive of state-patrolled boundaries as well as how these, as with the body, can be violated. What is passed down in the matrilineal? A silence as much as a yearning, fraught doublings of the domestic and public, inheritances in an economy of nurture that continues to privilege the desires of men over those of women; fissures that produced poems."

—Adrianne Kalfopoulou

Adrianne Kalfopoulou's blog posts, reviews, sample work & rants can be found @ www.adriannekalfopoulou.com.

ADRIANNE KALFOPOULOU

FROM WILD GREENS (2002)

A White Horse

For intervals there is the island, *Kea*,
a blue you could drink
and my friend Steve's words, that the game
gets serious, the stakes higher, as we dare to live
as we gather our living.

A woman on *Kea* strips the laundry lines of wash,
her muscled arms burnt from sun,
she thinks of nothing but the work, the wash,
the day's heat scarring her flesh.

Does he understand this fire?
The one who struggles with the idea of my child,
the difficulty of loving me with her.
There is the story of the grandfather
who sold off parts of his land to save
his young wife who died anyway.

In so much island dust and brown
a white horse stands in the night, luminous, loosely roped.
The vision is with me when we return
and my daughter waits for me.

There is the kitchen full of toys, the need
to pay, cook, wash, gather her demands.
She measures my presence, has no idea
of the distance I have come.

ADRIANNE KALFOPOULOU

Pirouette

The smell of *AJAX*, orange bits in the sink.
The children playing make-believe,
my hands getting old, my eyes
with that expression of first love
in a photograph taken years ago,
his arms firmly around me, my eyes on fire.
His wife will call now, pregnant
with their second child, she will tell me
of his long working hours, of her loneliness.
The children run breathless. I heat lunch.
My friend Elina's son takes charge, the eldest.
Elina teaches dance all day to pay the rent,
weekly fish soups, socks, tights, then
the dresses that shine expensively
in late bar nights where amateurs envy
her step into that full turn, the pirouette she says
beginners find difficult, grace in the limbs
that would move us into better lives.
Our children run the halls playing
that game the world will always change:
I hear them scream —
I'm the deer, me the rabbit!
Do rabbits live in forests?
I want them to live in forests…

I stir the food, think of how smoothly
the man flirted with me on a plane we took
almost a year ago, his life far away
(2 children, a devoted wife).
Smelling of magazine colognes, he wrote
a number with well-manicured hands,
the number later an ink blur in my washed jeans.
I spread one of Korina's drawings next to him,
he looked carefully at my hands
without creams or rings, the drawn house
exploding with color, windows
in the air, trees, she said it was a forest
with windows, I said a forest didn't have windows,
so she drew a house around it.

ADRIANNE KALFOPOULOU

My Daughter's Eyes

My daughter's eyes have all of Greece,
all of Turkey in their limpid darkness
lightening out of burnt shades of brown.
Wet and jeweled like Asian candy
they scatter a color so rich I see Bursa,
the *Anatoli*, deep Aegean velvets that lap
the jagged shorelines of so much discord, so much
fevered history. Her eyes resurrect ancient possibilities
alive the moment she will insist on truce,
the measured beauty of Platonic balance.
"Why can't you smile at dad?" she asks, "why
can't you and he be friends?" She is trying
to cross an unknown Bosphorus
to reach Agia Sophia's gorgeous spires.
But the saints are buried under plaster, their eyes
gouged out – her everlasting *why*
swims the turgid moment. I am her other-
cultured American mother, her short-tempered efficiency,
her father is his father's orphaned, barefoot escape,
a Smyrnian memory, the songs she sings
whose words stay foreign and full of intent —
her longing could almost bridge the amber depths,
her eyes ask for the world whole, and I
can only translate so much.

ADRIANNE KALFOPOULOU

Growing

She uses the apartment key to let herself in
from the neighbors. I am unnerved, maybe from drinking.
I know it will take all of my strength
to get through the bath hour, reading *Babar*,
the talk of hair, how and if we will braid it,
tomorrow's homework review — I am really in a poem I say,
cutting lines together, images, this poem I am always
aiming at, pulling the sheet over the day, pulling
the browned buds off the night flower (didn't give it
enough water this winter — it might not bloom
this spring). Brushing out my daughter's fine hair
over her wide forehead, caressing it, I put
another story together; she says in eight-year-old directness
"You threw him out didn't you?" This is the moment
I gather the lines, the poem, raw tendrils watered
or not, snapped in urgency (the night flower has such
a pungent smell). He wasn't with me anymore sweetie,
he slept on the couch in the living room, that's not
being together." She weighs this, the poem
in fragments, may never get written. We are managing this —
I am calm, I am on other territory, a kitchen of plenty,
school problems solved, pencils sharpened,
the lesson memorized. "Did I do it right?" she asks
of the math review. I am calculating the lesson —
motherhood, this sudden test. Unprepared, untutored
I am telling her the grade isn't important, it's what
you learn, what you can take with you.

ADRIANNE KALFOPOULOU

Cherries

Pits and all, we eat the cherries
as if these fat-skinned jewels came
straight from God, as if
no other berry matched this
sun-filled sweetness.
Our tongues dark
with the swallowed juice of it,
the fruit skins peeled
against our teeth when
she wants to know,
between the greedy eating,
what happens when you love,
when you really love a man
and have a child and five
years later want divorce?
Maybe that means, I think and say aloud,
the love wasn't enough.
Her fingers play the stems, pluck
two dark purple pairs,
eating them quickly, she says
so you need to know, and
looks for the sweetest ones,
the ripest gem-like colors, impatient
with the pits, swallowing them too,
summer's sweetest crop.
You never know, I assure her.

She murmurs, smacks her purpled lips,
quickly spits one out,
unripe and sour, rushes
to wash out her mouth. Sometimes
the fruit looks sweet beyond belief,
there are so many you just can't
get enough. We are leaning
against the kitchen counter top,
the cherries between us
in their bowl, the citronella candles
lit against June mosquito bites.

ADRIANNE KALFOPOULOU

FROM PASSION MAPS (2009)

"Are You Listening?"

We begin with practical things, the washing machine
that doesn't work, my unemployment benefits,
but before I know it I'm coughing tears
telling my mother after years I can't seem to speak
about what really scares me, as she tells me
my father worked all his life
in dangerous places *for us* so we could have
what we have. Saigon. Phnom Penh. Jakarta.
Countries of emerald leaves, the breadfruit trees,
fried bananas, and the sticky rice I loved to eat.
Dangerous places she repeats
and I'm inside the bullet-marked walls, inside
the back bedroom where war was not meant to reach
where my brother is asleep —
the music box in his hands, the tiny ballerina
twisting stiffly in her one dance when we find him
on the stairs cradling her faint song,
my mother unable to explain the mysterious way
he sleepwalked, a soundless sampan floating
down a mined Mekong. *Are you listening?*
I'm saying, *You never listen to what I'm really saying.*
The flooded shame, urine-soaked sheets, scared
as my father checked the streets.
The Vietcong outside, and inside my mother
irritated at having to change the bedding.
More urine-soaked sheets. And the war went on
and we left Saigon and years later my mother tells me
not to make such a fuss about a stupid machine.

ADRIANNE KALFOPOULOU

Mute As Lawns Nobody Dares to Walk Across

When my mother calls telling me of still freezing nights across the Atlantic,
I smell moldering pears, see the claret tinge of their bruised skins, as mother
talks of her darkness, the not-good-news that travels from where she lives in
thinner light, her voice in low cadences as she speaks of Kiveli who made pies
all her life and

I smell the moldering pears, see the claret tinge of their bruised skins, as
mother talks of *that awful man who rubbed Kiveli's face into the pavement and
broke her elbow*. Her voice in low cadences as she speaks of Kiveli who made
pies all her life and lay bleeding on an Athens street when a young woman
found her and asked if

that awful man who rubbed Kiveli's face into the pavement and broke her
elbow was someone she would recognize. *What man? What man?* Kiveli was
crying and lay bleeding on an Athens street when a young woman found her
and asked if with her face to the pavement she remembered the event.
Remembered if the man

was someone she would recognize. *What man? What man?* Kivelis was crying
and asked over the phone if I wanted a bottle of oil from her olives, *for your
salads?* With her face to the pavement she remembered the event. Remembered
if the man had hurt her any more she would not have been able to walk, but
won't say more, and

asked over the phone if I wanted a bottle of oil from her olives, *for your salads?*
I tell my mother I'm going to see Kiveli, and mother tells me if her arthritic
knee hurts her any more she won't be able to walk, but won't say more, and
I ask about her surgery, whether her knee is healing, and say she'll be okay.

I tell my mother I'm going to see Kiveli, and mother tells me if her arthritic knee gets any worse she will be left to the sad fact of a wheelchair life, so I ask about her surgery, whether her knee is healing, and say she'll be okay. *Do you have memories that won't heal?* the Vietnam vet asks, confessing had things

got any worse he would have been left to the sad fact of a wheelchair life, so *What man? What man?* The therapist wants to know, muffled voices, Vietnam. *Do you have memories that won't heal?* The Vietnam vet asks, confessing had things… There was a coup d'état. I learned to count in Thai then we moved to Bangkok.

What man? What man? The therapist wants to know, muffled voices, Vietnam. I had an uncle who thought it fun to slip my panties down in a circle of adults. There was a coup d'état. I learned to count in Thai then we moved to Bangkok. My uncle would say we played a game, the circle of adults nodded and laughed.

I had an uncle who thought it fun to slip my panties down in a circle of adults. He died in a hospice speaking in Greek his American wife couldn't understand. My uncle would say we played a game, the circle of adults nodded and laughed. Kiveli is healing fine, back to making pies. We talk and I tell her of my uncle.

He died in a hospice speaking in Greek his American wife couldn't understand. My mother says how sad to die speaking words your wife can't understand. Kiveli is healing fine, back to making pies. We talk and I tell her of my uncle. I'll revisit Vietnam, even Bangkok. *It all comes back*, the therapist insists.

My mother says how sad to die speaking words your wife can't understand. *And poor Kiveli, accosted by that man … What man? What man? …* I'll revisit Vietnam, even Bangkok. *It all comes back*, the therapist insists. So I tell my mother about my uncle and she is uncomfortable, interrupts with

And poor Kiveli accosted by that man … What man? What man?... her darkness the not-good-news that travels from where she lives in thinner light, her days mute as lawns nobody dares walk across, and I'm folding sweaters and scarves when my mother calls, telling me of the still freezing nights across the Atlantic.

ADRIANNE KALFOPOULOU

Mother Tongue

I always felt she would have preferred to sing
her words the way she stood in choir, part of the curve
of women in their choral robes who gave themselves
to song. Instead she swallowed her arias, whole operas,
ignored what seethed, entire sentences of crooked turns
she chained to contain how she might feel
letting loose a ballad or hymn instead of watching
Frank Sinatra on television, keeping time to my father's
banal rhymes. It was *Let's have some wine*
when things were fine or *You always whine* and she,
predictably, replied with her *I don't mind* and *that's fine*.

It was the pact she kept but didn't express, the way
she placed plain verbs like *see* and *eat* and *sleep* faraway
from the dangers of *dare* and *rage* or *age* (when she
hardly breathed seeing him beat the anger out of me)
that taught the importance of listening to what was not said.
What I couldn't understand, like the sermons in church
by the priests speaking in Latin or Greek, I came to admire
for tone and somber murmurings, and the rapture
of everything the words didn't capture.

ADRIANNE KALFOPOULOU

He Wants Me to Describe It

My friend wants to know what I think of
when I panic. I pause in front of lit shop windows of long
wrap-around scarves, beaded necklines and Indian silks.
Absence, *abandonment* are the words
but they don't satisfy him. Our kids are in a bakery
calling us to taste how quickly meringue
melts on the tongue, how sweet it is. We forget it's late
until we say goodbye.

He will go back to his apartment with his daughter
who will soon go back to her mother in New York.
I will drive home on the night road
where I almost met oblivion. His daughter will cry
because she doesn't know why Christmas didn't feel like Christmas.
I will remember how easily the car wheels skidded
off the wet road in a new year rain.

When I panic I think of that wide desert space,
the expanding field of it, the harsh, cold swallow of hope
in a black night drive when the roads are wet and I have had
too much to drink and desperately want to reach home, the feeling
is as still as a punished child waiting to slam its fist into the door.

ADRIANNE KALFOPOULOU

I Could Want

His hand, the smile that eludes me.
I could want a childhood that never happened.
I nudge the cat asleep at my feet,
her shape cushioned. I am envious of cushions,
expectant mothers, the curve that protects,
his clutching of my entire back
in love. I could want a future of love.
I could want to protect my daughter
with the fierce cushionings I did not have. I could
go about feeding live souls, the cat, the parrot.
I could manage the half expectation
of his wants, without wanting more. I could want
that he want more, and know he cannot
manage more. She has an expression in her eyes,
her gaze elsewhere, wanting. I could tell her
of my failed desires, I could assure her
of the effort that ropes in boats
when open sea scatters them. I could want
to never stop reaching toward her,
her own boat unanchored beyond what I can
cushion or reach. There's so much I want to tell her.
I could want what I don't have to give, give
what I don't have.

ADRIANNE KALFOPOULOU

Ritual

I throw out useless potatoes, soggy
onions in thinned skins, like grief
smelling of rot. I think of my daughter
in the shower, friends caught in narrow lives
— nothing spectacular, the floorboard sounds,
my neighbor's movements, men who've left scents
in my dreams, that one lost face, this
pavement in rain, nothing spectacular, this
dumping of the trash, its full thud, I do it
without much thought. Strange
how I see my daughter's wet hair, her body,
a cleansed altar.

ADRIANNE KALFOPOULOU

The Border

Ruska is preparing for the dawn trip
to Bulgaria, years since she saw
her two sons, Ivan and Evgenio,
but they are still small and when asked
what they want for Christmas
they say, "mother."
What Ruska fears is not
the village gossip, that she has lived
these years in Greece with another man,
or the unemployment she is sure to find
on her return, the shortness
of food and freedom.
What she fears is the border.
The men at the station stop
will force them off the bus in the black
winter chill, decide the hours,
even days, of their waiting
in some infinite space of doom.
They will make fun of the cargo,
spit slow laughter
at the luggage of life,
so dispensable — the packets, bags,
nudged and kicked, the contents
of an impossible life: Ruska
who left her sons at 22, penniless.
In Greece it was possible to hope
to return after having
gathered the money to make a life.

At this border Ruska fears
the soldiers will rip through the bags,
even her body, toys will spill
across the hardened ground,
tiny gold crosses will show through
torn linings, clothes will be shredded
as her frozen hands will gesture dumbly.
Crossing over into homeland
would have meant making it back
through so much pain.

ADRIANNE KALFOPOULOU

FROM A HISTORY OF TOO MUCH (2018)

First Audition

In the hazed windows — tomorrow's market wares,
plastic containers and cotton underwear stacked on one store shelf.
No takers this time of night, and I'm thinking she's unaware,
on stage in another hemisphere, reciting lines, herself
the daughter Iphigenia. And like Agamemnon listening to her plea,
the sages will decide, judge the worth of her words, and grief.
She's giving of her heart, fighting Calchas' decree
while I, the mother, walk the streets without relief.
Despite the hour, the drunks, the one man chewing on a rusk
with something close to lust, I can't stop thinking of her part —
what grim fate brought his man to his single crust?
I pass parked vans, tomorrow's meat in a lit shop, dark
chopping blocks clean behind the glass, see the skinned lamb last,
imagine butchers making cuts, how the blood will run, how fast.

ADRIANNE KALFOPOULOU

Refusing To Be Demeter

No, I don't like that myth, the way it brings the bled flesh
and death so close: I don't want or need the lesson —
I know it well and prefer to leave behind the grief,
let Persephone have her time with Hades or Hal, eat or not eat
the pomegranate. I did what I could, scoured every inch of what I loved
through her gaze — all of it, the blooming ground, acrid and sweet,
the burgeoning growth, while like winter I gradually stiffened,
weather whittling what I once knew to be me, and in this chill
that calamity — limbs torn in the sheer element of lament.

No, I refuse this story. I who am not a god,
I who cannot follow her anyway, bound to nature's law.
Why not sit to what I can enjoy — I could eat the fruit myself.
October coats the air, the temperature has dropped, the offerings are ripe.

Credits:

"Growing" in *poem, home, An Anthology of Ars Poetica*, eds. Jennifer Hill, Dan Waber.
"Mute As Lawns Nobody Dares Walk Across" in *BPJ* (*Beloit Poetry Journal*)
"He Wants Me to Describe It" in *Room Magazine* (contest winner)
"The Border" in *Crab Orchard Review*
"First Audition" in *JMI* (*Journal of Motherhood Initiative*)

Adrianne Kalfopoulou lives and teaches in Athens, Greece, and serves as a faculty mentor in Regis University's low residency MFA program. She is the author of three poetry collections, most recently, *A History of Too Much* (Red Hen 2018). Her publications include two essay collections, and several chapbooks, with featured or anthologized work in UK, Canadian, American, Polish, and Greek online and print venues. Recent or forthcoming appearances in *HOTEL*, *The Common, Inverted Syntax*, *Slag Glass City*, and *Writers and Their Mothers*; blog posts, reviews, sample work & rants can be found @ www.adriannekalfopoulou.com.

Book Reviews

The Mother-Daughter Puzzle: A New Generational Understanding of the Mother-Daughter Relationship

Rosjke Hasseldine
Durham: Women's Bookshelf Publishing, 2017

REVIEWED BY GILLIAN M.E. ALBAN

This book offers a road-map enabling readers to learn in what ways gender and generational relationships have gone off track, and suggestions regarding how to get back on the road complete with one's psyche, mind and relationships in working order. Hasseldine makes no concessions to traditional gender perceptions that silence women and their emotional needs. Nor does she tolerate the general mother blame that permeates our societies, placing the new generation's needs over the wholeness and completeness of those who have gone before and suffered. She asserts that the relationships between mothers and daughters are entirely central to a healthy life not only for women, but also for society as a whole. Her methodology offers a series of exploratory puzzles and straightforward diagrams for the reader to work through. She proposes that when women as daughters investigate and attempt to understand the history of their family relationships, this frequently reveals a history of abuse that women have inherited from their predecessors. Gaining insight into such fraught histories will enable the younger generation to empathise with the oppression of their mothers and grandmothers. At this point Hasseldine unfolds the story of her own mother's abuse of her, and her own generous blessing on her mother, despite the fact that she has apparently been unable to heal her fraught relationship with her mother.

She suggests that women have so frequently inherited a mantle of silence which gags their free expression, together with women's persistent enslavement within the traditional "Culture of Female Service." Perpetuating a system of women's servicing the needs of others, their own needs remain permanently on hold.

Rosjke Hasseldine is an internationally innovative psychotherapist working within the under-explored and under-valued key relationships between mothers and daughters. She expresses her frustration with attempting to solve women's issues, and feminism's struggles to instigate change in society, when we understand so little of the generational damage that has occurred between generations of women. She enlightens her reader regarding how women have been abused and gagged, leading to an endless cycle of female frustration, with women trapped and unable to voice their needs. Through the pertinent use of illustrations of problematic relationships, and demonstrating her own diagrammatic steps of self-analysis and enquiry into family history, she offers practical steps to enable women to break free of crushing relationships to end continuing under-achievement. Her questionnaires include such topics as "How emotionally Hungry are you?" and "How Strong is your Mother and Adult-Daughter Relationship?" while showing the reader how to draw their own family tree or genogram, complete with relevant lived experiences, in order to trace the patterns of frustration and abuse that may have dogged their foremothers. From this point of insight, she suggests methods devoted to changing such circularly destructive cycles, thereby empowering her clients to free themselves of the debilitating patterns of the past that have thwarted their family's inter-personal relationships.

This book is based on Hasseldine's extensive experience of working with clients throughout the world through their problematic relationships. Her personal legacy is of a generational journey traced all the way from Holland to New Zealand to England and finally America, indicating the universality and hence the relevance of her experience and treatment. Her methods enable her readers to empower themselves as independent and inter-caring human beings, rather than remaining doomed to be female doormats. Backed up with her extensive research, this book offers clues as to why feminism so frequently remains helpless at solving women's problems. She suggests that until we investigate the primal relationship between mother and daughter (and whether we actually have daughters or not, all women are daughters), then we cannot solve the problems of women in the world. I highly recommend Hasseldine's book and intend to instigate this programme myself where I can.

Mothering by Degrees: Single Mothers and the Pursuit of Postsecondary Education

Jillian M. Duquaine-Watson.
New Brunswick, NY: Rutgers University Press, 2017

REVIEWED BY VICTORIA BAILEY

In the opening of the acknowledgements, Duquaine-Watson shares:

> The process of creating this volume has been filled with both moments of absolute joy and numerous trials. At times, the trials took over and seemed unsurmountable, and I would put the project aside for weeks or months at a time. At one point, I even decided to discontinue the project altogether, tucking the completed chapters, observation notes, interview transcripts, and research files into the bottom of my filing cabinet and locking the drawer. I didn't open that drawer again for nearly two years. (195)

But thankfully Duquaine-Watson did persevere with her manuscript. Duquaine-Watson's text is nothing if not thorough, accessible, and most significantly, important. It frames struggle and challenges that no doubt continue to be experienced every day by single mothers striving to access and complete secondary education for a variety of reasons. And herein lies the key to *Mothering by Degrees*; students who are single mothers are not homogenous. They are individuals in aim of a personal academic goal sold to them, or believed by them, to be of benefit and a worthwhile pursuit.

The candor in the quote above also demonstrates Duquaine-Watson's engaging and frank writing style. The personalized story that opens the prologue of the book sets up a relationship with the writer that feels like an exchange along the lines of: "Others shared such personal stories, thus, here is mine." This positioning works as an equalization, serving to create a more equal power footing between researcher and participants. Though some of the included stories seem a little old; this may be due to the time span represented by the experiences and stories of Duquaine-Watson's interviewees, and the significant amount of time spent researching.

The chapters, especially the opening section entitled, "The Politics of Single Motherhood in the United States," provide an extensive and thorough outlining of history of experience, policy, and social and media perceptions of single mothers in the United States that demonstrates comprehensive and rigorous research. Duquaine-Watson affirms in the conclusion of this text that, "While four specific challenges emerged from my research, not all

participants faced all four of those challenges and not all participants faced them in the same way. Thus, it is important to begin by asking questions, [and] listening to the answers ...." (193). This text is a great first step in that process and I would recommend it to academic instructors, administrators, and policy makers to be inclusive in supporting and serving a significant, yet oft overlooked portion of the North American postsecondary student population.

Duquaine-Watson declares in the Prologue, "This project is ethnographic…," (11) yet in the same paragraph admits, "… I do not pretend that I engaged in this project as a sort of blank slate or that I wrote this book as a detached, dispassionate observer" (11). I wanted Duquaine-Watson to lay claim to being an advocate and overtly situate the work to fuel and inform activism and change. For example, in the chapter titled, "Trying to Make Ends Meet," Duquaine-Watson describes how many of her interviewees would freely provide detailed personal financial information that, "… felt almost too private to share with a researcher, even one who had promised to preserve their anonymity" and ponders if this was, "… due to the fact that they were seasoned pros about sharing their financial information," or that, "… their frankness about financial concerns was an indicator that the women had internalized a dominant American discourse related to poverty and single-mother-headed households," or that, " …maybe they had simply been raised in households that had very different attitudes about discussing personal finances than the household in which I had been raised" (44). Or perhaps there is a fourth possibility, and to be frank, it was the option shouting out to me between the lines and anecdotes. Maybe the interviewees experiencing daily significant struggle thought a researcher whose, "… academic interest lies, in part, in the persistent, pervasive, and dominant portrayal of single mothers as bad and in the blaming of single mothers for a variety of social ills …" (11) might be able to make a difference. When Duquaine-Watson shares how she has, "… shared my findings at formal presentations at academic conferences, at invited talks and guest lectures to college students and community groups, and in the form of book chapters and journal articles," (183) she is indeed advocating for these mothers. Overall, Duquaine-Watson's work is accessible, thorough, and well-worth a read; its credible value speaks for itself, and most importantly, allows the voices of others to speak for themselves too.

Everyday World-making: Toward an Understanding of Affect and Mothering

Julia Lane and Eleonora Joensuu, eds.
Bradford, ON: Demeter Press, 2018

REVIEWED BY RACHEL EPP BULLER

This new edited collection from Demeter Press opens with some guiding questions: What can we understand about mothering through the lens of affect, and vice versa? And, what happens to our (understanding of) mothering when we address its affective dimensions and potentials?

Mothering studies and the study of affect are each growing fields of interest, but this book brings the two together by foregrounding "the ordinary and the everyday as significant research sites for considering both affect and mothering" (6). The editors argue that mothering is often dismissed and depoliticized because of this ordinariness, but that the lens of affect – studying the capacity to affect and be affected – offers a productive way into the ordinary, framing it not as something easily dismissed but rather as a mode of world-making. "Affect theory provides tools to make sense of [the] affective intensities [of mothering] as they move between bodies, and between bodies and environments" (5).

As the first volume of its kind to investigate the overlaps and intersections of affect and the maternal, the book benefits from an experimental spirit. The editors note that many of the contributors were new to either affect theory or maternal studies, or both, and so the essays are "essays' in their truest form – trying out certain ideas and considering intersections perhaps for the first time. The editors divide the book into three sections: "Becoming and Performing Mother," in which contributors explore affective, relational, experiences of mothering as well as performative writing; "Mothering and the Potentials of Dark Affect," addressing topics such as ambivalence and child loss, the "dark affects" of mothering that make us profoundly uncomfortable; and "Manoeuvering the Boundaries of 'Mother,'" in which writers move beyond topics of pregnancy and birth and into expanded forms of relationality.

The format of the volume departs from that of many edited collections. In addition to the standard introduction, the editors also write mini-introductions to each of the three sections, helpfully framing the contributions and providing theoretical continuity throughout the book. The editors return frequently to ideas from the writings of Sara Ahmed, Lisa Baraitser, Brian Massumi, and *The Affect Theory Reader* edited by Melissa Gregg and Gregory Seigworth, continually putting feminist, maternal, and affective voices in conversation

and reminding the reader of their intentional multidisciplinary lens. Alongside the to-be-expected scholarly investigations, many of which incorporate autoethnographic methodologies, the book also includes poetry—Kari Marken's poem 'fail,' seeking to rewrite the cultural script about divorced mothers, is a particularly welcome addition – as well as "Sisterly Conversations," informal discussions conducted by each of the editors with their family members. While these conversations offer an in-the-moment quality to readers, they could be edited significantly to remove filler remarks and present greater focus.

The transdisciplinary nature of the book is sure to include topics of interest to a wide variety of readers. Brenda Benaglia explores the distinctive affective and relational space created by doulas. Sandra Faulkner performs a fascinating cost-benefit analysis of her own pregnancy as way to investigate maternal ambivalence. For this reviewer's interests, one of the most engaging pieces of the collection is Justyna Wierzchowska's "Empty Maternal" essay, an analysis of artist Marina Abramovic's performance *The Artist is Present*. In a surprising and innovative reading of the piece, Wierzchowska argues that Abramovic sets up an affective encounter with her audience that appears to offer them the promise of being cared for. Audience members' emotional responses, she suggests, are informed by a collectively repressed desire to be mothered. Rather than fulfilling their desires, however, Abramovic offers only an empty maternal, a simulation of nurturing that makes clear the illusory nature of the affective encounter.

No single volume ever covers the full range of possible topics, and the editors readily acknowledge areas still to be explored. Perhaps because the affective intensities of the pregnancy, birth, and early mothering periods are particularly acute, the essays heavily emphasize those time periods, with little attention given to later stages of maternal experience. But the larger project set forth in the book, putting affect theory and maternal studies into conversation, is a worthy beginning and lays the groundwork for further explorations.

Academic Motherhood: How Faculty Manage Work and Family

Kelly Ward and Lisa Wolf-Wendel
New Brunswick, NJ: Rutgers University Press, 2012

REVIEWED BY KIMBERLY CROSBY-HILLIER

Over the past decade, the demographics of women employed in higher education have changed dramatically (Statistics Canada 25). However, as the authors of this book highlight, although the demographics of the academy have changed, the normative view of the professor and 'ideal worker' have remained. While the authors focus primarily on the successful journeys of over one hundred women professors, pre-tenure faculty, and mothers, they also acknowledge the challenges these two roles inevitably produce. The purpose of this book is to dispute the commonly held belief that motherhood and academia are mutually exclusive and incompatible roles.

The findings contained within this book are derived from a longitudinal study of 120 women faculty members with children. The study began in 1998 and continued until 2008. Starting in 1998, the women were in their early careers and had young children, less than five years of age. Follow-up interviews were conducted in 2008 with the same women, only now in their mid-careers. The women in this study were from a variety of disciplines, which adds to the depth of the research collected.

Beginning with a personal narrative from each of the authors, this book demonstrates a reflexive component, representative of feminist research. Providing insight and context for their research, the authors provide a brief narrative describing their academic journey as mothers, pre-tenure faculty, and successfully tenured faculty. Their stories provide an optimistic outlook, as well as validation for aspiring academics and graduate students alike. The addition of graduate student perspectives on balancing the work and family interface provide a unique integration of voices that are typically unheard.

Attempting to expand the research on motherhood and academia, the authors included women from a wide range of institutions and faculty types on the premise that their experiences will vary according to their work context. In addition to exploring the similarities and differences between institution type and discipline, the authors explore the perspectives of women from dual-career households and those that withdrew themselves from the tenure track. Specially, the authors add the topic of marital status and social class and reveal many pros and cons these two characteristics had over the course of the women's academic journeys.

Drawing heavily upon liberal and post-structural feminism to demonstrate that the choices many women made, this term was found to permeate their findings, the authors suggest that choice is relational to social capital (150). The authors do add however, that this "choice" is limited within the constraints of gendered norms and expectations. These beliefs also had implications on the choices that the women made during their academic journey.

The final chapters highlight the vagueness of policy at all institutional types in the study. Regardless of institutional type, the authors discuss the ambiguity and general lack of awareness surrounding policies in regard to sick or disability leave, modified duty, tenure stop-clock, long term parental needs, and maternity leave. Incorporating a discussion of the United States' Family Medical Leave Act (FMLA) and Pregnancy Discrimination Act, the authors discuss how personal agency, fear and bias avoidance, faculty or department, influence the enactment and effectiveness of these policies.

Concluding the book is a chapter devoted to next steps and advice for all stakeholders in higher education. Drawing upon conclusions from their longitudinal study, the authors provide recommendations and parting thoughts regarding family and career. Returning to the intent of the project, the authors remind the reader that career and family paths can merge to create a meaningful and gratifying journey for academic mothers. Providing examples of effective strategies that are being successfully enacted at various campuses, this book is a strong resource for campuses alike.

As a current graduate student and mother of a young child, I found this book to be highly informative and timely. The integration of graduate student mothers' experiences and advice for this group was uplifting and inspirational. Far too often, the literature is exceedingly focused on the detriments of simultaneously pursuing motherhood and academia. This book provides hope to women academics beginning their journey with both career and family. The personal narratives add a unique personalization to each chapter and set the context of the discussions that follow. Offering suggestions to improve family friendly policies on campus, this book is also a supportive resource for academic administrators and faculty. In addition, this book will provide the guidance necessary to further pursue research in the area of motherhood and academia, as well as a personal resource of encouragement and inspiration.

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Finding the Plot: A Maternal Approach to Madness in Literature

Megan Rogers
Bradford, ON: Demeter Press, 2017

REVIEWED BY EMMA DALTON

Megan Rogers' book *Finding the Plot: a maternal approach to madness in literature* makes an important contribution to the field of feminist literary criticism. It makes recommendations for critics relating to new ways of reading heralded feminist texts, and for writers, in relation to new narrative journeys which could liberate their characters. Rogers contributes to the field of feminist literary criticism a text which considers "the eternal madwoman" (103) and attempts to liberate her, both from madness and the attic.

Discussing the texts *Wide Sargasso Sea*, *The Bell Jar*, *Surfacing*, *The Woman Upstairs*, and their protagonists, Rogers argues that female madness in literature is not a positive or liberating alternative to patriarchal narrative resolutions. Rogers uses Maureen Murdock's model of the heroine's journey to argue that female madness in literature follows a path of "descent rather than dissent" (107). Furthermore, she proposes that the eternal madwoman may be resolved. That she may ascend rather than descend. Rogers designs a new journey in order to instigate this ascension, "The maternal journey" (165). She argues that this journey provides both new ways of reading texts, and new ways for writers to write positive female protagonists.

Rogers does not limit her concept of the maternal to biological or nonbiological mothers, rather she uses the term maternal to denote care. Rogers seeks to associate representations of madness in literature with the lived experience of mental illness. She argues that using feminist literary criticism alongside psychoanalysis allows for a reading which considers both literature and life.

Finding the Plot: a maternal approach to madness in literature represents an amended version of Rogers' doctoral thesis. Rogers' thesis was submitted at RMIT University in Melbourne, Australia in 2013 and titled "Resolving the Madwoman: Unlocking the Narrative Attic by Writing the Maternal Journey."

Rogers begins by introducing the literary madwoman to her readers. To do so she provides a review of significant literature relating to literary representations of female madness. Rogers provides examples of nineteenth, twentieth, and twenty first century literary madwomen, prior to defining the literary madwoman as she sees her. Rogers discusses both French and American feminist literary criticism, attempting to treat both respectfully, but

clearly aligning herself with American feminist literary criticism. Rogers proposes that by looking to myth and the mythic journey critics may find new ways of reading literary madwomen, and writers may find new ways of liberating the literary madwoman from seclusion and silence.

Rogers takes her readers on a journey. *Finding the Plot* has a clear direction from the outset. Rogers means to persuade her reader that madness cannot be considered to bring female protagonists freedom. Rogers attempts to persuade her readers that the journey of female protagonists into madness is one of descent. Furthermore, she proposes to offer a framework for writers to follow which can liberate their female characters from this descent. Rogers' maternal journey offers interesting possibilities for the creation of new and active female subjects. However, personally I feel that it needs to be said that whilst the trajectory of the literary madwoman may oft' (if not always) be described as tragic, it also often breaks from traditional patriarchal endings for female protagonists. Rogers acknowledges this rupture (110-121), but argues that a better way forward for the literary madwoman can be found.

Rogers' voice is engaging, and *Finding the Plot* provides an insightful – and new—analysis of significant works of literature. I would recommend this book for academic researchers, teachers of literature, students and literary aficionados alike.

Mothers and Daughters

Dannabang Kuwabong, Janet MacLennan, and Dorsia Smith, eds.
Bradford, Ontario: Demeter Press, 2017

REVIEWED BY PATRICIA DREW

Relationships between mothers and daughters span decades, and exist in lived experience and memory. Mother/daughter connections may be intransigent or quite malleable; they can run the gamut from exceedingly supportive to incredibly negative. Given this variance, academics have a rich arena to explore. In 2000, Andrea O'Reilly and Sharon Abbey's edited collection revealed how social institutions and cultural norms shape women's daily mothering choices and, consequently, affect mother/daughter relations. Alice Deakins, Rebecca Bryant Lockridge, and Helen Sterk's 2012 reader explained how interpersonal communication creates and sustains mother/daughter relationships. The latest research addition, *Mothers and Daughters*, edited by Dannabang Kuwabong, Janet MacLennan, and Dorsia Smith Silva, adds

important nuance to this conversation by highlighting the range of issues faced by mothers and daughters across the globe. Chapters in this anthology include personal essays, scholarly analyses, fiction, and poems. Collectively, the readings demonstrate that individuals' hopes, interpersonal relationships, and culture help shape mother/daughter relationships, regardless of location or life phase. There are many worthwhile pieces included in the book, and those discussed in this review represent some of the most salient topics mothers and daughters encounter: relational changes; closeness; tensions; and, individuals' expectations.

Multiple chapters in *Mothers and Daughters* reveal relationship changes that occur as offspring turn into adults and enter into new social milieu and economic circumstances. In Laurie Kruk's short story, "The Wedding Collection," Lenore reflects on how her Ph.D. work is a world away from her working-class background where her mom sewed wedding dresses in the family's basement. Despite the educational and geographic gaps between their lives, Lenore's increased appreciation for her mother shines through. Batya Weinbaum's "Painting Through Ruptured Maternal Identity" similarly depicts relational changes; however, the empathetic daughter seen in Kruk's story is missing altogether in Weinbaum's poignant narrative. Weinbaum reveals how a once-close relationship suddenly and inexplicably dissolved when her daughter turned 18. The disappearance of their intense connection left Weinbaum feeling she had lost her child and herself. As Weinbaum grapples for answers through painting, she attempts to make peace with her daughter's decision. When read together, these two chapters display the range of relational changes that can occur as children grow up.

For other daughters, becoming an adult means increased similarity to their mothers. In "Costas (Or, If You Prefer, A Tale of Two Cafes)," Priya Parrotta Natarajan relates that childish mother/daughter conversations evolved into serious, creative interactions as the author grew into adulthood. Parrotta Natarajan's academic mother takes her daughter's environmental and activist concerns to heart, which enables the duo to remain firmly attached. Cheryl Chaffin's "Grandma's Husband: Parenting with My Mother" also highlights growing similarities between (grand)mother and adult daughter as they transform into feminists and work together to raise Chaffin's young son. Mutual respect is the hallmark of these relationships, and indicates that mothers and daughters can work to remain close throughout the life course.

Claims of lifelong mother/daughter closeness are reflected in Andrea O'Reilly's "Across the Divide: Contemporary Anglo-American Theory on the Mother-Daughter Relationship." O'Reilly rebuts commonplace claims that mothers and adolescent daughters naturally go through periods of conflict. O'Reilly demonstrates that the popular discourse of strife is, in actuality, a social construct based on patriarchal developmental theory. She argues that

daughters and mothers may remain connected by rejecting patriarchal dictates and self-devaluation. This viewpoint is a refreshing counterpoint to doomsday predictions that saturate both popular culture readings and academic work.

Other chapters articulate how actual mother/daughter relationships differ from personal expectations. Alma Simounet-Bey discusses coming to terms with disappointment in "The Worst Is Not the Worst: Memories of Motherhood and Multiple Miscarriages." She reveals how her aspiration to have multiple children remained elusive when her pregnancies do not hold. Similarly, Donna Sharky's "Isthmus" presents the bittersweet story of her daughter Alessandra's life, from international adoption at age 8, to sweet early years together, through mental illness and, ultimately, Alessandra's death. Despite the unknown traumas in Alessandra's pre-adoption past, Sharky's unwavering love for her daughter means providing support in unanticipated ways. Both of these touching chapters remind readers that women's mothering hopes can be quite different from actualities.

Collectively, the chapters in *Mothers and Daughters* provide readers with a fresh, detailed understanding of the mother/daughter relationship. They reveal that, globally, mothers and daughters grapple with and reflect on this significant relationship throughout the life course. The editors suggest that there are transformative possibilities related to mother/daughter relationships. While *Mothers and Daughters* would benefit from an enhanced discussion of these possibilities; this edited collection represents an important addition to scholarship on motherhood and families.

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Academic Mothers in the Developing World: Stories from India, Brazil and South Africa

Venitha Pillay, Nishi Mitra Vom Berg, Deevia Bhana, Carmen Lucia Guimaraes De Mattos, Paula Almeida De Castro
Trenton, NJ: Africa World Press, 2017

REVIEWED BY TALIA ESNARD

This is a welcome treatise on the socio-cultural and ideological landscapes of academic mothers in the Global South. In fact, the book presents a critical interrogation of the (i) ideologies, structures and relations (both within academe and the home), (ii) the tensions, oppressions, contradictions, and confrontations that they introduce for academic mothers in the Global South, and, (iii) the fluid ways in which they reproduce, modulate, isolate, and/or push back such inherent thinking and practices. In so doing, the book addresses the fundamental ways in which such contexts alter the consciences, maternal and institutional identities, as well as, the praxes of academic mothers in the Global South. These are comparatively addressed through the stories of academic mothers in India, Brazil, and South Africa.

Specifically, the book captures the ways in which gender structures the expectations and practices around both marriage and motherhood, the relations of power that reinforce these, and the implications for mothers who are part of the academic community. To a large extent, this is demonstrated through the nuanced discussion of the many complexities and incongruities that surface from such positionalities, and, the influence of these on how academic mothers experience, as well as, react to work-family dynamics/interface. The treatment of the latter is particularly strengthened by the metaphoric reference to the academic mother as a superwoman, the super mother, and the octopus across all three countries. No doubt, such images centre the weight of such demands, the struggles associated with managing the often conflicting demands for their time and effort, and the diverse responses that these produce.

As such, the use of personal narratives, reflective accounts, and critical ethnographies offer a rich assessment of the inherent contradictions within the socio-economic, political, and cultural landscapes in the Global South. Through interrogation, the authors also bring to the centre, the points and ways in which the thinking and practices of academic mothers converge and diverge with the structures that they confront within these social sites. By so doing, the authors offer needed insight into the contradictions embedded within the multidimensionality, politicality, and emotionality of academic

motherhood. This particularly resonates through the considerations of how feelings of powerlessness, isolation, guilt and strain, are often juxtaposed against those of pride, satisfaction, high self-esteem, and strength. Such contradictions however, do not take away from the equally valuable ways in which academic mothers give power to other forms of support/care for their children, their own sense of well-being and professional achievements, as well as, the importance of these for how they attempt to disrupt the systems of power that constrain their engagement within that space.

Thus, while the work is grounded within the applicability of standpoint theory, it presents a situated analysis of the issues that affect the experiences of academic mothers in the Global South. A central aspect of such analysis is the examination of the socio-economic and cultural facets that preconfigure how academic mothers engage in such contexts, and the investigation of how and/or whether they reproduce or disrupt the structures and relations of power that they encounter. In so doing, the comparative narratives of academic motherhood across India, Brazil and South Africa brings into focus the relative importance of social constructions, stereotypes, and relations, on the lived realities, (re)negotiation, and choices of academic mothers in such contexts.

These narratives therefore raise important questions of how we ensure the removal of institutional, cultural, and ideological barriers for academic mothers, if we are to ensure their participation and contribution to the academic community. At an institutional level, these call for gender-based policies that support academic mothers and that by extension promote notions of gender justice. At a familial level, the study advances the need for cultural shifts; in how both men and women are constructed (gender identities), how roles are understood (gender roles), and how relations are framed within these social sites (gender relations). At the level of research, it also calls for deeper interrogations of the discursive and relational contexts wherein academic mothers engage, the complex ways in which these enable or constrain they thinking and practices within these social spaces. Moving this work forward however would require more intersectional analyses of how race, gender, class, and culture affect academic motherhood, networks, and social relations. This is particularly important for countries in the global south where racial ideologies have produced particular relations of power that are intertwined with colour and class gradations, as well as that of gender.

Liberating Motherhood: Birthing the Purplestockings Movement

Vanessa Olorenshaw
Cork, Ireland: Womancraft Publishing, 2016

REVIEWED BY RAVEN HAYMOND

Vanessa Olorenshaw's 2016 book, *Liberating Motherhood: Birthing the Purplestockings Movement* is a rallying cry, a call for the feminists, leaders, and policy makers of the world to remember mothers. A mother, activist, breastfeeding counselor, and former lawyer, Olorenshaw declares that, "The time for a mother-movement has arrived" (ix). She does not shy away from the gendered terms "mother" and "mothering" because, she argues, "We must be able to speak our name" in the face of erasure by society (105). Olorenshaw urges readers to join her as part of the Purplestockings Movement. The name functions as a tribute to the Blue and Redstockings of the past and as a bold statement that we need to reconsider how we conceptualize feminism. "If feminism is for the rights of women but does not reflect or fully support the rights of a woman as a mother," she explains, "then it's letting women down" (6). She argues that modern feminism only really supports women who either opt not to have children, or those who combine motherhood with employment outside of the home (9).

According to Olorenshaw, it is time for a radicalized maternal feminism. While gaining access to education and the workplace for women were key first steps, Olorenshaw fears that feminism has swung too far in the opposite direction. Motherhood and care work has been painted as oppressive, as a drudgery to escape by taking up a job in the marketplace. She points out that many women are not asking to be saved from the oppression of motherhood. They actually want to dedicate their time to mothering. What they are asking for is freedom from the capitalistic chains that force them to work outside of the home or face economic consequences.

In the wake of biological essentialism, Olorenshaw argues that feminism has made the mistake of trying to ignore women's bodies. "Yes, yes, we must not be *reduced* to our bodies," she writes, "but we must *own* them, we must *live* them, we must *protect* them, we must *love* them" (48). Instead of denying that anything related to reproductive biology matters, she calls on feminism to attend to the "Five M's" of menarche, monthly menstruation, motherhood, mammalian milk-making, and menopause and to the politics that inform them (49).

Liberating Motherhood is divided into three main parts. Part 1: "A Mother's Body," addresses women's bodies, both their functions and their oppression

under patriarchal capitalism. Olorenshaw references Gaskin, Kitzinger, and Odent while problematizing the theories of de Beauvoir and Friedan. Pregnancy, birth, postpartum recovery, breastfeeding, and mothering, according to Olorenshaw, are all feminist issues and deserving of attention and activism (75). Part 2: "A Mother's Mind," acknowledges how women's minds and thinking change when they become mothers and calls for a radical overhauling of postpartum support and care. She also engages with images of toxic motherhood in the media and in culture at-large.

In Part 3: "A Mother's Labour," Olorenshaw discusses how the view that motherhood is oppressive actually works to further devalue mothers. What is truly oppressive, she claims, is the social environment that makes mothers economically dependent and that refuses to support their vital care work. She addresses the economics of motherhood and makes suggestions for reforms, like basic income, that would give women the freedom to dedicate their time to mothering. She urges readers to reconsider how we value and promote public versus private engagement and how our current social and political systems label the latter as unimportant and without value. Finally, Olorenshaw draws on her experience as a lawyer and as an activist to address maternal politics.

Liberating Motherhood is incredibly accessible and suited for a wide audience. Olorenshaw's writing radiates passion, knowledge, and a wry sense of humor. She includes a helpful glossary defining key terms and uses friendly footnotes to support her readers. For example, when explaining the concept of "the Other," she tells readers to "just think 'non-male', lesser, inferior and subordinate. The tinsel to the male Christmas tree" (33). Olorenshaw is committed to her message and works to make sure it is clear. This clarity, combined with the strength and revolutionary nature of her arguments, makes Olorenshaw's *Liberating Motherhood* a text that belongs on the bookshelf of every scholar interested in feminism and motherhood studies.

Fertility, Conjuncture, Difference: Anthropological Approaches to the Heterogeneity of Modern Fertility Declines

Philip Kreager and Astrid Bochow, eds.
New York, NY: Berghan Books

REVIEWED BY NAOMI M. MCPHERSON

Demographic transition theory assumes that, given similar socio-economic conditions of modernity in "developing" countries, fertility rates will decline to a statistical level of 2.1 births per woman as occurred in European societies. Demographic analyses show fertility rates both decreasing and increasing. This heterogeneity of fertility rates is a "central problematic in the study of population" (ix) that cannot be resolved using quantitative census survey. Ten authors address this contradiction utilizing demographic (quantitative/macro/statistical) reasoning and ethnographic (qualitative/micro/interpretive) methods and analyses. The editors' introduction presents an informative overview of demography and ethnography to focus on the work of anthropological demographer Jennifer Johnson-Hanks whose theory of "vital conjuncture" informs each contributors' analysis. Vital conjunctures are a "complex intersection" of current sociocultural and personal forces people consider when making reproductive (and other life) decisions for now and for their future. These ethnographically rich studies—six in Africa and one each in Tajikistan, Northern Italy (with Greece and Spain), and Cambodia, discover how pressures of kin, gender roles, family, marriage, employment inform peoples' decision-making processes and agency. These insights make sense of outcomes that run contrary to demographic transition theory.

Anthropological demography means "there is simply more to say than there would be if one stuck to a single discipline" (Heady 155) and space constraints mean I can only hint at the vital conjunctions informing fertility decisions in these case studies. Analysing a century of Catholic mission documents in four east African states, show how pressures of colonization redefined local reproductive mores to reflect western mores of sexuality, family form and reproductive behaviour (Walters). Similarly, Namibian women's fertility is impacted by changing moral values embedded in developing class formations (Pauli). Two groups of Tajik women, whose differing perspectives on reproducing group/identity or reproducing the Soviet state, resulted in different patterns of fertility increase (Roche and Hohmann). In rural northern Italy villages, a confluence of forces exposes a counterintuitive ultra-low fertility among non-migrants compared to higher rates among villagers

migrating for urban employment (Heady). Powerful social and religious ideals inform Senegalese gender relations and discourses. Men speak against stopping or delaying pregnancies publicly upholding what Muslim religious and social values, while privately leaving fertility decisions to their wives whose decisions rest on complex reasons of family economics and health (Randall, Mondain, and Diagne). A nuanced analysis of individual agency, social structures, and "the wider flux of the life trajectory" (van der Sijpt 208) shows Cameroonian women take best advantage of particular local contingencies to navigate personal and cultural issues when making reproductive decisions. In Botswana, reproductive decision making is not always about how many children but about "when, how and with whom to have children" (Bochow 222). Kroeker's Lesotho study reveals sexuality to be a male dominated domain, however, most men are migrant workers. Women manage their sexuality using contraceptives to separate sexuality from reproduction, to ensure unintended pregnancies cannot interrupt their employment, and to space pregnancies. Women's contraceptive use can result in more rather than fewer children during their reproductive life (266). Charbit and Petit's penultimate chapter reviews historic "misunderstandings and quarrels" defining disciplinary relations that demographers and anthropologists need to enable a "fruitful interdisciplinary dialogue" and "new and promising avenues for research" (323). Finally, Johnson-Hanks revisits her concept of vital conjunctions to discuss how contributors push forward understanding of the heterogeneity of events, sociocultural pressures, opportunities and timing that together inform reproductive choice making.

These rich interdisciplinary studies show fertility decisions are not made according to rational choice economic theory and a vague concept of "modernity." Each case study here presents cultural and personal factors coalesced around reproductive decisions that women and men consider when making life decisions. The editors and contributors are to be congratulated for this splendid and insightful contribution to understanding reproductive decision making and, not least, the benefits of interdisciplinarity. Highly recommended.

Contract Children: Questioning Surrogacy

Danna, Daniela
Stuttgart, Germany: ibidem-Verlag, 2015

REVIEWED BY DANIELLE ROTH-JOHNSON

Daniela Danna, a sociologist at the University of Milan, makes a remarkable and original contribution with her book *Contract Children: Questioning Surrogacy*. In this short work, she offers a wide-ranging and global survey of all practices included under the term "surrogacy", along with a comprehensive overview of the major debates surrounding surrogate motherhood. Recounting the evolution of surrogacy from the selling of so-called "gestational services" in the 1970's in the United States to its current status as a global industry, Danna presents readers with a profound and thorough discussion of the various legal and social meanings given to pregnancy as paid (or rather, poorly paid) labor in various countries around the globe.

Divided into five major sections, the book begins with a discussion of the different types of surrogacy arrangements that have been available to intended parents in both past and contemporary societies. In the first chapter, Danna also offers a reasoned argument of who should be considered the mother since this role can potentially be split among several different persons: (1) the "birth-biological-genetic" mother; (2) a social mother in the cases of formal/informal adoption and "traditional" surrogacy; and more recently, (3) the one who contributes eggs. One of her more interesting assertions in this discussion is that, due to the development of in vitro fertilization, for the first time in history, women may share in the experience of fatherhood in that she must wait like a father for another woman to deliver her (possibly) genetically-related baby. The other major question she poses in this section concerns the issue of the status of the birth mother in relation to the "contract child" (as she refers to the babies born of these surrogacy agreements). For Danna, a woman who becomes pregnant and gives birth is a mother even if the eggs are not hers. Thus, according to her, the original family is based on the Mother/Child relationship. Consequently, she believes the best interest of the child resides in recognizing the importance of the primordial relationship that begins for the child in a woman's womb. Hence, the author believes we need to put the notion of the Mother/Child relationship at the centre of any concept of the family rather than a sexual relationship between a man and woman. Taking such a stance, however, would have radical implications for all involved in surrogacy agreements because there would not be the automatic assumption that the best interests of the child would always be served by the birth mother

relinquishing the child to the intended parent(s) or giving up all rights to contact with the child after the birth.

The second chapter of *Contract Children* offers readers an educational overview of the various ways one may obtain children through surrogacy, while the third chapter focuses on the legal implications and consequences of surrogacy in a wide range of countries. Most poignant is her discussion of the fate of the contract children blocked at borders due to national laws and/or the problem of statelessness.

In line with Danna's particular concerns about the physical and emotional well-being of surrogate mothers, along with their legal rights, the fourth chapter of the book focuses on the subjective experience of these women as surrogates and looks at the thorny question of whether what surrogates are doing should rightly be considered work or not. Additionally, she also examines the impacts of the social exchanges that take place between the surrogate and intended parent(s), as well as the complications introduced by the creation and enforcement of surrogacy contracts.

In the final chapter of *Contract Children*, Danna ends with a discussion about how women's capacity to give birth has long been coopted by patriarchal societies to serve the interests of everyone else but themselves. Since women are still struggling to regain and/or maintain control over their own bodies, she fears that the commodification of children to perpetuate what she describes as the "ceaseless capitalist cycle" in the face of impending ecological disaster will only reduce all human transactions to money and result in the unnecessary exploitation of too many women. In order to avoid such a trivialization of human lives and labor, she believes that we must not allow market forces to appropriate the birth of children. Thus, she believes that in order to have ethical surrogacy, we must make sure that human dignity and the freedom of pregnant women are always protected in these arrangements.

An essential resource for policy makers and activists concerned with reproductive justice and human rights, *Contract Children* makes a unique and very important contribution to the burgeoning literature on the ethics of surrogacy.

The Baby Book

Robin Silbergleid
Fort Lee, New Jersey: CavanKerry Press, 2015

REVIEWED BY DORSÍA SMITH SILVA

In *The Baby Book*, Robin Silbergleid explores her long journey to motherhood in poetry. With rich candor, Silbergleid intimately reveals her battles with infertility, assisted reproductive technology, multiple miscarriages, high-risk pregnancies, and eventual birth of her two children. Her moving and powerful determination to conceive is adeptly highlighted throughout the text's five sections.

In the first section, Silbergleid initiates her path to motherhood. The first poem, "I Will Name My Daughter Hannah," reflects upon the narrator's intense desire to become a mother as she starts "carrying a needle / and a spool of pink thread, ready to sew buttons on tiny sweaters / or mend holes in cotton socks, just in case." The following poems further illustrate her maternal yearning as she reads books about childbirth, dreams of baby names, and drinks fertility concoctions. Silbergleid then brings the reader to the narrator's struggle with infertility, particularly in "The Fertility Patient" when she accentuates how fertility patients are viewed by doctors as simple medical codes on insurance forms. By the end of this section, the poems become even more gripping when the narrator describes the beginning of her miscarriage in "I Draw My Doctor a Picture" and laments the repeated cycle of fertility treatments in "After the Miscarriage, My Doctor Speaks."

The second section continues the intense exploration of the narrator's several miscarriages. In "Miscarriage (3)," the readers experience the narrator's deep pain of loss, especially when Silbergleid writes "and the baby who won't be / sits heavy in my pelvis / the placenta that tried so hard still / pumping blood to his stumped cells." Silbergleid also links the loss of the fetus to the miscarriage suffered by Frida Kahlo, as the narrator believes that they are connected spirits of women that mourn their unborn children. Silbergleid mentions Kahlo again in "An Open Letter to Frida Kahlo" when the narrator recovers from a medical procedure after she miscarries and envisions Kahlo painting her hospital room. Yet, even with this bond to Kahlo, the narrator knows that the agony of miscarriage cannot be assuaged: "there is no syntax / for loss" in the concluding poem, "My Doctor Writes Me a Poem."

The narrator's journey finally reaches fruition in the third section when the narrator gives birth to her daughter, Hannah. In "Amniotic," the narrator recalls the strong formation of the mother-dyad: "*Mama*, she says— / in an

instant one becomes two / becomes one again, our bodies / severed in the birth room." She also reminiscences about how quickly her daughter has grown in "First Day of Preschool": "*You still my baby?*" Hannah says, echoing / what I have told her for days." However, Silbergleid reminds the reader of additional miscarriages and fertility treatments when the narrator tries to have another child in the fourth section. The emotional turmoil is sharply heartfelt when Silbergleid writes, "Yesterday / my doctor scrawled *recurrent pregnancy loss*, / sent me for a blood draw. This / is what I carry with me" in "My Daughter Asks for a Baby Sister from the Tooth Fairy."

By the fifth section, Silbergleid has completely engaged the readers with her realistic depictions of suffering multiple miscarriages and enduring several fertility treatments. Instead of a traditional baby book, readers are drawn into the narrator's world of endless expensive IVF cycles in "In Lieu of a Baby Book" and "Lexicon." Silbergleid reveals that the arduous journey has been worth it when she writes that the narrator's son is three weeks old in the concluding poem, "Coda: Dear Doctor." Yet, the narrator warns that the difficult fertility experiences may reoccur, since she has "leftover embryos" and wonders if she should "use, donate, [or] destroy" them. Silbergleid does not provide any easy answers to this situation. Instead, she encourages readers to reflect upon our own challenges to the journey of motherhood and welcome this profound conversation.

Contributors Notes

Dr. Gillian M. E. Alban is Associate Professor of English Language and Literature at Istanbul Aydın University, Turkey; she previously worked at Bosphorus and Doğuş Universities. Her research focuses on women writers from the nineteenth to the twentieth century, as well as on Shakespeare. Her published books are *Melusine the Serpent Goddess in A. S. Byatt's* Possession *and in Mythology* (Lexington 2003), and the recent *The Medusa Gaze in Contemporary Women's Fiction: Petrifying, Maternal and Redemptive* (Cambridge Scholars Publishing 2017). These works are the fruit of her investigation into the psyche and status of women as seen in literature, which she has developed through historical, mythic and archetypal perspectives, deconstructing feminist approaches where they debilitate, and returning a powerful female gaze.

Victoria Bailey lives in Calgary, Canada and is currently completing a PhD in Creative Writing with a focus on historical representation of single mothers.

Bridget Boland's work has appeared in *The New Guard*, *Conde Nast Women's Sports and Fitness, YogaChicago*, and *The Essential Chicago*. Her debut novel, *The Doula*, was published by Simon and Schuster September, 2012. Excerpts from her work have won the Writers League of Texas Memoir Prize, and the Surrey Writers Conference Nonfiction Award. Through her business Modern Muse, Ms. Boland teaches writing classes on fiction and memoir, coaches other writers in creative nonfiction, fiction and business writing, and offers seminars on yoga, energetic medicine, and writing as life process tools. She holds an MFA in creative writing from the School of the Art Institute of Chicago, a JD from Loyola University of Chicago, and is the recipient of five residencies at The Ragdale Foundation for Writers and Artists and a grant from the Illinois Arts Council. She is also a shaman and an attorney. Learn more about Bridget and her work at www.bridgetboland.com.

Dr. Rachel Epp Buller maintains dual critical and creative practices, exploring the maternal body, feminist care, and embodied knowledge(s) in contemporary art. Her books include Reconciling Art and Mothering (Ashgate) and the forthcoming Inappropriate Bodies: Art, Design, and Maternity (Demeter).

Noreen Anne Cauley is a graduate student in the Faculty of Environmental Studies at York University. Her research explores the intersectionality of sexual violence and environmental destruction. She uses narrative- and arts-based based research to explore the challenges involved in healing from trauma in a culture where misogyny is deeply ingrained.

Haile Eshe Cole is a Visiting Assistant Professor at Amherst College. She received her PhD in Cultural Anthropology and African Diaspora Studies at The University of Texas at Austin. In addition to years of community work, her research examines conditions of health and reproduction for black women in the U.S.

Kimberly Crosby-Hillier is a PhD Candidate in Educational Studies at the University of Windsor. Her research focuses on the experiences of graduate student mothers within a Canadian context. As both a mother and graduate student, she hopes to shed light on the journeys of this unique graduate student population.

Dr Emma Dalton is an Honorary Research Associate in the Department of Creative Arts and English at La Trobe University, Melbourne, Australia. Emma graduated with her PhD from the Theatre and Drama Program at La Trobe University in September of 2017. Her research investigates the representation of mothers in contemporary Australian female authored plays.

Patricia Drew is an Associate Professor of Human Development and Women's Studies at California State University, East Bay. Her research examines the intersection of health and identity; in particular, how individuals' embodied experiences shape self-concepts and social interactions. She is currently studying mothers who have undergone post-partum breast reduction surgery.

Talia Esnard (PhD) is a Sociologist attached to the Department of Behavioral Sciences, The University of the West Indies. Her research centers on the work, work and organization with comparative scholarship across the Caribbean and the United States. Some of her work has been published in Women, Gender and Families of Color, Journal of the Motherhood Initiative for Research and Community Involvement, and NASPA Journal about Women in Higher Education. She recently co-authored a book on Black Women, Academe and the Tenure Process in the United States and the Caribbean.

Kryn Freehling-Burton is a Senior Instructor in the Women, Gender, and Sexuality Studies program at Oregon State University where she also coordinates their online WGSS program. She co-edited the encyclopedia Women's Lives Around the World (ABC-CLIO 2018) with colleagues from OSU and Performing Motherhood: Artistic, Activist, and Everyday Enactments (Demeter Press 2014) with Amber Kinser and Terri Hawkes. Kryn and her partner, Eric, have four mostly-grown children.

Raven Haymond is a doctoral candidate in American Studies at the Pennsylvania State College, Harrisburg. A former certified birth doula and childbirth educator, Raven is also a mother to four children. Her research focuses on issues of authority and body autonomy during pregnancy, childbirth, and the postpartum period.

Dr. Nané Jordan is a birth-keeper, scholar, artist, community worker and mother who has been active in the midwifery and mother-centred birth movement for over 30 years, having worked as a home-birth apprentice in pre-regulation Canadian midwifery and as a postpartum doula. Nané completed a PhD in education at the University of British Columbia, and was a SSHRC Postdoctoral Fellow in women's and gender studies at the University of Paris 8, France. She recently published the anthology Placenta Wit with Demeter Press, and continues her birth-based projects and writing on themes of mothering, midwifery, placentas, feminist art practices, women's spirituality and goddess studies.

Christiana MacDougall is an Assistant Professor at Mount Allison University in the Sociology Department and the Women's and Gender Studies program, and is also a registered social worker. Her research interests include mental health, reproduction, motherhood and the intersection of these.

Naomi M. McPherson is Associate Professor Emerita, Cultural Anthropology, at the University of British Columbia. Since 1980 she has conducted ethnographic research in Papua New Guinea, a key research focus gender relations, gendered violence, and women's maternal and reproductive health. With Michelle Walks she co-edited Anthropology of Mothering (Demeter 2011), contributed a chapter "Black and Blue: Shades of Gendered Violence in West New Britain, PNG" to Engendering Violence in Melanesia (ANU Press 2012), and edited Missing the Mark? Women and the Millennium Development Goals in Africa and Oceania (Demeter 2016).

Danielle Roth-Johnson is currently Associate Professor-in-Residence in Gender and Sexuality Studies in the Department of Interdisciplinary, Gender

and Ethnic Studies at the University of Nevada, Las Vegas. Her current work focuses on public and environmental policies on women's health and women's activism in environmental justice movements around the world.

Josephine L. Savarese is an Associate Professor in the Department of Criminology and Criminal Justice at St. Thomas University in Fredericton, New Brunswick. She is a regular contributor to Demeter Press collections. Josephine is co-editing a book on infanticide and mothers who kill with Dr. Charlotte Beyer. She is particularly pleased to share this poem on a young mother who faced a tragic situation.

Dorsía Smith Silva is Associate Professor of English at the University of Puerto Rico, Río Piedras. She is the co-editor of the Caribbean without Borders: Caribbean Literature, Language and Culture (2008), Critical Perspectives on Caribbean Literature and Culture (2010), Feminist and Critical Perspectives on Caribbean Mothering (2013), Mothers, Mothering, and Globalization (2017), and Mothers and Daughters (2017); and editor of Latina/Chicana Mothering (2011). Her work has appeared in several journals and she is currently working on two book projects about mothering, which will be published by Demeter Press.

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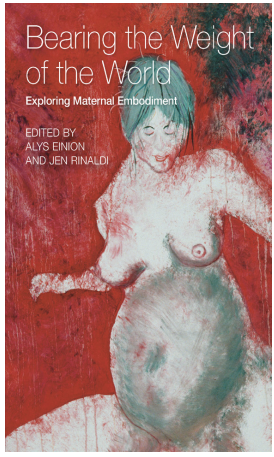

October 2018
258 pages $34.95
ISBN 978-1-77258-171-3

The maternal body is a site of contested dynamics of power, identity, experience, autonomy, occupation, and control. Representations of the maternal body can mis/represent the childbearing and mothering form variously, often as monstrous, idealized, limited, scrutinized, or occupied, whilst dominant discourses limit motherhood through social devaluation. The maternal body has long been a hypervisible artifact: at once bracketed out in the interest of elevating the contributions of sperm-carriers or fetal status; and regarded with hostility and suspicion as out of control. Such arguments are deployed to justify surveillance mechanisms, medical scrutiny, and expectation of self-discipline.

This volume helps to develop a more critical understanding of what it means to be an embodied mother. The materiality of maternity and its centrality to family and social life remains too often viewed as a 'fringe' subject, the province of feminists, activists, hysterical women. For too long, the maternal body has been subject to 'expert' advice, guidance, censure, and control. Those of us maternal bodies are at risk of being commodified and diminished, having our bodily realities reduced to mechanistic functions and our lived experience disregarded. From art to medical surveillance, from genetics to radioactivity, goddess to breastfeeding, poetry to Indigenous community, dance to body size, the critical eye of the academic and the lived experience of the mother bring into being in this work a body of understanding, of expression, of knowledge and the power and authority of the lived experience, through and about the embodied mother. This critical-creative work encompasses new insights, new research, and redeveloped perspectives which combine the personal with the pervasive and point to new meaning-making in critical motherhood studies via the medium of the maternal body.

"This complex book thoughtfully explores the nuances of women's relationships to their bodies and bodies' relationships, in turn, to their contexts and environments. A must-read for anyone who seeks to make sense of the intersections of emotion, embodiment and critical feminist thought."
-May Friedman, Associate Professor, School of Social Work, Ryerson University

"This collection of works is an example of how childbearing these days is receiving the scholarly attention it requires. It brings together fascinating topics and fresh perspectives from across disciplines and theoretical and methodological approaches."
-Sallie Han, SUNY Oneonta, author of *Pregnancy in Practice: Expectation and Experience in the Contemporary United States* and co-editor of *The Anthropology of the Fetus: Biology, Culture, and Society*.

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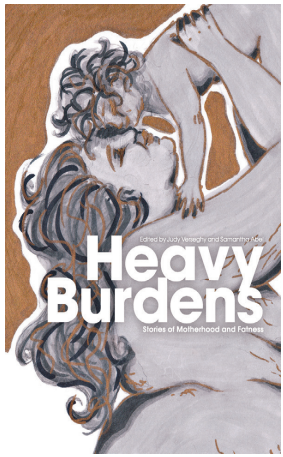
Edited by Judy Verseghy and Sam Abel



November 2018
200 pages $29.95
ISBN 978-1-77258-174-4

Heavy Burdens: Stories of Motherhood and Fatness seeks to address the systemic ways in which the moral panic around "obesity" impacts fat mothers and fat children. Taking a life-course approach, the book begins with analyses of the ways in which fatphobia is enacted on pregnant (or even not-yet-pregnant) women, whose bodies immediately become viewed as objects warranting external control by not only medical professionals, but family members, and even passers-by. The story unfolds as adults recount childhood stories of growing up fat, or growing up in fear of being fat, and how their mothers' relationships with their own bodies and attempted weight-loss experiences shaped how food, exercise, and body management were approached in their homes in sometimes harmful ways. Finally, the book concludes with stories of women who have since become mothers, examining the ways in which having their own children altered their views on their own bodies and their perceptions of their mothers' actions, and working to find fat-friendly futures via their own parenting (or grandparenting) techniques.

This book contains the artwork, stories, and analyses of nearly 20 contributors, all of whom seek to change the ways in which fatness is perceived, experienced, and vilified. It is the editors' hope that these works will compel readers to reconsider their negative views on fatness and to retain softness toward every mother and child who are simply fighting to exist in the face of fatphobia.

"*Heavy Burdens* takes up the important discussion of fat and motherhood by blending both scholarly and personal analyses. This collection looks both "up" at mothers (from a child's view) and "down" from motherhood, complicating ideas about motherhood, responsibility, and individuality through the rocky terrain of weight stigma." – Dr. May Friedman, Associate Professor, School of Social Work, Ryerson University

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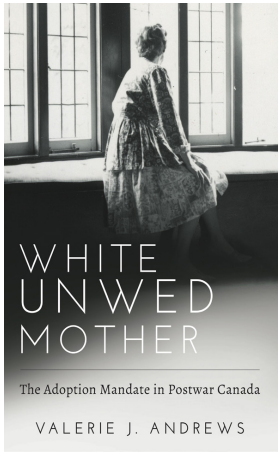
November 2018
White Unwed Mother:
The Adoption Mandate in Postwar Canada
By Valerie J. Andrews



November 2018
307 pages $34.95
ISBN 978-1-77258-172-0

In postwar Canada, having a child out-of-wedlock invariably meant being subject to the adoption mandate. Andrews describes the mandate as a process of interrelated institutional power systems that, together with sociocultural norms, ideals of gender heteronormativity, and emerging sociological and psychoanalytic theories, created historically unique conditions in the post WWII decades wherein the white unmarried mother was systematically separated from her baby by means of adoption.

This volume uncovers and substantiates evidence of the mandate in Canada, ultimately finding that at least 350,000 unmarried mothers in Canada were impacted by illegal and unethical adoption practices, human rights abuses, and violence against the maternal body.

White Unwed Mother makes a unique and important contribution to the history of the adoption mandate in Canada. By including the voices of women impacted by forced adoption, and amassing unprecedented evidence about daily practices in maternity homes and the numbers of children taken, Andrews proves unequivocally that women did not surrender children by choice. This book is required reading for anyone interested in the history of adoption and theories and practice of maternity.
– Lori Chambers, Chair, Women's Studies, Lakehead University.

Valerie Andrews is an adoption activist, a Masters graduate from York University in Gender, Feminist and Women's Studies, and the Executive Director of Origins Canada. Some of Valerie's works include The Language of Adoption, Crimes Against the Unmarried Mother, Sales and Marketing in Modern Domestic Adoption, #Flip the Script on Teen Mothers, Motherhood Denied: Canada's Maternity Homes, and Scripting/Disrupting "Birthmother" Identities.

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DEMETER PRESS

Forthcoming

January 2019

Mothers Without Their Children

Edited by Charlotte Byer and Andrea Robertson

January 2019
307 pages $34.95
ISBN 978-1-77258-173-7

Conceiving of and representing mothers without their children seems so paradoxical as to be almost impossible. How can we define a mother in the absence of her child? This compelling anthology explores these and other questions from a range of interdisciplinary perspectives, examining the experiences, representations, creative manifestations, and embodiments of mothers without their children. In her 1997 book, entitled Mother Without Child: Contemporary Fiction and the Crisis of Motherhood, the critic Elaine Tuttle Hansen urged for critical and feminist engagement with what she described as 'the borders of motherhood and the women who really live there, neither fully inside nor fully outside some recognizable "family unit", and often exiles from their children' (p.10). This anthology extends and expands this important enquiry, looking at maternal experience and mothering on the borders of motherhood in different historical and cultural contexts, thereby opening up the way in which we imagine and represent mothers without their children to reassessment and revision, and encouraging further dialogue about what it might mean to mother on the borders of motherhood.

"Mothers Without Their Children is an important and fascinating collection. It explores, challenges and questions the figure of the mother without child in literary, cultural, creative and social contexts. In this collection, you will find raw and heart wrenching personal reflection, critical analysis and ethnographic study. Each offers distinct insight into a much under explored topic."
–Dr Kate North, SFHEA, Senior Lecturer in Creative Writing and Programme Director MA Humanities, Cardiff School of Education, Cardiff Metropolitan University

"A compelling and timely study of motherhood in its contexts of loss and absence, Mothers Without Their Children explores the junctions at which scholarly studies of motherhood can be confronted in their complexities. A significant contribution to the field, the book's key achievements can be found in the presentation of maternal subjectivities and scholarship as an essential nexus of socio-political counter-narratives and discourse. An account of four women giving birth whilst incarcerated is an essential documentation and interrogation of US policies surrounding motherhood in jail. Another chapter interrogates mothers and the prison system in Ireland, presenting the concept of 'a bad mother' – a frequent media phrase – in a new light, revealing the consequences of perceptions and inadequate social infrastructure upon mothers. Contributors come from a broad range of disciplines and geographical locations and engage with an impressive range of scholarly perspectives relevant to the topic. Fundamentally, the book makes a dynamic and urgent case for motherhood-as-lived-experience, presenting those maternal subjectivities that are often silenced or dismissed as valuable counter-narratives."
- Carolyn Jess-Cooke, Lecturer in Creative Writing at the University of Glasgow.

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Forthcoming

February 2019

Stories We Live and Grow By: (Re)Telling Our Experiences as Muslim Mothers and Daughters

Edited by Muna Saleh

February 2019
330 pages $34.95
ISBN 978-1-77258-175-1

Interweaving my experiences as a Canadian Muslim woman, mother, (grand) daughter, educator, and scholar throughout this work, I write about living and narratively inquiring (Clandinin and Connelly, Narrative Inquiry; Clandinin) alongside three Muslim mothers and daughters during our daughters' transition into adolescence. I was interested in mother-and-daughter experiences during this time of life transition because my eldest daughter, Malak, was in the midst of transitioning into adolescence as I embarked upon my doctoral research. I had many wonders about Malak's experiences, my experiences as a mother, and the experiences of other Muslim daughters and mothers in the midst of similar life transitions. I wondered about how dominant narratives from within and across Muslim and other communities in Canada shape our lives and experiences. For, while we are often storied as victims of various oppressions in media, literature, and elsewhere, little is known about our diverse experiences—particularly the experiences of Muslim mothers and daughters composing our selves and lives alongside one another in familial places.

Alongside three mothers (Safaa, Ayesha, and Layla) and their daughters (Rayyan, Zahra, and Maya), I make visible many of the personal, familial, intergenerational, institutional, linguistic, cultural, temporal, faith-based/religious, and social narratives we live by, with, and in (Clandinin). Together, in over two years of being in relation, we inquired into many of the stories that have been planted in us, the stories we are planting in ourselves and others, and the stories we are relationally shaping and reshaping as Muslim mothers and daughters. Reverberating across the stories we shared and inquired into are our experiences of living in the midst of, and in relation to, multiple arrogant perceptions (Lugones) and single stories (Adichie) from within and across Muslim and other communities in Canada. However, sharing, living, and inquiring into these stories alongside one another foregrounded the many ways we live stories of relational resistance (Saleh) to these unhealthy narratives. Within our chosen communities (Nelson), we speak back to these narratives and illuminate the many ways we are continually (re)composing our selves and our lives with imagination and improvisation (Bateson, Composing a life) … and always in relation (Huber).

"Stories We Live and Grow By: (Re)telling Our Experiences as Muslim Mothers and Daughters is a delightful and engaging read that teaches the reader about the narratives that three Canadian Muslim girls and their mothers are living as the girls transition into adolescence. Saleh weaves theoretical perspectives along with the lived experiences of the girls and their mothers to inspire the reader to question the personal, familial, intergenerational, institutional, linguistic, cultural, temporal, faith-based/religious, and social narratives that they live by and live with alongside other human beings. This is a must read for anyone who is interested in the ways developing understanding of lived experiences - as a researcher, instructor, teacher educator, teacher, graduate or undergraduate student, social worker or as a human being."
-Florence Glanfield, PhD, Professor & Chair, Department of Secondary Education, University of Alberta

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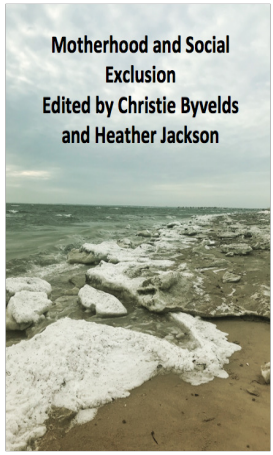
Forthcoming

June 2019

Motherhood and Social Exclusion

Edited by Christie Byvelds and Heather Jackson



June 2019
250 pages $34.95
ISBN 978-1-77258-198-0

Though the negative effects of social exclusion are well documented, there is a paucity of research on women's experiences of social exclusion as they relate to mothering within the institution of motherhood. Social exclusion is a socially constructed concept; it refers to a multi-dimensional form of systematic discrimination driven by unequal power relationships. It is the denial of equal opportunities, resources, rights, goods, and services for some, by others, within economic, social, cultural, and political arenas. Carrying, birthing, and mothering children place women in a unique position to face social exclusion based on their role as mothers. Perhaps at no other time in our lives could we benefit more from feeling as though we are engaged in our community than when we enter into and are experiencing the patriarchal institution of motherhood. As the widely used proverb states, "It takes a village to raise a child", it also takes a village (of societal institutions) to support mothers.

This collection explores motherhood in the context of social exclusion. The book is divided into four parts, each exploring the topic from a different perspective: A Historical Look at Motherhood; Mothers and Crime; Disability, Care Work, and Motherhood; and Personal Narratives.

"This compilation provides an insightful new angle to the inherent experience of social exclusion by mothers. Understanding the ways in which motherhood can be associated with exclusion is crucial for mothers themselves, their social networks, mental health practitioners, child care professionals and policy makers."
-Dr. Verena Graupmann

Christie Byvelds is a mother and registered social worker. She is a sessional instructor with the School of Social Work at Carleton University, and she practices both clinically and as a private research consultant.

Heather Jackson, a former teen mom, is now a 30-something single mom of a teen. She is often mistaken as her daughter's friend or sister! She is a former site producer of girl-mom.com. Currently, she works as a birth doula and an early childhood counsellor in Rhode Island. She published a chapter in The Bakken Goes Boom regarding the change of maternal health related to the oil boom in North Dakota (where she grew up!). In addition to this, she is also co-editor of Feminist Parenting and is currently co-editing Motherhood and Abortion anthologies through Demeter Press (http://demeterpress.org/). Her writing has also been published on thepushback.org, hipmama.com, girl-mom.com, muthamagazine.com, books, and zines. She loves bike riding, going to the beach, playing guitar, drums, and ukulele, going to shows, making zines (etsy shop: ramonegirl), and writing.

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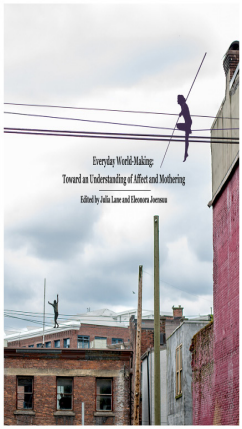
DEMETER PRESS

Recently Released

February 2018

Everyday World-Making: Toward an Understanding of Affect and Mothering

Editors: Julia Lane and Eleonora Joensuu



February 2018
274 pages $34.95
ISBN 978-1-77258-140-9

This cross-disciplinary collection considers the intersection of affect and mothering, with the aim of expanding both the experiential and theoretical frameworks that guide our understanding of mothering and of theories of affect. It brings together creative, reflective, poetic, and theoretical pieces to question, challenge, and re-conceptualize motherhood through the lens of affect, and affect through the lens of motherhood. The collection also aims to explore less examined mothering experiences such as failure, disgust, and ambivalence in order to challenge normative paradigms and narratives surrounding mothers and mothering. The authors in this collection demonstrate the theoretical and practical possibilities opened up by a simultaneous consideration of affect and mothering, thereby broadening our understanding of the complexities and nuances of the always changing experiences of affect and mothering.

'Maneouverability is a fresh, authentic and inclusive opening to a question we don't give enough space to: what can affect theory bring to our understanding of the mothering(s) we witness and experience in this moment? Helpfully, the book also seeks to answer an opposing question: what can the mothering(s) we know and see bring to an understanding of this vast and growing thing, affect theory? This will be an important reader for scholars and classes looking for a multi-genre collection of works exploring the relationship between affect and the maternal in its various forms. A pleasure to read, and an exciting opening to a much-needed conversation."
-Kim Mulder MA, BC teacher of Secondary English and Researcher with the Canada's Early Women Writers Database.

"This book provides a beautiful, visceral and expansive conceptualization of mothering, legitimizing the contradictions and messy everydayness that exists alongside the moments of pure wonder and revealing the interconnectedness of it all. The editors bravely expose the intimate realms of affect and mothering, a space that is theoretically far too underexplored. It is an empowering book that makes one feel like anything is possible. A book that actively defies westernized theories of the autonomous self, revealing instead the communal, relational, and always changing aspects of mothering."
-Melinda Vandenbeld Giles, Editor of *Mothering in the Age of Neoliberalism*

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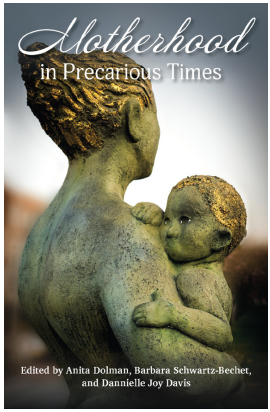
DEMETER PRESS

Recently Released

March 2018

Motherhood in Precarious Times
Edited by Anita Dolman, Barbara Schwartz-Bechet, and Dannielle Joy Davis



March 2018
178 pages $24.95
ISBN 978-1-77258-142-3

Parenting brings countless hopes and worries. But when external factors create fear and cast a shadow long and deep across motherhood, what happens to the act of mothering? Through personal and academic essays and poetry from Canada, the United States, and Palestine, these authors explore what it means to mother through times of struggle, uncertainty, danger, and change.

From doctors and professors, to writers and environmentalists, women of different ages, cultures, and backgrounds share their insights and perspectives on what it is to mother when life, society, and the very future of those you mother are precarious. Sharing ideas, best practices, models, research, and creative work, this book's writers explore the decisions made by mothers and potential mothers in the face of violence and trauma, environmental and political upheaval, career insecurity, uncertainty in a new country, discrimination, and other barriers.

"*Motherhood in Precarious Times* explores through reflections and academic analyses in poems, stories, and essays how environmental, socio-economic, political, and cultural and gendered threats shape mothering. The diverse voices combine powerfully in this vital anthology that will undoubtedly shape many debates from choosing Mother Earth vs. Motherhood, to fatherhood's role in emergent maternal independence."
– Sylvie Hill, Writer, Poet and University Continuing Education Professor of provocative literature courses on sexuality, relationships, and female "awakenings."

"What remarkable insights into mothering! Each author presents a different perspective using their own unique linguistic lens, including poetry, stories, and research. Through these different writing styles, characteristics of precarious times are woven into the book that definitely adds an extra element to exploring mothering. As a mother of two adult children, and a speech-language pathologist who has championed many mothers, I know this book will open up dialogue and keep up hope for all who read it."
– Carrie L. Knight, PhD, CCC-SLP, SLP (C)

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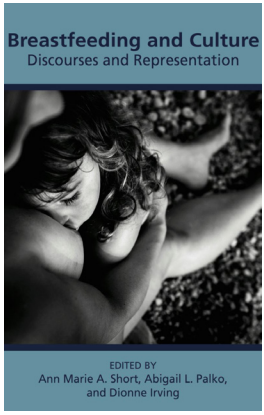
Recently Released

April 2018

Breastfeeding & Culture: Discourses and Representations

Edited by Ann Marie A. Short, Abigail L. Palko, and Dionne Irving



April 2018
308 pages $34.95
ISBN 978-1-77258-155-3

For myriad reasons, breastfeeding is a fraught issue among mothers in the U.S. and other industrialized nations, and breastfeeding advocacy in particular remains a source of contention for feminist scholars and activists. Breastfeeding raises many important concerns surrounding gendered embodiment, reproductive rights and autonomy, essentializing discourses and the struggle against biology as destiny, and public policies that have the potential to support or undermine women, and mothers in particular, in the workplace. The essays in this collection engage with the varied and complicated ways in which cultural attitudes about mothering and female sexuality inform the way people understand, embrace, reject, and talk about breastfeeding, as well as with the promises and limitations of feminist breastfeeding advocacy. They attend to diffuse discourses about and cultural representations of infant feeding, all the while utilizing feminist methodologies to interrogate essentializing ideologies that suggest that women's bodies are the "natural" choice for infant feeding. These interdisciplinary analyses, which include history, law, art history, literary studies, sociology, critical race studies, media studies, communication studies, and history, are meant to represent a broader conversation about how society understands infant feeding and maternal autonomy.

"*Breastfeeding & Culture: Discourses and Representations* reminds us that, although thought of as a "natural" activity, breastfeeding is a site of intense social interest and regulation with complex personal and political meanings and consequences. Indeed, these essays reveal that breastfeeding is caught up in discourses of biology, religion, philosophy, medicine, law, and social policy, and is represented in cultural expressions that span media forms and symbols. This volume responds to the need for interdisciplinary investigations into breastfeeding and contributes to feminist knowledges of gender, bodies, reproduction, care work, and motherhood."
-Mary Thompson, Coordinator, Women's and Gender Studies Program, James Madison University

"The topic of breastfeeding is shown in this book to both empower and outrage mothers. The wide variety of disciplines represented in the volume make it perfect for both general and academic readers. Book clubs, mothers' clubs, undergraduate and graduate courses in women's studies, health education, communication and the like all would find it of value."
-Helen M. Sterk, Professor and Head of the Department of Communication, Western Kentucky University

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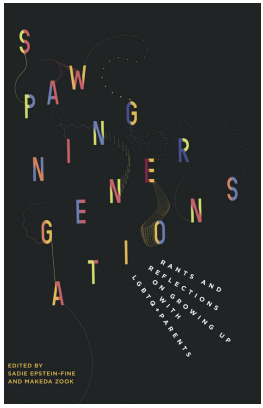
Recently Released

May 2018

Spawning Generations: Rants and Reflections on Growing Up with LGBTQ+ Parents

Edited by Sadie Epstein-Fine and Makeda Zook



May 2018
208 pages $29.95
ISBN 978-1-77258-159-1

Spawning Generations is a collection of stories by queerspawn (people with LGBTQ+ parents) spanning six decades, three continents, and five countries. Curated by queerspawn, this anthology is about carving out a space for queerspawn to tell their own stories. The contributors in this volume break away from the pressures to be perfect, the demands to be well adjusted, and the need to prove that they turned out "all right." These are queerspawn stories, airbrushed for no one, and told on their own terms.

"Thoughtfully curated by co-editors who identify as queerspawn themselves, this astute anthology highlights stories by people with LGBTQ+ parents ready to share their experiences without glossing over the complexities of family, truth, community, and culture. Spawning Generations deftly demonstrates how authentic voices emerge when queerspawn have the opportunity to speak for themselves."
-Abigail Garner, Author of *Families Like Mine: Children of Gay Parents Tell It Like It Is*

"This groundbreaking book provides a lovely and personal entry into the world of queerspawn. As both a queerspawn and queer parent, I felt real gratitude to these brave writers for sharing their stories—they provide insight into my own life as well as parenting guideposts."
-Shoshana Magnet, Associate Professor, Institute of Feminist and Gender Studies, University of Ottawa

"Queerspawn answer, on their own terms, the litany of questions proposed to them by friends, co-workers, strangers, as well as anyone and everyone who have asked what it's like to be raised by queer parents. Sometimes these questions are asked in genuine and loving ways, but too often, they are voyeuristic, titillating, and upsetting. They don't want to be your circus sideshow, your poster child, or your role model. They have claimed the pages of *Spawning Generations* to share their complicated stories of playgrounds, potlucks, pride marches, secrets, family, dancing, desire, mourning, and an intimate view of the best and worst of queer culture."
-Karleen Pendleton Jiménez, Author of *How to Get a Girl Pregnant*

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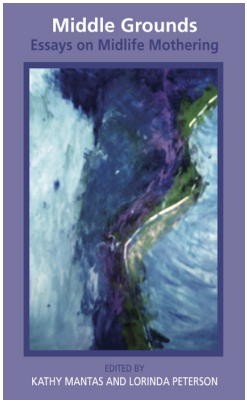
Recently Released

June 2018

Middle Grounds: Essays on Midlife Mothering

Edited by Kathy Mantas and Lorinda Peterson



June 2018
284 pages $34.95
ISBN 978-1-77258-163-8

Although motherhood writings are rich and emerging, the available literature on midlife motherhood and mothering is incomplete and often presented from a narrow perspective. Middle Grounds: Essays on Midlife Mothering fills this gap, widening the lens on a sociological phenomenon that is expanding in the twenty first century. It brings together scholarly and creative essays from diverse disciplines and cultural perspectives to reflect a more contemporary viewpoint — that motherhood and mothering is not limited by the stages of life or chronological age. It echoes distinct voices speaking about experiences that represent a global reality for midlife mothering practices. In essence, this collection demonstrates that everything can transpire in the middle period of a woman's life. Thus, in midlife, we encounter a broad range of mothering experiences and practices, and ways of representing and expressing them.

"This powerful collection of essays explores the timely and important topic of mothering and midlife. One of the strengths of this collection is the variety of voices and genres, including scholarly chapters, personal reflections, and graphic narratives. Women today face professional responsibilities and caregiving pressures from multiple directions, and the chapters of Middle Grounds: Essays on Midlife Mothering offer scholars important insights and reassuring narratives to those working to reconcile competing demands. As the contributors poignantly demonstrate, mothering from the middle poses challenges as well as exciting possibilities."
—Abigail L. Palko, co-editor of *Mothers, Mothering and Globalization* and *Cultural Representations of Breastfeeding*

"*Middle Grounds* opens up the possibilities that so much transpires in the middle of mothering between joy, suffering, tensions and limits. In reading these authors from diverse perspectives and forms, we are beckoned to conscious mothering, as their tales dance us between light, shadow, dark and colours. This is a book that calls forth a turning from scared to sacred, reaffirming the connection between the personal and universal. These authors caress the details with depth, nuance and wisdom and sing into the world; shifting midlife out of the doldrums of predictability. Packed with insights and wisdom, artfully crafted, I am beckoned to once again honour every moment."
—Celeste Snowber, author of *Embodied Inquiry and Wild Tourist*

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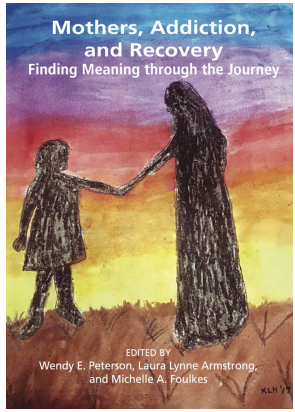
Recently Released

July 2018

Mothers, Addiction and Recovery: Finding Meaning Through the Journey

Edited by Wendy Peterson, Laura Lynne Armstrong, and Michelle A. Foulkes



July 2018
252 pages $34.95
ISBN 978-1-77258-168-3

This anthology is a collection of personal accounts, research, treatment approaches and policy commentary exploring women's experiences of mothering in the context of addiction. Individual chapters focus on a variety of addictions during pregnancy or mothering including misuse of substances, food and smartphones. A central theme of the book is the meaning of women's maternal identity as key to recovery. Part I focusses on women's lived experiences of mothering through their addiction and recovery. The chapters in part II report findings from studies that have prioritized the perspective of mothers living with addiction. In Part III of this collection, we expand our view of addiction and turn to approaches for supporting mothers of daughters with eating disorders and prevention of smartphone addiction. In part IV, contributors expand on the themes of harm reduction and restorative, healing approaches to the treatment of mothers' addictions that have echoed throughout the chapters of this book. The anthology concludes with a gendered analysis and critique of addiction programs and policy.

"Mothers, Addiction and Recovery: Finding Meaning Through the Journey is a timely and innovative book, which provides a significant exploration of the topic of addiction. The book effectively highlights mothers' unique experiences of addiction from their own voices, provides a comprehensive overview of current scholarly research and theorization on addiction, and offers a critical discussion of addiction treatment and recovery programs and practices. The authors provide invaluable insight into the various ways that women mother in the context of addiction, the challenges and struggles they encounter, and the strengths and capacities they demonstrate despite the difficulties and stigmatizations that they face. This book should be read by policy makers, academics, service providers, the wider general public, and anyone who seeks to gain a greater understanding of the unique experience of mothering in the context of addiction."
-Caroline McDonald-Harker, Professor, Department of Sociology & Anthropology, Mount Royal University, Calgary, Alberta

"This book addresses the topic of motherhood and addiction and clearly articulates that there are many different roads to recovery. The inclusion of lived experience is important as well as the need for non punitive approaches and access to programs where both women and their infants/children may attend. This would be a valuable book for anyone considering working in the field of addictions as childbearing women will make up at least half their practice."
-Sarah Payne, Retired Senior Practice Leader, Perinatal Addictions, BC Women's Hospital

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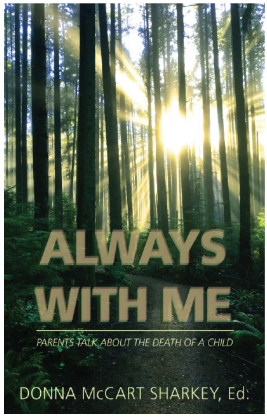
August 2018

Always With Me: Parents Talk About the Death of a Child

Edited by Donna McCart Sharkey



August 2018
198 pages $29.95
ISBN 978-1-77258-169-0

How does a parent cope after the death of a child? Each essay in *Always With Me: Parents Talk about the Death of a Child* reveals the experiences of parents who have lived through the devastation and upheaval of their child's death. Parents describe the maelstrom they face in their inner landscapes, coping strategies, and realigned place in the world. The writers in this collection of stories take on such topics as shock and isolation, despair, guilt, and how they attempt to make sense of their shattered lives. They offer insights into how their grief and loss are worked through, and why certain personal connections are severed, others strengthened. Importantly, they describe how, with lives altered indelibly, they try to press forward to find a new place in the world.

"The death of one's child is possibly the harshest blow life can deliver. This extraordinary anthology offers diverse perspectives on how and why parents survive the pain of their child's death. It is aimed at general readers, other survivors, and those who work with grieving families. The book is sad but not depressing. Read it in small doses to fully appreciate the depths of parental love, sorrow, remorse, and yearning represented here."
—Deborah Yaffe, Senior Instructor Emerita, University of Victoria

"This book is a gift to all of us. The collection of vignettes takes us into the centre of the heartbreaking and unimaginable pain that parents who have lost children live through as they try to make sense of a world where the natural order of things is gone. Raw, honest, and powerful, the stories cannot but make an impression on the reader. The book is instructive and filled with valuable lessons not only for those in the helping professions—social workers, nurses, physicians, teachers, therapists—but also for the general public that needs to get past its discomfort with all parents' worst nightmare and learn how better to provide compassionate support to bereaved parents and their families."
—Therese Jennissen, Professor, School of Social Work, Carleton University

"I was deeply moved by the immediacy of this book's stories, the candour of the writing. Between its pages, I found important insights on the nature of loss, grief, and hope. These heartfelt testimonies, so representative of what it means to be human, provide a close understanding of grieving. One by one, these stories change us for the better. As a health professional, I now feel closer to my fellow humans and more skilled to be there for them in times of profound pain. After the last word was read, I was left with a deep sense of compassion and gratitude for those who so generously shared their journey. True to its title, this book will always be with me."
—Rachel Thibeault, Ph.D. FCAOT, O.C., Sisyphus Resilience Consulting

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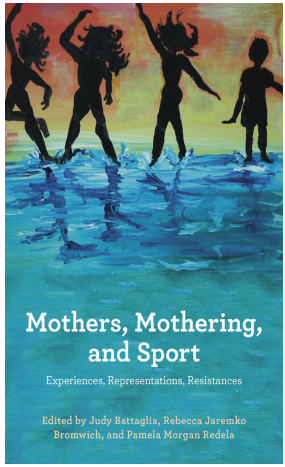
Recently Released

September 2018
Mothers, Mothering, and Sport
Experiences, Representations, Resistances
Edited by Judy Battaglia, Rebecca Jaremko Bromwich, and Pamela Morgan Redela



September 2018
120 pages $24.95
ISBN 978-1-77258-170-6

Mothers and mothering have been a longtime focus of research and study in various academic disciplines, and common topics of interest in mainstream press and popular culture, yet the experiences of mothers and mothering in the area of sport have been less explored. This innovative, interdisciplinary collection provides a space for exploration of the complex dimensions of intersections between mothers, mothering, and sport, as athletes, players, participants, parents, and discursive figures. Topics discussed are wide-ranging, from motherwork in sport, mothers as athletes, the athlete mother in sports, representations and expectations of motherhood and health, legal regulation of sports and parenting, as well as sexuality and gender in sports and gaming.

"There is no other text like it. The articles provide watershed feminist theorizing about the process and practices of mothering athletes from intersectional feminist perspectives from all over the world. There are no other anthologies that I know of that critique the world of sports for children with a focus on gender from a mother's point of view or a theoretical grounding in intersectional feminism. The chapters in this book challenge cissexism, interphobia, racism, classism, hegemonic feminism, and mother blame. These critiques turn the heteronormative, masculinist, cisgender world of competitive sports on its head.

The authors approach the world of youth sports teams and individual sports from a myriad of voices—relational voices, embodied voices, voices of mothers, and mothers who coach. They challenge and resist masculinist and misogynist views of sports." –PAIGE P. EDLEY, Ph.D., Communication Studies Professor at Loyola Marymount University

"Mothers, Mothering, and Sport introduces a necessary discourse of the relationship between motherhood and sports. The multigenerational voices and experiences dismantle the heteronormative and patriarchal misconceptions and myths of what it means to be female in the sports community, launching nuanced and intersectional areas of notable discussion." -Elizabeth Megrabyan, Media strategist and writer with works focused in intersectional feminism, body politics, and social justice. Master of Communication Management, University of Southern California

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Journal of the Motherhood Initiative for Research and Community Involvement

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Important note: MIRCI membership is for the calendar year and must be renewed annually in January.

The Motherhood Initiative for Research and Community Involvement (MIRCI) (formerly the Association for Research on Mothering) is the first activist and scholarly organization devoted specifically to the topic of mothering-motherhood. MIRCI is an association for scholars, writers, activists, professionals, agencies, policy makers, educators, parents, and artists. Our mandate is to provide a forum for the discussion and dissemination of feminist, academic, and community grassroots research, theory, and praxis on mothering-motherhood. We are committed, in both membership and research, to the inclusion of *all* mothers: First Nations, immigrant and refugee mothers, working-class mothers, lesbian mothers, mothers with disabilities, mothers of colour, and mothers from other marginalized communities. We welcome memberships to MIRCI and submissions to the *Journal of the Motherhood Initiative for Research and Community Involvement* (formerly the *Journal of the Association for Research on Mothering*), our biannual publication from all individuals.

This special issue on "Pregnancy, Childbirth, and Post-Partum" features 13 articles, eleven book reviews and a poetry folio featuring the work of Adrianne Kalfopoulou. Articles include:

- **Post-Partum Support For New Mothers**
- **Birth Stories on Mommyblogs**
- **Trauma and Mothering**
- **Placental Thinking**
- **Childbirth: From Curse to Creation**

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