

Journal of the Motherhood Initiative

# Maternal Health and Well-Being

Spring 2020

Volume 11, Number 1



**Andrea O'Reilly, Erin Kuri, Emma Posca, Ornaith Rodgers,  
Iris Galili, Sherri Rose, Nicole Willey and many more**





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## *The Journal of the Motherhood Initiative* (ISSN 1923-4139)

The defining mission of the Journal of the Motherhood Initiative is to promote and disseminate the best current scholarship on motherhood, and to ensure that this scholarship considers motherhood both in an international context and from a multitude of perspectives, including differences of class, race, sexuality, age, ethnicity, ability, and nationality, and from across a diversity of disciplines.

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# **Maternal Health and Well-Being**





ANDREA O'REILLY

## **“Trying to Function in the Unfunctionable”: Mothers and COVID-19**

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*The central directive of the COVID-19 pandemic has been conveyed in two words: stay home. Yet there has been little media coverage, public policy, or social research on how families are managing under social isolation. Few have acknowledged, let alone sought to support, the crucial work mothers are doing as frontline workers to keep families functioning in these times of increasing uncertainty. Mothers do the bulk of domestic labour and childcare, and with social isolation, the burden of care work has increased exponentially, as mothers are running households with little or no support and under close to impossible conditions. Many mothers are also now engaged in paid labour from home and are responsible for their children's education as schools remain closed indefinitely. Mothers have little to no respite from their 24/7 schedule, since most outdoor activities have been cancelled for children, and no one is allowed into their homes. Add income or employment loss, financial or housing instability, food insecurity, single parenting, abusive situations, or recent experiences of migration and the stress is amplified. The article explores the care and crisis of mothers under COVID-19 through an examination of comments and discussions on the Facebook group Mothers and COVID-19, which I set up over a two-week period in early May 2020. The article considers how mothers are managing the new requirements of motherwork under the destabilizing restraints of this pandemic. It also addresses and asks why the essential and frontline work of mothering in this pandemic has been so discounted, disregarded, and dismissed by governments, media, and the larger society. The article seeks to make visible what has been made invisible and render audible what has been silenced—the labour of motherwork under COVID-19—in order to inform, support, and empower mothers through and after this pandemic.*

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This article explores the crisis of mothers under COVID-19 through an examination of the comments and discussions on the Facebook group Mothers and COVID-19 established by the author over a two week period: May 1 and May 14 2020. It also considers how mothers are managing the new requirements of motherwork under the destabilizing restraints of this pandemic. In its explorations, the article addresses and asks why the essential and frontline work of mothering in this pandemic has been so discounted, disregarded, and dismissed by governments, media, and the larger society. It seeks to make visible what has been made invisible and render audible what has been

silenced—the labour of motherwork under COVID-19—in order to inform, support, and empower mothers through and after this pandemic.

### **March 11, 2020: The Day the World Changed**

All of us will remember where we were when the COVID-19 pandemic was officially announced on March 11, 2020. I was in the Denver airport with my daughter Casey en route to the Association for Studies of Women in Mythology conference in Albuquerque, New Mexico. Our flight from Toronto was delayed, resulting in us missing our connecting flight to Albuquerque and leaving us stranded at the Denver airport. After struggling to connect to the airport’s Wi-Fi, both our social media pages opened with post after post about the pandemic and directives from the Canadian government to return to Canada immediately. We spent that night at an airport hotel in Denver, and after many queues and questions concerning the rerouting of our luggage, we finally boarded an early morning flight to Albuquerque. The first days of the pandemic were spent at a near-empty hotel with other goddess scholars in the expansive and remote beauty of the New Mexico desert. We returned home on the Monday on crowded planes with other shell-shocked passengers, and upon arrival at the Toronto airport, I said goodbye to my daughter Casey not knowing that our future times together would be via FaceTime. My son Jesse was travelling in Asia, and after having to change flights several times as borders around the world closed, he returned home on the Wednesday. My partner was at our cottage where he has been living close to fulltime since his retirement two years earlier. Now in a fourteen-day self-quarantine with no food in the house and no means to get it, my son and I packed up our family’s six cats to join my partner at the cottage.

My employment and income have continued as a professor, and as the publisher of Demeter Press, I am now working harder than ever to keep the press going as book sales plummet. My nine planned conferences and speaking engagements for the spring and summer have all been cancelled. Like other professors, I am struggling to keep up with my committee work, research, teaching, graduate supervision through Zoom meetings, endless emails, research and writing without an office, and with a wavering resolve to keep focused and disciplined in the uncertainty, anxiety, and worry of this pandemic. In social isolation at the cottage, my sole contact with the outside world has been through Facebook and the television news.

## **Why Is No One Talking about This? Mothers, Care, and Crisis under COVID-19**

As I am a scholar of motherhood, publisher of a press on motherhood, and have many mother friends, the majority of the posts on my Facebook newsfeed are by mothers who feel exhausted, overwhelmed, panicked, and terrified; they share stories of guilt, self-blame, and despair at not being able to manage or cope, and talk about feeling shamed and judged for their failures caused by the pandemic. One particularly heart-wrenching post from April 2, 2020, and shared by a friend, was by a single mother who was bullied and harassed when she took her children with her to shop for needed groceries:

If anybody has ever wondered what defeat looks like, here it is folks. This is the look of a single mom during a pandemic. The look of a single mom who hasn't left the house except for a grocery order pickup since they called the State of Emergency. A grocery order which had \$100 worth of items that wasn't available, but that I still needed even though it wasn't available. The look of a single mom who decided to pack up the children to go to Costco to pick up a prescription and to hopefully get the rest of the things I needed to be able to stay home for a few weeks at least. Because my options are a) get a babysitter which I'm not allowed to do b), leave the kids home alone which I'm not allowed to do, or c) get someone to pick up my stuff which by the way equaled 300\$. So this is the look of a single mom who was rudely told by not one, not two, but three Costco employees that it is the last time I will be able to bring in my children, and overheard two employees rudely point at me and say "yeah are we putting up signs about children because clearly they're not gonna listen until we do." Most employees were amazing, smiling, and friendly, but I'm guessing a few stressed ones took it out on me. You're looking at the face of a single mom who can't ship their kids off to their dads and have a break. A single mom who's been trying to follow the rules, who has been trying my best at working from home with an eight-year-old and a four-year-old who fight and scream and need to eat and are bored just like every other kid. And the look of a single mom who came out of Costco with tears streaming down her face to hear that I will now have to add homeschooling to the mix.

I shared the post with these comments:

The current situation of forced social isolation for single mothers is not sustainable. Governments and communities must act now to provide support for mothers in such impossible situations. While I applaud the Canadian government for all they are doing for those in

paid labour—Canada Emergency Relief Benefit, wage subsidies, and so forth—mothers in their homes doing the impossible are frontline workers in this pandemic and are more than entitled to, and deserving of, our respect and support.

Although most of the many comments were supportive of this single mother’s untenable situation, a few wrote that “what she did was still wrong” or wondered “Doesn’t this woman have any family or a friend to help her?” However, and as I responded, “Under the rules of social distancing, no one can be in her home other than those that reside there; no family, babysitter, etc. can give a single mother even an hour of respite. No one can live like this for weeks, let alone the now proposed several months.” Indeed, another single mother commented: “I have emotional resources to draw on, people to FaceTime, and only one toddler—who doesn’t have additional needs—but have been REALLY challenged by the isolation. I can’t imagine what it’d be like to have compounding factors making things harder AND to be facing months and months alone. It is a massive reminder that we are NOT designed to mother alone; it’s completely unnatural.” Indeed, the situation is completely unnatural and unsustainable, but why I ask is no one talking about this in the media? And why is there no public policy being developed or research undertaken to support mothers in this pandemic?

As mothers’ stories filled my Facebook newsfeed, another story was being told in mainstream news media. Commercial after commercial and news story after news were acknowledging and giving thanks to the frontline workers of the pandemic: first doctors and nurses, but the list soon expanded to include social workers, retail workers, truck drivers, transit workers, fire fighters, letter carriers, restaurant staff, pharmacists, first responders, and sanitation workers.



We are rightly honouring the essential services of those who are keeping us safe and cared for, but no one in the countless commercials or news coverage I have seen is publicly thanking mothers or acknowledging, let alone honouring, the essential work mothers are doing in our homes that are keeping families safe and cared for. Jackie Dunham argues that “there’s this idea that we’re all in this together, but in many ways, it certainly is not an equal-opportunity pandemic.... The people that are impacted most will always be the most marginalized ... that includes all women, but especially those women who are from racialized groups, newcomer communities, Indigenous women, and those with disabilities.” I would suggest that it is more specifically mothers who are most impacted by the pandemic because it is mothers who are doing the necessary and arduous carework to sustain their families and communities. However, no one is recognizing let alone supporting mothers as frontline workers or acknowledging and appreciating what mothers are managing and accomplishing in their homes under unimaginable circumstances. Indeed, as Claire Gagne asks, “Why is no one talking about how unsustainable this is for working parents?” She continues: “While it seems like every day, we hear of new funding for businesses, support for students, and money for the unemployed (all necessary and worthwhile of course), I haven’t heard a damn thing about a solution for parents who’ve suddenly had all their supports—school, childcare, and extended family—ripped away, and then been expected to carry on with their fulltime jobs.” With the increasing pressures caused by the pandemic, which have removed all separation between work, family, and home life, we need to be asking what toll this situation is taking on mothers and how as a society we can support mothers and their essential service of caregiving. As Farhad Majoo asks, “How could anyone think [that] attempting to work fulltime while rooming with, feeding, and educating one or more children during the pandemic [is sustainable]?”

### **#Mothersarefrontlineworkers**

In April, increasingly frustrated and angered by the deafening silence on mothers and mothering in the pandemic, I created the hashtag #mothersarefrontlineworkers and developed a call for papers for the forthcoming Demeter Press collection *Mothers, Mothering and COVID-19: Dispatches from a Pandemic*. I was also interviewed for the York University media story “Mothering through a Pandemic: COVID-19 and the Evolving Role of Mothers” (Goodfellow) and did a webinar titled “Mothers are Frontline Workers: Crisis and Care under COVID-19.” In each, I talked about the disconnect between what was happening in homes across the world and what was being reported, and I emphasized that we need to ask and address why motherwork, even during a pandemic when it is so crucial, remains so

devalued and invisible. I talked about the importance of knowing how mothers are managing in this pandemic and what can be done to better support them. I decided that one way to both learn about what mothers were experiencing in the pandemic and to support them through it was through a mothers and COVID-19 Facebook group as well as an accompanying website. Both aimed to inform, support and empower mothers through and after the pandemic. I then learned about a COVID-19 grant from my university, and with much haste and earnestness, I applied.

I did not receive the grant funding, and although I was disappointed, I was not truly surprised: if governments and the public are not interested in mothers, why would a granting agency be? Though disillusioned, I still went ahead and set up the Facebook group Mothers and COVID-19. In twenty-four hours, the group had two hundred members, and after finishing this article on June 1st, two weeks after the launch of the group, 940 mothers had joined. The mothers are a diverse group: single, partnered, young, older, poor, affluent, multi-racial, queer, straight, rural, urban, secular, religious, with young and older children, and differently abled. The mothers come from more than two dozen countries, including Argentina, Australia, Austria, Brazil, Canada, England, France, Germany, Guatemala, Greece, Lebanon, India, Ireland, Israel, Italy, Kazakhstan, the Netherlands, Norway, Portugal, Pakistan, Tunisia, Turkey, Trinidad, Scotland, Spain, the United Arab Emirates, and the United States. The website, [mothersandcovid.com](http://mothersandcovid.com), was launched on May 7th.

### **Mothers and COVID 19 Facebook Group: Reflections from a Pandemic**

In this section, I will share some of the posts and discussions from the Mothers and COVID-19 Facebook group that took place between May 1 and May 14. The comments shared are from single, partnered, straight, and queer mothers from various countries, including Argentina, Australia, Brazil, Canada, England, Pakistan, and the United States. I selected a meme titled “The Invisible Load of Motherhood: Working from Home during COVID” by @\_HAPPYASAMOTHER for the group’s photo banner (pictured next page).

The responses to the image were as rapid as they were fierce with more than forty members commenting on the meme in a few hours. Below are some examples:

Here’s another: Doing cooking or some similar thing to be creative and to reduce stress, but family members don’t recognize the contribution (and step up and do some other housework to compensate).

And another: taking care of kids while an elderly, terminally ill parent is under hospice care over 500 miles away and coordinating care for her over the phone.

And when did I have to do all the damn cooking and foraging for food?





Totally. Since when am I suddenly the only person who can think in advance of what we might need to buy from the supermarket or the local shop if we can magically get someone to go and fetch it for us?

Taking responsibility for cooking healthy meals for the family, and for organizing weekly deliveries of shopping, selecting the food and other goods needed and negotiating everyone’s needs and likes alongside availability in shops.

I hadn’t realized marriage instantly meant that one person miraculously loses most of their cognitive functions and the other attains even more miraculous superpowers such as psychically knowing what is needed by every member of the household on two or four legs.

It’s hard and then WASHING all the damn vegetables and groceries to make them safe when they come into the house. It sometimes takes an hour to go through them one by one 😞. It’s exhausting and takes time away from work.

This is me even before the pandemic as I work from home, but at least I got a “break” during school hours to focus on my work. And yet all I ever hear is you’re so lucky to be able to work from home. You must have so much free time.

Now it’s even worse, as I have to help with schoolwork, coordinate deliveries for myself and my elderly parents, [and] try to keep my son happy and occupied as he has no siblings. I just want to lock myself in my room and cry. But I can’t. I must keep on going because there’s no other choice 😞.



Many members shared commiserations:

[I am] feeling all of this is absolutely impossible, particularly as a precariously employed academic with young kids. Publish or perish? I'm perishing ... trying desperately to keep afloat and feeling more pressure than ever to do so. Meanwhile, Mom guilt could swallow me whole. It really feels like a lose-lose situation here, whereby work and mothering come at the expense of each other.

The replies to her post were many:

I feel it but have been carrying this primary mothering/caring/home load since before COVID19, but it makes me slow and COVID19 has amplified it.... My tip is you work every day no matter how slow; keep at it every day slow and steady.

I agree; slow and steady is key. I couldn't wrap my head around revisions for this chapter I was working on. Some days I didn't touch it, but other days, I worked a little on it and was able to finish it for its deadline.

I feel your pain. I am continually two or three weeks slower behind schedule at the present time; COVID19 has intensified it by putting me behind any deadline by at least another week or two minimum.... It's also impossible to get any deep thinking writing time. I use a strategy where I keep a journal of what am up to, so I don't lose track.

I am caught with this constant feeling of never being able to do any of the things I normally do correctly—lousy and absent-minded mum, terrible teacher, awful housewife, poor home office worker. My twenty-four-hour-day is divided into a million things, and none of them are satisfactorily done, at least not to my usual standards.

Most posts were on the unbearable load under COVID-19, particularly for mothers who are now working from home and for the many who are also now responsible for their children's education with schools closed indefinitely. The examples below highlight this pressure felt by mothers:

COVID 19 has definitely hit the world hard. Its shaken it to the core, shuffled everything that was considered routine and thrown it right at our faces—BAM! As a working mother, I would say that the load is unbearable. We are picking ourselves up every hour to meet the needs of everyone around us, especially our little babies, toddlers, and young children.

I am working much longer than usual. My seven-year-old daughter complains to me because I can't play with her. The times of work and

those of care are totally mixed. This is an unprecedented situation for everyone. My positioning as a mother, worker, cleaner, cook, etc. are permanently mixed. Also, now my home is the space for work, play, watching TV, etc.

Since lockdown started, the care of our toddler has been a fulltime responsibility for my husband and I, in addition to our work (which has actually increased in the context of the pandemic). Add to that fasting (it is the month of Ramadan for us), and you have a mama who is really seconds away from a breakdown (in fact I have multiple breakdowns a day).

WTF just happened? The working day is now relentless.

The homework helping, oh my gosh. I have a grade 6 student with learning disabilities,... I have cried by the end of the day a few times now. We can't not do the assignments because making it through school is already a struggle, and she is so often written off as 'bad' [that] I don't want this to be a slip through the crack's opportunity. EXHALE.

Lots of us parents are also working from home. I have a full caseload of my social work clients that I have to talk with each day, and write case notes for, and make referrals for, and now I also have to spend hours doing homework with my son who has ADHD! It's HARD!!

I am a professor of sociology and have been working fulltime from home since the second week of February. I am a single parent of two boys who are ten and twelve, and their dad has them one or two nights each week. I am the primary caregiver of my children. My youngest son has [had] extreme asthma since the age of three: his oxygen is monitored throughout the day, and he is taking steroids and anti-allergy meds. On a good year, he lands in the hospital once or twice, due to his asthma. There is always underlying stress with his health. Thank God, Shiva... and all deities!! :) that my other son is relatively healthy and only has anaphylactic allergy to peanuts and most nuts!! As for me, I was diagnosed with MS seven years ago, and so I take medication that makes me immuno-compromised. I am incredibly stressed ... juggling the many education platforms that my kids are using and their educational deadlines, the underlying health conditions of my family and now with the decisions that I need to make going forward with my kid's education. The school in my province will be opening up in June for one day a week.... I am currently weighing my option of homeschooling my children starting in September because if COVID is introduced to our family, it could

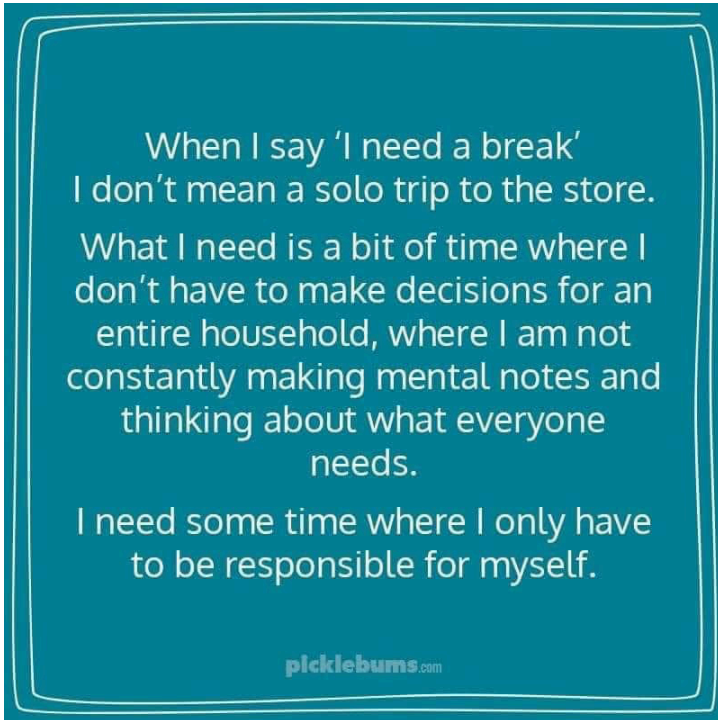
be fatal for my son and I. If I decide to homeschool, I will need to reduce my teaching load, which will mean a pay reduction and loss of employer-paid benefits. Because of my and my son's health conditions, I will be forced to take a sizable pay cut (so, a 25 per cent pay reduction plus now paying for extended medical premiums). There is so much injustice ... but maybe I should just focus on being thankful that I have a job! I experienced extreme work-family conflict. It is overwhelming, and perhaps sometime soon I will go on stress leave ... but this I fear would be too stressful!

I am a mother, grandmother, and educator. I'm juggling what I sometimes ... well, most times, feel is an unattainable workload. I have been raising our grandson for over five years. My partner left us after eighteen years of being together, two weeks before COVID-19 came into our lives. So now another ball has been added to my juggling act that emotionally, socially, and financially is taxing me to the limit. I'm trying to teach my seven-year-old (whose routines and home structure have been completely broken down) and [give] lessons to the nine classes that I teach. Then you throw in ... lawyers, social distancing, and isolation to boot. Sometimes I go to my room and sit on my bed and cry. I feel guilty because I feel I'm not doing a good job at anything because I'm spread so thin. On a positive note, I am fortunate and blessed to have a "village" of strong women and my family holding my head above water so that I don't sink.

I am a mother of two minions, who are four and two years of age. Been working from home and quarantined from the world for seven weeks now, and it is getting really hard to keep sane. I feel like I am just a few days away from a mental / emotional breakdown. I hope it doesn't happen but I sense it will.

My husband works in essential business and leaves in the morning to come back in the evening and helps out as much as he can during those limited hours. My mother is living with me for the time being and has been a great support in helping with my eleven-month-old. But I find it very difficult to manage my workload with home schooling, meal preparations, play time with the kids, and my nonstop conference calls. My daughter's iPad time has gone up, my productivity gone low and as a result I've totally deprioritized my health. Sometimes I just want to throw away my phone and laptop so I can breathe in peace without having calls and emails and messages to respond to! My support system (the nanny, daycare, school) has all fallen apart and I really don't know how long I can go on for.

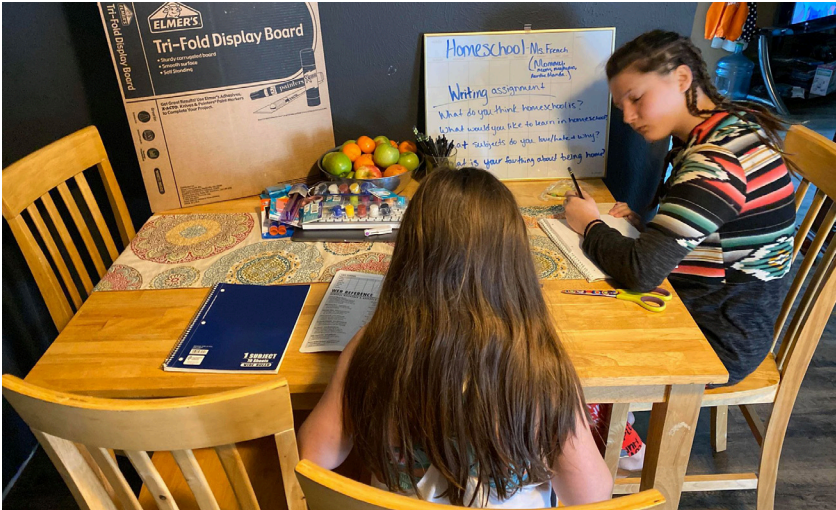
The mothers' comments poignantly capture the mental (over)load of motherwork in this pandemic: specifically the "third shift": the emotional and intellectual labour of mothering or what philosopher Sara Ruddick has termed "maternal thinking." Indeed, the mothers, as conveyed in the well-liked meme (see below) in the Facebook Group are overwhelmed by the demands of maternal thinking—the organizing, remembering, anticipating, worrying, and planning of motherwork—that have become amplified and compounded in the pandemic.



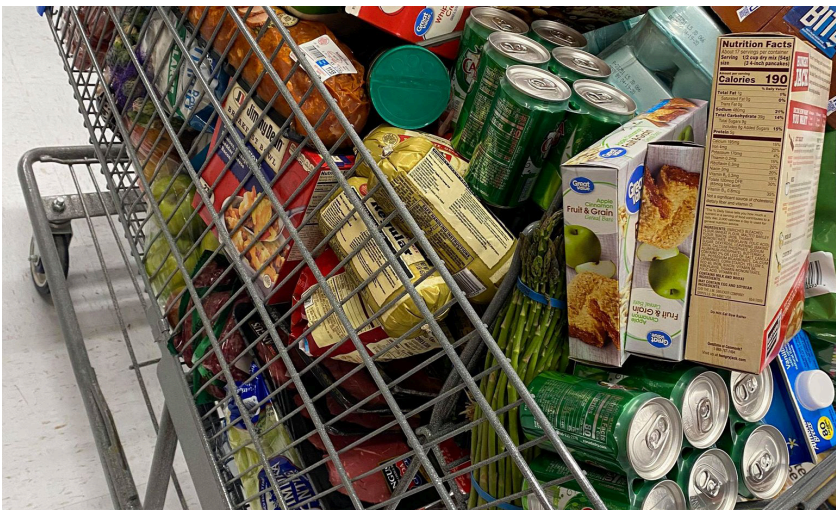
I conclude this section with some words and images (the later sent by the mother for this article) from Amanda French's poignant and powerful post "Sorry, I'm Just Tapped Out":

I said this to one of my kids' teachers this morning as she requested a private zoom with my child and I. At the same time as this, I had two other kids hopping on their Google Meets. I had to pull my oldest from her work to hold the baby; the kids' Dad had a call just starting, and as I struggled with my laptop to even find which godforsaken link I needed to even click, I was ready to crumble. The laptop wouldn't

connect to the Internet. The baby was fussing. My oldest was frustrated. I had to pull her from what she was in the middle of. I had noise coming from each room with all the kids trying to, you know, “school,” and it took every fiber of my being not to throw the laptop off the table.



I'm one person trying to juggle the schedule for five kids, and every day, I fluctuate between moments of having it together and seriously, well ... losing it. This isn't normal.





ANDREA O'REILLY

Any of it.

Trying to function in the “unfunctional.”

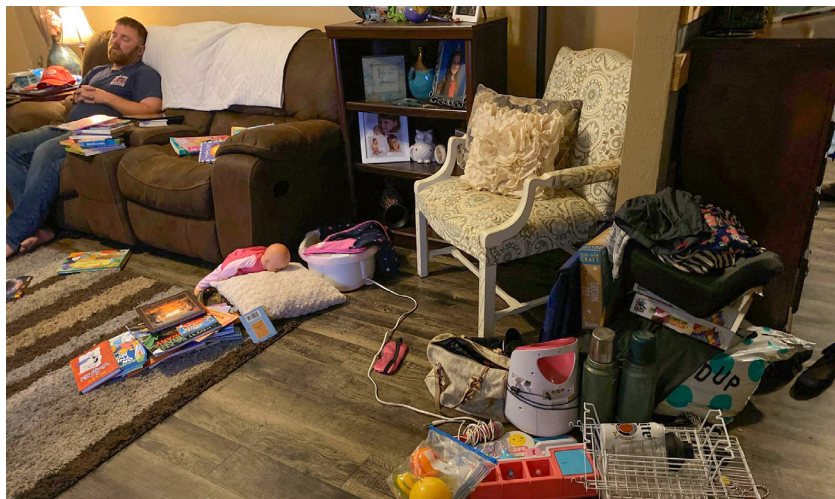
That’s the best way to explain all of this: trying to function in the unfunctional.

This all will be over soon. Right?

Or at least I keep telling myself.

This just isn’t normal.

Any of it.



We’re not supposed to be able to turn to our manuals of “living through a global pandemic and total, utter chaos” and just snap our fingers and handle this all with grace.

It’s impossible.

It’s okay to not love this time and feel okay or good about it in every hour of every day.

I can’t think about tomorrow or the next day or how I’m going to get through next week. I’m literally taking it one day at a time and focusing on surviving the next hour.

If you’re reading this and asking yourself how you can do it, well ... good news is, you already are.

It may not always be pretty, but you’re doing it.

There are crumbs on my counter.

The dishes need done.

The laundry needs switched.



The dog needs to go out.

The baby needs fed.

A kid needs help on their work.

There are massive bags under my eyes as if I haven't slept in twelve years.

I wore this outfit yesterday and to bed and today, which is now tomorrow.

Here we go.

We're freaking rock stars ... every single one of us



## Conclusion: We Need to Be Talking about This

The pandemic has resulted in a greater appreciation for work that was little valued and poorly paid before the pandemic, such as social workers and retail workers. As a result, there have been calls for higher wages along with improved working conditions, but this sadly has not been the case for mothers and motherwork. No one is talking about mothers who—as evidenced in the Mothers and COVID-19 Facebook group—are “doing the impossible,” carrying “an unbearable load,” and “trying to function in the unfunctionable.” Nor are governments providing support for carework as they are for waged work. Despite the cataclysmic upheavals of the pandemic, one thing remains unchanged; mother work remains invisible, devalued, and taken for granted. “School closures and household isolation,” Lewis writes, “are moving the work of caring for children from the paid economy—nurseries, schools, babysitters—to the unpaid one.” Lewis goes on to ask: “What do pandemic patients need? Looking after. What do self-isolating people need? Looking after. What do children kept home from school need? Looking after. All of this looking after—this unpaid caring labor—will fall more heavily on women, because of the existing structures of the workforce”. Andrea Flynn also observes the following in *Ms. Magazine*: “The coronavirus has laid bare many divisions in our society. And, like any serious crisis does, it has elevated the extent to which structural sexism permeates our lives: impacting the gendered division of labor within the home and also shaping what is possible for women, and particularly mothers, in the public sphere.” Relatedly the pandemic has also revealed what has been termed a “crisis in social reproduction”—the failure to recognize the value of motherwork and carework more generally. As Liza Featherstone explains “while capitalist profit-making is completely dependent on the essential work of caring for people, of keeping them alive and healthy—what the historian Tithi Bhattacharya calls ‘the processes of lifemaking’—it is also completely at odds with this labor.” Or as the most-liked meme in the Mothers and COVID-19 group succinctly states: The economy is not closed. Everyone is cooking, cleaning, and taking care of their loved ones. It’s just not valued by economists because it is normally unpaid women’s work.



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To answer the repeated questions of the article—why is motherwork not recognized as an essential service?—I would suggest it is because, motherwork, does not, in the words of Marilyn Waring, count. But as the comments from the Mothers and COVID-19 Facebook group make compellingly and cogently clear mothering, in the words of Meg Luxton, is more than a labour of love, and in the context of a pandemic, it is a frontline essential service

This article is certainly not a final or definitive statement on Mothers and COVID-19. It draws upon only two weeks of mothers’ comments and references and only a handful articles that were available at the time of writing. It provides a snapshot of the care and crisis of mothers and mothering in this pandemic as well as a place to start for future research projects. I hope to develop and expand this study as the group grows and the discussions continue, with my emphasis more on academic members. But I do hope that the article helps to make visible what has become invisible and renders audible what has been silenced—the labour of motherwork under COVID-19—in order to inform, support, and empower mothers through and after this pandemic. As I conclude this article, the economy is slowly and cautiously opening where I live in Ontario, Canada. But most schools in Canada will remain closed until the fall, and children’s summer programs have been cancelled. For many mothers, this will likely present new and more difficult challenges, as they are required to return to the workplace without childcare. And in many countries, pandemic protocols are being reimposed after an increase in COVID-19 cases. It will be a long time before we return to normal—whatever that may be in a postpandemic world. Until then, we must continually and insistently ask why no one is talking about the care and crisis of mothers under COVID-19 and

demand that governments, the media, and the public begin this necessary conversation so that mothers are rightly recognized and supported as frontline workers performing essential service in this pandemic.

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## **Beyond Victims: Motherhood and Human Rights**

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*This article discusses specific cases in which women's reproductive capacity and maternal roles have resulted in human rights violation. It finds that in the context of genocide, women and girls may be specifically targeted because of their reproductive capacity; in assimilationist contexts, mothers may be targeted because of perceptions about their gendered role in the transmission of culture; and women's gendered role of caring for children and the elderly may also increase their vulnerability to harm in some contexts. The role of mothers' groups who work for justice in the aftermath of human rights violations is also discussed. Such activism falls within the range of socially acceptable behaviour by mothers, but some dismiss it as innately conservative and limited. It is important to recognize the range of roles that women (and mothers) undertake in the context of human rights violation, extending beyond that of victim, to ensure that women's agency and activism are recognized.*

This article examines a specific aspect of maternal health and wellbeing: whether women's status as mothers or potential mothers can at times place them at enhanced risk of human rights violations. Drawing on the scholarly literature exploring motherhood and human rights abuses, this article identifies a number of cases in which the biological or social aspects of women's maternal roles have resulted in women and girls being particularly targeted by states or other groups who wish to control or limit their maternity. Maternal health is often defined narrowly as encompassing the relatively short span during women's lives when they are pregnant, give birth, and the immediate postpartum period (World Health Organization). However, Felicia Knaul et al. have argued that this narrow conception of maternal health fails to provide an integrated, comprehensive approach to the health of mothers across their lifecycles, as it focuses too closely on the biological aspects of maternity and fails to consider broader aspects of mothers' social roles as nurturers and caregivers (227). Maternal health and wellbeing are lifelong issues spanning

well beyond the “brief episodes in years of mothering,” which pregnancy, birth, and lactation comprise (Ruddick 48). Some have argued that the maternal health agenda also needs to encompass those women who do not have children (Knaul et al. 228), which is particularly relevant in the context of human rights violations, as women and girls are often targeted because of their potential maternity. The article also explores the role of mothers’ groups seeking justice in cases of child loss and highlights that women’s roles in human rights violations extend beyond that of victim.

### **Motherhood and Human Rights Violations**

Does a woman’s status as a mother or a potential mother put her at particular risk of human rights violations? Feminist theorists have long critiqued human rights mechanisms for their oversights in relation to issues of gender and their failures in addressing violations of women’s rights. These critiques include an analysis of the complete lack of recognition of the gendered dimensions of human rights violations; assumptions about women’s victimhood and the lack of recognition of their agency (Nesiah 808); concerns about limited analyses of gender; an overemphasis on sexual violations (Franke 822); a focus on public sphere violations by state actors (Aolain and Turner 234), excluding analyses of violations occurring in the so-called private sphere; the primacy of civil and political rights within transitional justice processes and the exclusion of economic, social, and cultural rights (Bell and O’Rourke 34), which are seen to have a differential impact on women; the structural barriers to women’s participation in transitional justice mechanisms, relating to both the legal standards on which such mechanisms are based and the processes they deploy (Bell and O’Rourke 24); and concerns about the gendered consequences of participation in transitional justice mechanisms (Aolain and Turner 48; Rubio-Marín 21). However, many of the feminist analyses of gender and human rights violations do not specifically examine issues of motherhood or the implications of women’s potential and actual reproductive and carer roles for their exposure to human rights violations. This article seeks to address this gap by identifying and analyzing examples of the range of human rights violations that women and girls have experienced because of their maternity or potential maternity.

Genocide has been defined in international law as acts committed with the intention of destroying a group, in whole or part, on the basis of its nationality, ethnicity, race, or religion (see Genocide Convention 1948, Article II). The Genocide Convention contains clauses relevant to both the biological and social aspects of women’s status as mothers or potential mothers, covering acts designed to prevent births within a national, ethnic, racial, or religious group (Article II [d]), or the forcible transfer of children from one group to another

(Article II [e]). In the context of genocide, women and girls may be specifically targeted because of their reproductive capacity; in assimilationist contexts, mothers may be targeted because of perceptions about their gendered role in the transmission of culture; and women's gendered role of caring for children, people with disabilities, and the elderly may also increase their vulnerability to harm in some contexts.

“Genocidal rape” has been identified as a feature of modern genocide. It was used extensively in the Rwandan and Bosnian genocides as a tactic not only to appropriate women's reproductive capacity (Fein 54) but also to underscore the helplessness of males from particular cultural groups to defend “their” women (Fein 58), which highlights the interrelationship of the biological and social aspects of maternity. Genocidal rape also has the lasting impact of socially stigmatizing its victims (Dal Secco 95). Catherine MacKinnon has commented that “peoples are also destroyed by acts short of killing” (qtd. in Rafter and Bell 9), and Helen Fein had poignantly described the “social death” in life” of rape survivors in the wake of the Rwandan genocide, who suffered horrific physical and psychological injuries and who were subjected to community ostracism, were sometimes deliberately infected with HIV, and, at times, were left to raise the babies resulting from their rape (57). The International Criminal Tribunal for Rwanda was the first to recognize in its Akayesu Judgement that rape could be used as a tactic of genocide; it is estimated that 350,000 women and girls were subjected to sexual violence during the Rwandan Genocide (Woolner, Denov, and Kahn 705). Research suggests that for at least some Rwandan mothers of the children born of rape, their motherhood has provided a reason to live, indicating that positive experiences of motherhood may assist the recovery of survivors of genocidal rape (Kantengwa). However, other research highlights the ongoing stigmatization and marginalization of both these mothers and of their children, who are dubbed “the little killers” and are frequently viewed as a lasting and unwanted legacy of the violence and suffering of the genocide (Woolner, Denov, and Kahn 707-8). The Rwandan genocide resulted in another legal first, with the conviction of Pauline Nyiramasuhuko, the former Rwandan minister for the family and women's affairs, for inciting “rape as a crime against humanity” (Trial International). Thus, the roles played by mothers in the context of human rights violations can also include that of the perpetrators of violence.

Although the Rwandan genocide provided the first legal recognition that rape could be a form of genocide, there has been a long history of the instrumental use of sexual violence in times of war and conflict. Urvashi Butalia has researched the hidden history of violence against women during the Partition of India, where it is estimated that over seventy-five thousand women were raped, kidnapped, abducted, and forcibly impregnated (Butalia

35). She discusses how women have been killed during periods of conflict by members of their own families and communities due to the complex interrelationship between women and perceptions of nation, community, and male honour. During the violence and chaos of the Partition specifically, women and girls were killed by male family members because of the fear that they would be raped, impregnated, and then would give birth to “impure” children (Butalia 155). Negotiators seeking the return of abducted women forced mothers to face the agonizing decision to leave their children born of rape behind (211). Highlighting the paradoxical situation that these women were viewed as both too precious to be dishonoured as well as disposable, Butalia comments that in the view of their male relatives, “Killing women was not violence, it was saving the honour of the community; losing sight of children, abandoning them to who knew what fate was not violence, it was maintaining the purity of the religion” (Butalia 284). In parallel with the experiences of rape victims in Rwanda, Indian women who had children as a consequence of rape faced social isolation and shame. Even at the time of Butalia’s research, undertaken some fifty years after the events took place, these women still maintained a deep silence about their experiences (284). In the Democratic Republic of the Congo, the prevalence of rape as a tool of war has been so widespread that some argue that sexual assault has lost its social stigma, resulting in increased support for victims; however as filmmaker Lisa F. Jackson comments, “Rape is cheaper than bullets and it has a more lasting effect.... It sends a ripple effect that goes forward for generations” (qtd. in Goetze 5).

In Australia, Aboriginal child removals during the Stolen Generations era highlight how the potential for maternity can also result in human rights violations at the hands of the state. During this period, Aboriginal children were forcibly removed from their families. The first phase of Aboriginal child removals—lasting approximately from 1900 to 1950, which was the height of the White Australia policy—was motivated by attempts to address the “half-caste problem” (Evans 118), the term applied to the growing population of children of mixed white and Aboriginal descent. Some Australian states and territories led efforts to encourage “half-caste” Aboriginal women to marry white men, which was referred to as “breeding out the colour” (Manne 227-28), whereas other states focused on racial segregation combined with other strategies to discourage miscegenation—which was nearly always focused on controlling the sexuality and reproduction of Aboriginal women and girls (Goodall 82; Manne 234). One of the most widely reported on and controversial findings of the *Bringing Them Home* report—the outcome of the national investigation of these child removal practices—was that the forcible removal of Aboriginal children constituted genocide. This finding was based on Article 2 (e) of the Genocide Convention, specifically the argument that the removal

of Aboriginal children constituted the “forcible transfer” of children from one group to another (218). However, the gendered removals of Aboriginal girls and attempts to manage their reproductive choices arguably also fell within Article II (d) of the *Convention on the Prevention and Punishment of the Crime of Genocide*, which addresses “imposing measures intended to prevent live births within the group”; however, this line of investigation was not pursued by the investigation (Payne 49), which did not focus on gender in its analysis.

Mothers often undertake the social practices that contribute to gender construction, kinship networks, and the formation of social identities within families and communities (Woolner, Denov, and Kahn 703), and in some cases, women may experience human rights violations because of their gendered role as those most likely to be responsible for the transmission of cultural values to future generations. The second phase of Aboriginal child removals in Australia, dating from approximately the 1950s onwards, focused on the assimilation of Aboriginal people into the wider community. During the assimilation phase, the state primarily focused on Aboriginal women, whom Heather Goodall has argued were the target of state interventions because their key role as mothers and homemakers was identified as a critical point of state access to and intervention in Aboriginal families (83). Aboriginal women’s motherhood was policed; inspections of Aboriginal homes on missions and reserves were regularly undertaken by white authorities to report on levels of cleanliness and hygiene. Those Aboriginal women identified as lacking in domestic skills were sent to classes and supervised in their health and childcare work, while the systemic issues that contributed to poverty and overcrowding on Aboriginal missions and reserves were not addressed (Kidd 176). Aboriginal families in Australia have experienced extremely high levels of state intervention in almost every aspect of their day-to-day life (Pettman 195). This increased state scrutiny and regulation of Aboriginal families resulted in further child removals, leading to cycles of child removal occurring within Aboriginal Australian families; the impact of which is still being felt today (Cripps 27).

Women may also at times be more likely to become victims of human rights violations because of their gendered roles as carers for children and the elderly, which can expose them to increased risk of violence and murder. Many young Jewish women remained in Germany in the years before the war rather than emigrate because they wanted to care for their elderly parents (Ofar and Weitzman 5). Young Jewish mothers capable of working were instead selected for immediate elimination on arrival at the death camps because they were pregnant or accompanied by young children (Dublon-Knebel 70-71). Fein has noted that “Primarily, it was the motherhood and care-taking of their children by Jewish women which increased their death-chances in the camps rather than direct gender discrimination” (53). Women are socialized to prioritize



the needs of others over their own, and they are demonized if they fail to do so. Sara Horowitz has argued that scholars' accounts of motherhood during the Holocaust tend to be divided into "narratives of heroism," in which a mother's actions led to a child's incredible survival against the odds, or "narratives of atrocity," in which the mother failed to keep her baby alive. She contrasts these to the more complex accounts of survivors, in which "the strands of these two narratives are often intermeshed" (372).

The examples I have discussed highlight some specific contexts in which motherhood or potential motherhood has increased the risk that women and girls will be the victims of human rights violations. Obviously, women's status as mothers or potential mothers does not result in them being at increased risk of human rights violations or the principal targets of genocide in every context. Sometimes, men or boys are the principal victims, or the young or the elderly of either gender. Moreover, the objective may be the indiscriminate destruction of all members of an ethnic group irrespective of gender, age, or other personal characteristics. Although Nicole Rafter and Kristin Bell have argued that "all genocides are gendered events" (3), it is also vital to acknowledge that each genocide is different and "is likely to be driven by different assumptions about gender" (8), which necessitates a careful consideration of the specific context of each case under consideration.

### **Mothers as Human Rights Activists**

Whereas women's status as the victims of human rights violation has often been the focus of research, their agency and activism can be harder to identify. Many mothers' groups have formed in the wake of human rights violations, including the Mothers for Peace in the former Yugoslavia, the Mothers' Front in Sri Lanka, the CoMadres in El Salvador, the Tiananmen Mothers in China, as well as mother groups in Chile, Nicaragua, Honduras, Guatemala, and elsewhere. When mothers become involved in human rights campaigns and processes, it is often to protest against the violation of the rights of others rather than to defend their own rights. Such activism is a form of behaviour that falls within what society defines as an appropriate role for mothers, who are often expected to prioritize the needs and desires of those people for whom they care, particularly their children.

Women often participate in human rights inquiries to testify about the harms done to others, rather than themselves. Katherine Franke has described women testifiers as "repositories of memory for the suffering of others" (822), which has interesting parallels to Carol Gilligan's early findings as a pioneering feminist psychologist about women's tendency to act and speak only for others rather than in their own interest (x). In her study of the South African Truth and Reconciliation Commission (SATRC), Fiona Ross describes the "particular



difficulties” faced by women who were mothers testifying at the SATRC: “Motherhood is a status that traditionally carries great weight and some women felt it damaging both to conceptions of womanhood and to their relationship with future generations to declare the harms inflicted” (158). Ross notes that approximately equal proportions of men and women testified at the SATRC, but “for the most part women described the suffering of men whereas men testified about their own experiences of violation” (17). Perhaps, mothers’ human rights groups are the ultimate expression of this trend, as they base their campaigns on recognition and justice for violations of the rights of their children rather than the violations they themselves have suffered.

In the case of the Madres de la Plaza de Mayo—an internationally renowned group of mothers fighting for accountability after the “disappearance” (that is, abduction and murder) of their children in Argentina—individual mother’s personal experiences of immense grief and loss were transformed into a collective campaign for justice and human rights. A number of studies have examined the factors that led to the success of the Madres’ campaigns, and theorists have debated whether the Madres’ fight for human rights was a radical restatement of women’s carer roles or whether it was ultimately constrained by and reinforced traditional beliefs and stereotypes about women as mothers.

The Madres emerged into the public eye in 1977, when fourteen mothers first gathered at the Plaza de Mayo in Buenos Aires, traditionally the centre of Argentine civic life, to raise public awareness of their plight and to try to pressure the regime into providing information about the fate of their children (Arditti 35). Commentators agree that this was a bold and brave move at a time when the military regime was still at the height of its powers and disappearances were ongoing. However, some feminist scholars are uncomfortable with the Madres using traditional conceptions of women’s roles as mothers and nurturers to legitimize their public protest (Miller 11-12); they argue that such approaches lock women into their reproductive roles (Guzman Bouvard 184). Molly Ladd-Taylor has highlighted that campaigns for the rights of mothers, at least in Canada and the United States, are often set in opposition to human rights (21). Human rights campaigns based on women’s status as mothers are dismissed as maternalism and are seen as innately conservative and limited. Such dismissals are reflective of deeper tensions and ongoing debate within feminism about the nature of motherhood itself: Is it something that needs to be accommodated to enable women to pursue formal equality with men, a contributor to women’s oppression (at least under patriarchy), a form of unpaid domestic labour which contributes to women’s economic marginalization, or is it an expression of women’s difference that should be celebrated?

A significant factor in the impact of the Madres was the revered status of mothers in South American culture (Pieper Mooney 2). Regardless of whether

the Madres indeed transcended or merely reinforced cultural norms, the social status of motherhood in Argentina provided a platform from which the Madres could speak and be heard. Intersectional analysis highlights, however, that not all motherhood is equally valued (see, for example, Roberts 232) and not all mothers have access to the social standing that enables them to speak out about experiences of human rights violations. It is interesting to contrast the outspoken Argentinian Madres with the silence, invisibility, and powerlessness of the Aboriginal mothers of the Stolen Generations, who did not participate in the national inquiry investigating Aboriginal child removal (HREOC 212). Whereas the Madres could draw on the social standing of motherhood in Argentina, Aboriginal mothers in Australia were demonized, and even their capacity to love and care for their children was questioned. It is not surprising, therefore, that disempowered Aboriginal mothers during the Stolen Generations era—operating as they were with diminished parental rights that were curtailed by Aboriginal protection legislation and without the citizenship rights to participate in the political process—were silent about their experiences of child removal. However, it is important to recognize that despite their silence, Aboriginal mothers of removed children still displayed agency. Rather than being passive victims of government policy, Aboriginal mothers in the Stolen Generations era struggled to keep their families together and were often faced with agonizing choices, such as surrendering one or more children in order to keep others, leaving a child behind, or surrendering them to be raised by other family members because circumstances prevented them from caring for all of their children themselves. Rather than being completely absent, a number of mothers managed to maintain some ongoing foothold in their children's lives after their removal—whether through letters, visits, phone calls, holiday visits, standing outside the fence of their children's school, or camping near the homes their children had been relocated to. All of these are actual examples of the strategies used by Aboriginal mothers identified in my research (Payne). Some mothers' experiences are not able to be understood in terms of simple dichotomies, such as victim-oppressor, good mother-bad mother, victim-agent, and present-absent; their stories are complex and messy (Malki 232). They require an "empathetic listener" (Felman and Laub 68), with knowledge of the structural disadvantages these mothers faced, an appreciation of the difficult choices they confronted, and a measure of empathy with their experiences to be properly heard and understood. As a result, these stories remain largely untold.

## Conclusion

This article has explored the relationship between maternity and human rights violations and has highlighted that in the context of genocide, women and girls may be specifically targeted because of their reproductive capacity. In assimilationist contexts, mothers may be targeted because of perceptions about their gendered role in the transmission of culture, and women's gendered role of caring for children and the elderly may also increase their vulnerability to harm in some contexts. Looking beyond seeing maternity as increasing women's risk of becoming victims of human rights violations, the role of mothers' groups who work to address human rights violations raises interesting issues about the perceived strengths and limitations of maternal activism. The legitimacy of women drawing on their maternal roles and status to underpin their human rights campaigning has been questioned by some theorists, paralleling ongoing debates within feminism about the nature of motherhood. Motherhood undoubtedly provides a platform and social standing for some mothers to speak about their experiences and seek justice for their losses, whereas more marginalized mothers may remain silent. It is vital to have an understanding of the complex array of factors that place women and girls at risk of harm because of their maternal roles and potential or actual maternity in order to eliminate these factors. In this way, important aspects of maternal health and wellbeing—which have the potential to impact on all women and girls—can be effectively addressed.

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## Challenging the Invisibility of Queer Young Mothers

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*The social identity category of “young mothers” refers to a diverse and marginalized group, which has been socially constructed by dominant political and faith-based regimes in Western society. For youth who identify as queer young mothers, multiple vectors of oppression result in the erasure of their identity and material needs, contributing to reduced access to appropriate healthcare which impacts the quality of their health and wellness and the health and wellness of their children. In this article, I argue that although the visibility of queer pregnant and parenting youth is an important step in order to collectively establish particular material needs, that recognition alone is not enough. Collaborative advocacy efforts must take an intersectional approach. I place two texts into conversation with one another: Gayle Rubin’s essay titled *Thinking Sex* and Rebecca Trotzky-Sirr’s retrospective memoir-style essay, titled *The Revolutionary Artist Mom and Baby League: Putting Young Queer Parents on the Map*, which centres the voices of youth who identify as queer young mothers. By placing these two texts together, political factors relating to both sexuality and gender, as well as age and economic status, are made apparent, allowing one to trace how and why this group is rendered invisible by communities that serve young mothers and by communities that support queer parents. I then discuss how the combination of these two texts establishes a clear need to collaboratively advocate with queer pregnant and parenting youth to ensure that their particular material needs are met. I explore an intersectional approach to advocacy, and I suggest a sense of direction with respect to advocacy efforts for the needs of youth who identify as queer young mothers. In support of my argument, I draw from feminist theory, contemporary motherhood studies, and queer studies.*

Gayle Rubin remarks that attention to sexuality is always political (143). Rubin’s insights can support our critical understanding of the politics surrounding the social identity category of “young mothers”. “Young mothers”

refers to a diverse and marginalized group, which has been socially constructed by dominant political and faith-based regimes in Western society. For youth who identify as queer young mothers, multiple vectors of oppression result in the erasure of their identity and material needs. Social determinants of health include social and economic factors that make access to healthcare services and to a lifestyle that supports health and wellness more available to some individuals than others. The government of Canada recognizes that “experiences of discrimination, racism, and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, LGBTQ and Black Canadians” (Government of Canada). It would, therefore, be salient to incorporate an intersectional lens that attends to the dynamics of social power and oppression when focusing on the maternal health and wellness of queer young mothers.

In the following article, I argue that although the visibility of queer pregnant and parenting youth is an important step in order to collectively establish particular material needs, such as inclusive maternal healthcare services, that recognition alone is not enough. Collaborative advocacy efforts must take an intersectional approach and prioritize the dismantling and reconfiguring of systems such as child welfare, education, financial aid, healthcare, and family legal systems that distribute opportunity to some and withhold it from others. These systems have historically been shaped by dominant values of patriarchy, capitalism, and white supremacy, acting as enduring sites of oppression and violence towards marginalized communities.

I am writing this article as a mental health care provider, with clinical experience working directly with young mothers and their infants across several urban multiservice community agencies for young families. I identify as a white settler and second-generation immigrant as well as a middle-class, able-bodied, heterosexual, and cisgender woman (pronouns she/her). I am writing as an ally to LGBTQ parenting youth and as a mother. As part of my role working with young mothers across various young parent agencies, I had the opportunity to notice different ways in which agencies expressed inclusivity through their websites, program materials, and practices as a means of attending to the diverse needs of their clients. Working from a feminist perspective, I was often puzzled by the lack of attention to gender identity and sexual orientation in programming and discussion around caregiving and families. Although some youth self-identified as bisexual, queer, or gender fluid, unless one did self-identify as such, it would often be assumed that the mother identified as heterosexual and cisgender. There were no spaces on the intake forms to provide this aspect of their identity and no specific recognition of this possibility in program descriptions or discussion about family composition. Although program descriptions and healthcare services were described as broadly inclusive, reflections of LGBTQ identity were not



specifically recognized across agencies. I observed that recognition of LGBTQ identity in young mothers depended very much on the particular agency or service provider, which could be made apparent by having a rainbow sticker in the waiting room or on an office door. Training and education on LGBTQ-related healthcare matters would depend on the service provider and what training is offered within the agency. In an effort to better understand the lack of visibility relating to gender identity and sexual orientation in services directed towards young mothers, I engaged in further research to analyze the various social factors that contribute to this invisibility and how it may be affecting pregnant and parenting youth. As I myself do not identify as a queer young mother, I aim to centre the voices of theorists who do identify as members of the queer community. The perspectives and lived experience shared by these individuals contribute to a deeper understanding of how queer young mothers are rendered invisible in Western society and how social services and healthcare systems may be improved in support of more equitable care.

I place two texts in conversation with one another: Gayle Rubin's essay titled *Thinking Sex*, and Rebecca Trotzky-Sirr's retrospective memoir-style essay, titled *The Revolutionary Artist Mom and Baby League: Putting Young Queer Parents on the Map*, which centres the voices of youth who identify as queer young mothers. In the first section of this article, I demonstrate that by placing these two texts together, political factors relating to sexuality and gender, as well as age and economic status, are made apparent, allowing one to trace how and why this group is rendered invisible by social service and healthcare communities that serve young mothers and by social service and healthcare communities that support queer parents. In the second section of this article, I discuss how the combination of these two texts establishes a clear need to collaboratively advocate with queer pregnant and parenting youth to ensure that their particular material needs are met. In the third section of this article, I will then turn to the work of Dean Spade, who demonstrates that recognition in itself cannot achieve effective political gains and that an intersectional approach to advocacy must focus on the administrative and legal systems that distribute life chances to groups who exist outside the dominant norms of society. Finally, I return to the political institutions identified through the work of Rubin and Trotsky-Sirr to suggest a sense of direction with respect to advocacy efforts that support positive maternal health and wellbeing in the lives of youth who identify as queer young mothers. In support of my argument, I draw from feminist theory, contemporary motherhood studies, and queer studies.

For the purpose of this article, "young mothers" will be described as youth who give birth or become a parent to their first child during their teenage years or early twenties. It is important to note that not all young pregnant or

parenting individuals identify as women or mothers or with the female gender pronouns “she” and “her,” as some prefer alternative parent labels (Lewis 162); therefore, I will integrate gender neutral language throughout this essay in an effort to be inclusive of youth who identify as genderqueer, trans\*, or nonbinary. It is also important to identify that not all young female parents are biologically related to their children (Lewis 154).

Regarding the particular texts under study, I employ the terminology used by the author, as such terminology may represent particular sources of research or identity. Gender-based oppression that women in particular experience must be acknowledged (Gladu 1) as well as particular forms of oppression and social exclusion experienced by youth who identify as queer and/or trans\* (Gibson 352; Trotzky-Sirr 133). This article seeks to bridge these two areas of knowledge. Much of the literature cited in this work, specific to pregnant and parenting youth, refers specifically to youth whom the authors identify as women. This author, along with numerous authors cited in this article, recognizes a dearth of academic and popular-culture literature that focuses on the experiences of pregnant youth who identify as queer (Gibson 348; Packebush 23; Toews 1; Trotsky-Sirr 134). Further representation is needed that focuses on the intersection of these social identities.

### **Invisibility of Queer Young Moms: Where Feminism Meets Sexual Oppression**

In the 1980s, battles were waged between liberal sex-positive feminists and conservative “sex-negative” feminists over pornography and sex work (Barker and Scheele 48). It was within this context that Gayle Rubin wrote *Thinking Sex*, in which she conceptualizes the topic of sexuality within historical, political, and social movements, attending to ways that sexuality has been influenced by neoconservative ideology and right-wing religious groups (148). *Thinking Sex* was influenced by Foucault, poststructural, and feminist theory, with an aim to deconstruct forms of erotic injustice (157; Barker and Scheele 48). Based on historic and contemporary forms of sexual oppression that individuals were experiencing in the 1980s, Rubin asserted that there was an urgent need to develop a radical theory of sexuality (148).

Rubin’s essay outlines societal barriers to the development of a radical theory of sexuality (149), which remain relevant today. Rubin’s theory is situated within a western historical context that emphasizes social inequality and a sexual system of discrimination (155). Perhaps most impactful in Rubin’s work is a visual diagram that depicts how various sexual populations can be divided into a hierarchy, with some forms of sexuality being accepted by the dominant culture and some forms being marginalized and oppressed (153). Particular aspects of this study relating to the oppression experienced by

pregnant queer youth include Rubin's identified influence of Western industrialization relating to laws that were created to govern and punish sexually active minors (Wilson 94), an ongoing history of racialized and nonconforming individuals being pathologized (Joseph 1021) and criminalized (Trotzky-Sirr 137; Wilson 94), and the potential for friction to develop among sexually oppressed groups who "engage in political contest to alter or maintain their place in the ranking" (Rubin 157). I will elaborate further on these elements in the next section.

Corinne Wilson describes how Britain's Industrial Revolution in the early to mid-nineteenth century drastically altered societal views about childhood; division between child and adult was created, as children were deemed to be developmentally incomplete and in need of protection (Wilson 95). From that point, childhood came to symbolically represent innocence and morality in Western society (Wilson 95). This shift further shaped moral attitudes towards children who were either deemed innocent and deserving of protection or delinquent and deserving of punishment (Wilson 95). Sexually active (female and unwed) teenagers were then judged to be delinquent and a threat to the moral fabric of society (Rock 20; Wilson 96).

Stereotypes of young mothers as irresponsible and delinquent continue to contribute to the judgmental treatment of this group today (Darisi 29). Rebecca Trotzky-Sirr once identified as a queer young mom herself and is currently a medical doctor. Through her autobiographical account, she illustrates the impact of moral judgment when she reveals that many queer young mothers avoid disclosing their sexual orientation within social service and healthcare settings due to fear of stigma. The quality of the prenatal healthcare they receive could be compromised or they may risk being reported to child protective services by their healthcare provider (137).

Rubin identifies the various ways her theorized sexual hierarchy is upheld by powerful societal structures, such as legal systems, bureaucratic regulations, the institution of the family, and the general public (160). I would add to this list the institution of motherhood, which upholds societally constructed ideals of what it means to be a so-called "good mother" (Rock 21). Rubin demonstrates that the material consequences of not fitting into the ideals of these structures may include risks to housing, employment, immigration status, and social supports (160). Trotzky-Sirr describes material consequences, such as low income, an inability to access fertility services or legal support (135), unaddressed or unmet unique healthcare needs (137), and a lack of social supports (134). These material needs are all identified as social determinants to health (Government of Canada). Better or worse health outcomes for queer pregnant or parenting youth are directly connected to whether or not they are able to get these needs met as well as the quality of the services they receive.

Rubin describes Jeffrey Weeks's concept of "moral panic" (162), which is

highly relevant to the topic of young mothers, especially those who have been socially constructed as a risk to the economic and moral fabric of society (Vandenbeld Giles 120; Gore 756). Margaret Gibson describes the tensions experienced by queer mothers faced with the pressure to assimilate into mainstream parenting cultures that uphold the dominant patriarchal institution of motherhood and the nuclear family as a means of avoiding societal judgment associated with being different (351; Lewis 162). Rubin explains that moral panic can occur when societal fears are projected onto a particular sexual activity or group, which then becomes symbolic of that fear (162).

Rubin's essay concludes by addressing the relationship between feminism (focusing on gender oppression) and sex (focusing on sexual oppression) (165). Although she views that the "oppression of women is mediated through and constituted within sexuality" (165), she asserts that ultimately feminism and sexuality should be two separate realms of study (169). To move past the binary of sex-positive and sex-negative positions, she calls for attention to be given to the issues of social equality and consent (165). In her final section, she returns to her theory of gender hierarchy and argues for a view of benign sexual variation among diverse forms of sexual activity and sexual identities (169).

### **The Need for Collaborative Advocacy**

Rubin's approach to conceptualizing how and why sexual oppression occurs is useful in understanding the political context that contributes to the invisibility of queer young mothers. However, her desire to separate theories of gender oppression from theories of sexuality oppression does a disservice to this group with respect to comprehending their experiences of social injustice. As Trotsky-Sirr illustrates, both gender and sexuality (in addition to race, class, age, ability, etc.) are interwoven in a complex intersectional manner. She recounts her feelings of social exclusion as a queer young mother, as she could not relate to the "hetero-married-suburban culture" of mainstream parenting groups or to the queer parenting groups that consisted of older, middle-upper-class folks who did not share the social stigma or income barriers of being a teen parent (133).

Trotsky-Sirr describes how her efforts to seek more young people like herself resulted in the forming of a collective of queer-identified young mothers called the Revolutionary Artist Mom and Baby League (RAMBLE) (134). Although the group had a great deal in common, she also acknowledges the diversity between members with respect to social identity and life experience. She recalls a member of the collective named Susan who identified as queer punk at twenty-two and was trying to conceive (135). Another member, Nori, a nineteen-year-old mom aiming to complete her college education, identified as a female-partnered sex worker, (135). Katrina was engaged to a female-to-

male trans partner, following separation from an abusive relationship with her baby's biological parent (135). Sexually active teenagers, who identify as both mothers and queer, live under both umbrellas of gender oppression and sexual oppression. When this group is analyzed in only one category or the other, important aspects of their experience of oppression become invisible and therefore unintelligible.

This phenomenon can be analyzed through intersectionality theory. Kimberlé Williams Crenshaw is a feminist legal scholar who coined the term "intersectionality" to describe the experiences of social injustice through the eyes of women of colour within a legal system that fails to understand how racism and sexism intersect with one another to shape particular forms of oppression (Crenshaw 1, 243). Attention to queer intersectional parenting identities creates new possibilities for reconceptualising the notion of family (Lewis 164). Despite the exciting potential of new spaces for mothers to inhabit, many parents who identify as queer continue to be lured to the desire to appear normal (Gibson 347).

Perceptions of normalcy are deployed by some queer mothers as a means to combat discrimination, to uphold a positive family identity, and to foster positive interactions within the community (Gibson 351). Gibson (353) describes critiques against "strategies of normalization" exercised by LBQ mothers and the broader LGBTQ community. Jasbir Puar uses the term "homonationalism" to describe the political and economic dynamics that create a form of national "exceptionalism" in the United States, in which some queer identities (white, male, Christian, upper middle class, and conforming to heteronormative values) are accepted at the expense of others (people of colour, non-Christian, female, trans\*, nonbinary, bisexual, nonmonogamous, young, working class, or those living below the poverty line) (2, 28). Citing the work of Sara Ahmed, Puar (22) discusses how attempts that some queer couples make to assimilate dominant heteronormative lifestyle practices can be harmful to those individuals who cannot or choose not to. Individuals, such as queer youth (particularly queer youth of colour who identify as female, trans\*, or nonbinary), then become dismissed, dehumanized, or rendered invisible by society (Puar 2, 32).

Discussing the battle of "commonality" over "difference" within communities of LBQ mothers neglects the perspectives of youth who identify as queer mothers (Gibson 352). Dominant discourses that focus on "fertility services, adoption, and parenting, highlight ideas of consumer-style 'choice'" (Gibson 354) that many LBQ mothers cannot access due to various constraints: income, biological, ideological, and institutional (Lewis 157). According to the accounts of Trotsky-Sirr (133), one may assume that such constraints would be exacerbated by age and income-related challenges as well as the moral judgments faced by many young parents.

The RAMBLE collective offers the opportunity for vital support and political work to be done by and with queer young mothers (Trotsky-Sirr 134). As a former queer young mother and current healthcare provider, Trotsky-Sirr declares her aim to “claim a place in queer parenting history (134), as this is a highly invisible group in need of recognition, appropriate healthcare, and resources (134). Trotsky-Sirr shared that she went to great lengths to find scholarly literature about pregnant and parenting queer youth, and although she was able to find one study, it was near impossible to locate. She shares evidence that teens who identify as bisexual or lesbian are equally likely to engage in intercourse but are significantly more likely to become pregnant (134). She acknowledges that this study gave no indication as to what circumstances shaped these outcomes. Based on the lived experiences shared within the collective, she suggests correlations with housing insecurity, interpersonal violence, and challenges engaging with reproductive healthcare services. Such factors are widely recognized as social determinants to health (Government of Canada). These challenges are also well documented within feminist research that focuses on the impacts of social injustice relating to patriarchy, misogyny, racism, and capitalism in the lives of young mothers (Byrd et al. 11, 490; Fortin et al. 9; Kennedy 579; Keys 102; Kulkarni 189; McDonald-Harker 1).

### **An Intersectional Approach to Resistance**

The social identity category as well as material needs of youth who identify as queer young mothers is rendered invisible in a society that predominantly values patriarchy, white supremacy, capitalism, and the nuclear family. The combination of Rubin and Trotsky-Sirr’s texts demonstrates that an intersectional approach to collaborative advocacy is needed in order to understand and support the autonomy of this diverse group.

Dean Spade published an essay titled “Intersectional Resistance and Law Reform” that explores how Crenshaw’s theory of intersectionality is applied by communities who seek social justice reform. He draws on feminist, critical race, anticolonial, and poststructural theory to support his efforts to draw connections between successful methods of intersectional resistance (1031). He demonstrates why resistance strategies focusing on recognition and legal equality fail, since such efforts do not address the root causes of injustice entrenched within administrative and legal systems. Spade uses various examples that illustrate how focusing on specific marginalized groups not only creates divisiveness but also may actually support and expand systems of violence (1033).

Spade explains that the current American legal system addresses civil cases of discrimination on a single-axis basis (e.g. race, gender, or class) and that onus rests with the victim of discrimination to demonstrate that the accused

perpetrator meant harm and intentionally discriminated based on that particular axis of identity (1034). He then presents critiques of this system and suggests the use of the concept of “population control,” which “removes the focus from discrete incidents or individual’s and allows for an analysis of multiple systems that operate simultaneously to produce harms directed not at individuals but at entire populations” (1035). Spade contributes an alternative to forms of resistance that focus on legal equality of particular groups; he instead offers a method that both acknowledges multiple vectors of harm and seeks to dismantle the institutions that transmit systemic oppression (1037).

Spade’s work in conjunction with Rubin’s and Trotsky-Sirr’s demonstrates the dangers of engaging in discourses of deservingness between various groups, as defined by Rubin’s sexual hierarchy, as well as intragroup differences. Echoing the work of Rubin and Trotsky-Sirr, Spade also shows how groups that are perceived to be a “threat or drain” on the dominant population become perceived as “internal enemies”, which are destroyed and abandoned by the state (1046). He distinguishes the privileged groups and makes it clear that queer pregnant and parenting youth lack these socially desired characteristics and can be classified as “internal enemies” of the state (1046). Spade offers a valuable account of intersectional methods of resistance that have demonstrated promise in achieving aims of social justice (1050). Although it is beyond the scope of this article to expand at length on Spade’s approach, healthcare policymakers would do well to draw on these intersectional approaches to encourage equity in policy development and implementation.

### **Queer Young Moms in Resistance**

In this final section, I return to the political institutions identified by Rubin and Trotsky-Sirr to suggest a sense of direction queer young mothers advocacy should take. In accordance with Spade’s text, I first outline what processes to avoid and identify forces of “population control” that impact queer parenting youth. I then review relevant historical contexts and, finally, identify helpful directions for advocacy.

Spade lists three ways harm can be perpetuated through advocacy efforts. Therefore, one should exercise caution and consider avoiding these dangers (1037). First, advocacy efforts should avoid making the argument that queer young mothers are more deserving than older queer parents, straight young mothers, or any other marginalized group in order to prevent further divisiveness. Second, advocates should avoid participating in structures (such as the legal system) that are complicit in the oppression young mothers are trying to resist. Third, advocacy efforts should be avoided that may result in further expanding dominant structures (1037). As a result, one could ask if it is even possible to effect change from within these systems.



Due to unjust societal perceptions of risk, young parents are placed at a much higher level of surveillance than older parents (Vandenbeld Giles 120). As Rubin points out in her work, being identified outside of the dominant norm may lead to increased precarity in various domains of life (160). Spade provides examples of relevant forces of population control—capitalism, patriarchy, homophobia, transphobia, ageism, white supremacy, gender, criminalization, immigration enforcement, ableism, settler colonialism, and environmental destruction—and how they overlap and interlock in nature (1040).

Another important theme of resistance threaded through the works of both Rubin (157) and Spade (1043) is the influence of historical contexts and progressive narratives. In the case of young mothers, Deborah Byrd traces the historic prevalence of teen pregnancy alongside societal attitude shifts relating to unwed and single mothers (488). Her findings reveal that although the prevalence of teen pregnancy has actually decreased, moral panic has increased, as there are now fewer male breadwinners to offer financial support.

Finally, according to Spade's findings, advocates for queer youth must directly mobilize affected communities (1050). These may be neighbourhoods, gay-straight alliances within schools, or cultural communities. Spade states that horizontal structures of power are vital within successful resistance movements. Such a system would centre the voices of those with the least power and develop capacities for autonomy and leadership in those who are most exposed to situations that exacerbate vulnerability (Butler 25; Kelly 13; Mackenzie 42). Spade asserts that a failure to work collaboratively, through an intersectional lens, will only lead to reforms that contribute to ongoing domination and violence (1050).

## Conclusion

Pregnant and parenting youth who identify as queer are a diverse and marginalized group. Throughout this article, I have demonstrated the necessity of bringing visibility to the existence and material needs of this group, but recognition is not enough to establish effective change within social services and healthcare systems. Collaborative advocacy efforts must be rooted in critical theory that values an intersectional lens of analysis with aims to dismantle and reconstruct administrative and legal systems.

By introducing the works of Gayle Rubin and Rebecca Trozky-Sirr (2009), I have shown how political factors surrounding sexual and gender oppression contribute to the lack of visibility experienced by this group. In the second section of the essay, I analyzed these two texts together to show there is a need to collaboratively advocate with queer pregnant and parenting youth to ensure that their distinct material needs are met. In the third section, I brought the

work of Spade into conversation with the first two texts. Spade's work highlights advocacy steps that would be reasonable to carry out on a broader scale, as they use an intersectional approach to resistance and could meet the needs of queer pregnant and parenting youth.

Teen mothers and their young children who are currently seeking services do not have time to wait for the long and arduous processes involved in systems being dismantled and reconfigured. Their health and wellbeing, and that of their infants, are being affected right now, with life-long and intergenerational consequences. What can direct service providers, healthcare administrators, and policymakers do right now to better support queer young mothers? In alignment with Spade's recommendations, programs must be designed and promoted as generally inclusive of all marginalized groups of young mothers; they must recognize various forms of intersecting societal oppression, shared vulnerabilities, and ways that precarity is socially distributed. Most program websites for young parent programs and queer parent programs do offer more inclusive language, yet they do not name examples of groups they are including (for example, young families or families of all ages and composition). Visually creating space for younger parents or LGBTQ parents (in addition to intersecting identities relating to race, class, ability, size, etc.) within intake forms and program descriptions would increase visibility and a sense that these moms can expect to be accepted within these services. Examples could include images of same-sex or gender diverse families and inclusive language on websites and program brochures. Visual references and inclusive language also set a tone for group members who do not identify as younger or queer to anticipate that they are entering into a program that supports queer young mothers. Inclusive scenarios and situations can be presented by group facilitators to recognize diversity and to promote a safe and welcoming space.

Even if programs are labelled as inclusive to queer youth, some mothers may not feel physically or emotionally safe to be "out" or may choose to exercise their ability to pass as a means of meeting the idealized image of the good mother. All individuals connected with social service and healthcare organizations (e.g., direct service providers, administration, and policymakers) should undergo professional development that supports knowledge and sensitivity about ways that various social determinants affect the maternal health and wellbeing of queer young mothers. Healthcare providers must respect a mother's decision to disclose this aspect of her identity. If the healthcare provider is aware of this aspect of their client's identity, they must not "out" them through shared healthcare documentation without the consent of their client. Sharing such information must be treated as a safety issue, and the client must be supported to decide for herself if, how, and when she would like to share this information with her peers or other service providers.

Healthcare services and systems must promote awareness and inclusivity of

all marginalized caregivers. These systems must value and prioritize ongoing relational care that is offered over time as a means to support autonomy for service users. Appropriate funding and resources must be allotted to accommodate the diverse need of marginalized caregivers across various sectors in recognition of social determinants to maternal health. Services must have flexibility to ensure equitable access to care and to recognize the dynamics of power as well as the impacts of social oppression within societal systems and infrastructure. Through recognizing the importance of visibility for queer young mothers and through engaging a broader intersectional approach to maternal health and wellbeing, we can begin to envision a more inclusive healthcare system for young families.

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## **Alone in Paradise: A Review of the Literature Related to Single, Immigrant Mothers in Canada**

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*In most studies, the phenomena of immigration and single motherhood are examined and explored in isolation from each other. In this manuscript, we adopted intersectionality theory as the framework for examining the literature related to the lived experiences of single, immigrant mothers in Canada. We explored single motherhood and immigration in relation to multiple points of intersection concerning dimensions of cultural identity. We began by examining how intersections of gender and ethnicity affect single, immigrant mothers in terms of self-perception, sociocultural experiences, and acculturation processes. Single, immigrant mothers receive specific gendered messages from their families, cultures of origin, and Canadian culture. These messages, specific to the context of mothering, shape their cultural identity and role in society.*

*We also examined the impact of Canadian and country of origin mothering ideologies on single, immigrant mothers, how discourses around these ideologies endorse potentially unrealistic images of the ideal or good mother, and how they affect the mother-child relationship. Single, immigrant mothers hold multiple, nondominant intersecting identities and may not portray adherence to the dominant mothering ideologies, from either Canada or their country of origin. As a result, they are more vulnerable to marginalization, discrimination, and mental health problems. We considered how the intersections of gender, ethnicity, single motherhood, social class, and immigration affected single, immigrant mothers' labour market participation, social support, mental health, and acculturation. We offer insights into the challenges that single, immigrant mothers face and point to ways to improve social and mental health services for these women.*

Being a single, immigrant mother can be a lonely and challenging experience. Many immigrants arrive in Canada with hopes of gaining economic and educational opportunities, particularly for their children (Vesely et al.).

However, they face considerable acculturation challenges, such as acculturative stress, unemployment, culture shock, and loss of support systems (Browne et al.; Vesely et al.; Viruell-Fuentes, Miranda, and Abdulrahim; Zhu). Although there is a growing body of research on immigration and cross-cultural transitioning, little is known about the sociocultural experiences of single, immigrant mothers in Canada (Browne et al.; Zhu).

Single, immigrant mothers often hold multiple nondominant identities related to their immigration status, gender, ethnicity, social class, and status as a single mother. The intersections of, and interplay among, these dimensions of cultural identity affect not only their sociocultural experiences but also their perceptions of the world and themselves (Viruell-Fuentes, Miranda, and Abdulrahim). Intersectionality theory can be instrumental to understanding the multiple points of marginalization, which may influence counselling practices and mental health outcomes for this population (Collins, “Enhanced”; Crenshaw; Viruell-Fuentes, Miranda, and Abdulrahim; Warner, Settles, and Shields). Intersectionality is described as “the complex ways in which social variables, such as race, ethnicity, gender, sexual orientation, social class, and other factors combine to shape a person’s overall life experiences—particularly with respect to the prejudice and discrimination that one may face within society” (García, para. 20). In this article, we examine the interplay between single motherhood, immigration, gender, ethnicity, and social class. We critiqued these intersections and considered each of the following: (a) cultural discourses and norms related to gender; (b) Canadian and culture of origin ideologies of motherhood; (c) the mother-child relationship; (d) vulnerability to marginalization; (e) labour market participation; (f) potential for lack of social support; (g) challenges to mental health and acculturation; and (h) barriers to accessing health and mental health services.

It is rare for single mothers and their children to immigrate to Canada on their own because sole custody or permission from the father is required (Immigration, Refugees and Citizenship Canada). Immigrant women most often migrate with their spouses as economic immigrants in search of a better life for themselves and their children (Sinacore, Kassan, and Lerner; Statistics Canada; Vesely et al.), and they subsequently end up as single parents. Single motherhood has many forms: unplanned motherhood outside of a committed relationship, single motherhood as a result of relationship breakdown or death of a spouse, and, more recently, single motherhood by choice (Daryanani et al.; Kelly). It is important to note that much of the research on single mothering across cultures assumes heteronormativity and positions the institution of marriage as a social norm. We note these dominant discourses (Collins, “Enhanced”), which go beyond the scope of this manuscript, and report these studies using the language of the authors. Following Collins (“Culturally Responsive”), we do not capitalize “euro-western” to counter dominant,



power-over discourses, and we use lowercase white, but we capitalize specific nondominant ethnicities such as “Asian.”

### **Intersections of Gender, Ethnicity, and Motherhood**

Understanding the experiences of single, immigrant mothers begins with recognizing the complex interplay and influence of gender and ethnicity in their countries of origin and throughout the process of cross-cultural transitioning (Palmerin Velasco). It is important to note that the experiences of gender and gender role socialization vary significantly across ethnicities (Curry Rodriguez; Palmerin Velasco). For example, males and females are assigned different gender roles in Mexican families. Housework and childcare responsibilities are exclusive to girls and women; males are given more freedom, permission, and choices (Palmerin Velasco). In South Asian households, girls are taught to nurture, to obey, and to stay inside the house; boys, in contrast, are expected to become successful breadwinners for the family and so are exposed to the outside world (Zaidi et al.). Because these gender roles involve positioning of power in many cultures, females are more likely to fall victim to intimate partner violence (Abraham and Tastsoglou; Du Mont et al.; Palmerin Velasco).

Culturally embedded messages about gender and gender roles often influence choices about, and experiences of, mothering (Wong and Bell). Sociocultural messages and ideologies about how to be a so-called good woman vary across cultures (Schafer; Stoppard and McMullen; Wong and Bell) and reflect deeply entrenched expectations that impact a woman’s self-identity and her place and privilege in society (Wong and Russell-Mayhew). Cultural narratives that convey shared ideas about what it means to be female shape sociocultural pressures that girls and women bear (Wong and Russell-Mayhew). These messages dictate how women should think, feel, and act in ways that follow gender norms in their society (Schafer; Wong and Bell). For example, if the mother from a culture that values women remaining in the home becomes an economic provider in the household, the family may face public scrutiny for their nonnormative power distribution (Palmerin Velasco).

Although Chinese mothers differ culturally from Mexican mothers, they share similar “good mother” socialization (Caplan; O’Reilly; Schafer; Wong). The good mother ideologies, in both dominant and nondominant cultures, define good mothers in accordance with pervasive and potentially oppressive ideals. Chinese mothers, for example, are expected to be consistently giving, caring, nurturing, capable, fulfilled, sacrificing, and happy (Wong). In urban China, mothers are responsible for the physical, emotional, educational, and moral development of the child (Evans). Women adopt the role of the “wonder mother” who must take on all maternal tasks, including the role of the

supportive and empathetic friend (Evans) and be “supereverything” (Choi, Baker, and Tree). Messages about gender roles exist across multiple media and may affect women’s self-identity, experiences, and life decisions (Wong; Wong and Bell).

Women’s experiences of cross-cultural transitioning also are affected by the interplay of gender discourses and norms between their countries of origin and their receiving countries (Browne et al.; Palmerin Velasco; Zaidi et al.). Mexican women, for example, are not granted the same autonomy with regards to cross-cultural transitioning because migration is viewed as a masculine domain (Palmerin Velasco). In other words, women are discouraged from immigrating alone because they do not fit the image of the traditional breadwinner (Zaidi et al. 2014). Upon arrival in Canada, the United States, or other euro-western-influenced countries, immigrant mothers often hold a sense of responsibility to preserve their traditional norms, including their role as women in their cultural community (Browne et al.; Zaidi et al.). However, they may face conflicting views between the dominant individualist ideology in the receiving country, in which autonomy and independence from others are prioritized over connection and mutuality (Collins, “Enhanced”; Lenz), and the beliefs and practices of their country of origin. As a result, many begin to question their self-identity (Zaidi et al. 2014). For example, according to South Asian family norms, the role of the mother is to maintain the traditions and customs of their culture (Zaidi et al; Wong). The reputation of the family is heavily dependent on the mother’s ability to conform to gender-specific norms (Zaidi et al.; Wong). Immigrant women, and immigrant mothers specifically, face tensions as they begin to challenge their traditional beliefs and values related to different family systems (Jamal Al-deen and Windle; Zaidi et al.). The lived experiences of these women, regardless of their immigration status, is greatly impacted by their gender role, which necessitates further exploration of gender in relation to the social, cultural, and institutional influences on mothering in immigrant populations (Curry Rodriguez).

### **Intersection of Mothering Ideologies and Immigrant Women**

Motherhood has long been recognized as a socially constructed concept for which there is no universal definition; as a result, it positions women to raise their children in accordance to potentially oppressive social norms (Hays; Jamal Al-deen and Windle,). The image of the ideal mother exists within euro-western parenting beliefs and practices and is often associated with idealized notions of the white, middle-class, and nuclear family (Jamal Al-deen and Windle; Zhu). In Canada, there are dominant and pervasive myths surrounding the concept of “perfect mothering,” which can make it difficult for mothers to feel confident in their parenting abilities (Sawers and Wong; Wong and Bell;

Wong). So-called failed mothering is often connected with the parenting practices of nondominant groups, including single mothers and immigrant mothers, who do not, or cannot, conform to this dominant Canadian cultural norm (Wong & Bell, 2012; Zhu, 2016). Mothers from nondominant cultures often deviate from the ideological construct of the good mother in euro-western countries, and as such, these so-called bad mothers face social consequences such as marginalization and disconnectedness from society (Jamal Al-deen and Windle; Wong and Bell). These social consequences often negatively affect their mental health and cross-cultural transitioning experiences (Browne et al; Jamal Al-deen and Windle; Zhu).

Immigrant mothers encounter new western ideologies in which more social capital and power is available to the ideal mother than the failed mother (Wong and Bell; Zhu). Immigrant mothers who are unable to mirror dominant euro-western norms for infant care, breastfeeding, and work-life balance are portrayed as bad mothers (Zhu). For example, mothers immigrating from East Asia are confronted with stereotypes and potentially harmful assumptions, such as the image of the “model minority” (Petersen). The model minority discourse is manifested in potentially harmful stereotypes, which are used to position Asian people as overachieving, competitive, successful in math, and so on (Duncan and Wong; Petersen; Wong). Muslim immigrants are further marginalized because they are compared unfavourably to this model minority discourse (Chang). East Asian mothers also encounter the “tiger mother” stereotype (Chua), in which the mother has strict rules and high academic expectations for her children (Duncan and Wong; Wong). Due to this strong and pervasive generalization about East Asian mothers, these mothers are measured against the differing western parenting norms, thus strengthening ideological constructions of motherhood and segregating these women from their new receiving society.

Due to societal pressure, immigrant mothers often find themselves trying to balance their parenting style in accordance with the new culture while maintaining values and norms from their culture of origin (Baum and Nisan). They may face additional social consequences for not fully meeting the good mother discourse from their original cultural group (Baum and Nisan; Kiang, Glatz, and Buchanan). Nehami Baum and Ravit Nisan interviewed immigrant mothers about their experiences of mothering. Participants disclosed that their own mothers laughed and ridiculed them for following “modern” Canadian parenting norms, such as talking to the baby (Baum and Nisan). Indeed, immigrant mothers face familial and societal pressure to instill traditional cultural values in their children (Baum and Nisan; Kiang Glatz, and Buchanan). When these mothers fail to achieve the good mother ideology from their culture of origin, not only do they experience judgment from their families, but they also judge themselves (Baum and Nisan; Kiang, Glatz, and

Buchanan). For example, Lisa Kiang, Terese Glatz, and Christy Buchanan conducted a study on parenting self-efficacy in immigrant families and found that Asian immigrant mothers were more likely to feel competent when they can efficaciously convey heritage and traditional values to their children. The opposite also holds true: Asian immigrant mothers who are unable to transmit these cultural messages may feel less competent in their mothering skills. Within the notion of the ideal immigrant mother, women are expected to follow rules and ideals of mothering (Zhu), which is particularly challenging for immigrant women who face both euro-western and culture of origin social constructions of the ideal mother. These mothers often develop feelings of severe guilt and shame over time because of these unrealistic, and sometimes conflicting, standards (Wong and Bell; Zhu).

### **Mothering Ideologies and Single, Immigrant Mothers**

In addition to the challenges of living up to the good or ideal mother discourses, socially constructed stereotypes of single motherhood and family structure also pose barriers for single, immigrant mothers (Liegghio and Caragata; Wiegers and Chunn). Within the scope of the research on single motherhood, social stigma has been documented as an increasing concern (Liegghio and Caragata; Wiegers and Chunn). The social depiction of single motherhood, often manifested in the form of divorce, has long been considered a “violation of women’s moral code” (Boney 65). There are lingering biases against single mothers in North America despite the increased prevalence of divorce (Liegghio and Caragata; Wiegers and Chunn).

The divorce of two living parents may precipitate experiences and challenges that differ from families who suffer from the death of a parent (Rappaport). For divorced mothers, the mother-child relationship may be weakened. Due to high stress, changes to the family environment, and postmarital conflict, mothers may be less emotionally available to their children (Muhammad and Gagnon; Rappaport). Although divorce is gaining more acceptance in euro-western cultures, many nondominant cultural groups are strongly against the notion of divorce and separation (Wang). Within the Muslim community, Zahra Ayubi notes that women are encouraged to stay in relationships, regardless of any abuse or infidelity that they encounter. A woman who chooses to file for divorce is often characterized as “a woman of little patience and loose morals” (Ayubi 79). For Chinese immigrant wives, their marital role becomes a significant aspect of their self-identity (Yu). In an interview conducted by Yan Yu, one of the Chinese immigrant wives revealed that she had chosen to stay in a marriage that made her feel devalued and inferior to her husband. She stated that “if she divorced ... she [would] lose more than expected and she would struggle financially” (664). Similarly, due to strong

values in familism, Hispanic women feel obligated to maintain the family structure. When these women consider divorce, they risk losing the social support networks of their family and community members (Afifi et al.).

Due to pervasive patriarchal gender roles, American women face pressure in meeting a set of responsibilities that included childrearing, nurturing, and sustaining family relationships (Boney; Ferraro et al.; Wiegers and Chunn). In 2015, Wanda Wiegers and Dorothy Chunn conducted interviews with twenty-nine Canadian women who identified as single mothers to examine experiences of stigma in a heteronormative, two-parent dominated society. The participants described feelings of otherness, shame, and unworthiness due to prejudicial and discriminative attitudes from others. These single mothers were labelled as selfish for depriving their child of a two-parent family or were seen as too incompetent to raise their child in a father-absent environment. These attitudes towards single mothers lead to status loss, isolation, and social exclusion, causing detrimental effects to the mental health of these participants.

Single mothers, particularly immigrant mothers, are expected to stay in relationships and conform to socially constructed norms (Ayubi; Yu). These external expectations can significantly impact their mental health and overall wellbeing (Zhu). The pervasive and potentially harmful effect of mothering ideologies can lead to increased feelings of guilt and shame in this population due to the societal consequences of stereotyping and marginalization (Afifi et al.; Ayubi; Wong and Bell). The experience of being a single, immigrant mother therefore cannot be understood fully through research that explores immigrant mothers or single mothers alone and independently. Instead, careful examination of the complex and intertwining identities of this population, from an intersectionality perspective, is needed.

### **Intersectionality of Immigration and Single Mother-Child Relationships**

Immigrating to a new country can cause tremendous stress to, and imbalance within, the family (Guo et al.; Renzaho et al.). For many migrant families, immigration is associated with acculturative stress, intergenerational conflict, and behaviour problems in children (Belhadj, Koglin, and Petermann; Browne et al.; Renzaho et al.). First generation immigrants often face psychological, social, cultural, and economic barriers for which they lack coping skills and practical resources; the result is acculturative stress (Nassar-McMillan; Rogers-Sirin, Ryce, and Sirin).

In a study conducted by Xinyin Chen and Hennis Chi-Hang Tse, first generation Chinese immigrant children were more likely to develop problem behaviours than their second generation counterparts. In Chinese households, it is both a norm and an expectation for children to take care of their aging parents. However, when immigrating to Canada, the younger generation often

adopts individualist values (e.g., independent living and autonomy in decision making) that conflict with their parents' worldview (Bemak and Chung; Guo et al.; Rodriguez-Keyes and Piepenbring). As a result of this conflict, stress in the mother-child relationship is inevitable (Belhadj, Koglin, and Petermann). Intergenerational conflict and parent-child alienation occurs when the immigrant parents and youth diverge in their acculturation processes, negotiate bicultural or multiple cultural belongings at different paces, or embrace different sets of beliefs, values, and worldviews (Renzaho et al.; Rodriguez-Keyes and Piepenbring). In Arab families, for example, conflicts may exist about choices surrounding education, culture, religion, dating, and marriage (Rasmi). This is especially the case for daughters because females are more restricted than males in Arabic culture (Rasmi).

The intersectionality of immigration and single motherhood adds another layer of complexity to the lived experiences of single mothers and their children (Curry Rodriguez; Viruell-Fuentes, Miranda, and Abdulrahim). When the mother's language competence in English is low, the child and mother may feel stressed and frustrated with the communication barrier (Belhadj Koglin, and Petermann). In Canada, immigrant women are susceptible to poverty, discrimination, and barriers to financial aid (Dlamini, Anucha, and Wolfe; Holumyong et al.). In addition, single, immigrant mothers are more likely than partnered mothers to experience challenges related to physical and mental health as well as social, economic, and parenting demands (Daryanani et al.; Dziak, Janzen, and Muhajarine; Muhammad and Gagnon). Add to this the challenges of dealing with cross-cultural transitions and mother-child conflicts (Dziak, Janzen, and Muhajarine). These cumulative challenges have an effect not only on the single, immigrant mother's experiences but also on the development and mental health of their children (Dziak, Janzen, and Muhajarine; Muhammad and Gagnon). For instance, Elizabeth Nixon, Shelia Greene, and Diane Hogan suggest that youth who grow up in single-mother families are more likely to engage in disruptive and dysfunctional behaviours than youth who grow up in two-parent families. The authors posit that single mothers have difficulty balancing autonomy and control in their parenting practices (Nixon, Greene, and Hogan). Another possibility is that single mothers' parenting is sometimes compromised due to external demands and stress (Daryanani et al.). Although current literature exists on the single mother-child relationship, as well as on the immigrant mother-child relationship (Belhadj, Koglin, and Petermann; Curry Rodriguez; Daryanani et al.; Dziak, Janzen, and Muhajarine; Viruell-Fuentes, Miranda, and Abdulrahim), there is a need for additional research about how the intersections of single motherhood and immigration affect these complex family systems.

## **The Added Influence of Discrimination and Social Marginalization**

Like other nondominant populations, immigrants are more likely to be exposed to discriminatory interactions, practices, and policies (Ginsberg and Sinacore; Ratts et al.). Discrimination and stigmatization can have profound adverse effects on the psychological wellbeing of immigrant populations (Viruell-Fuentes, Miranda, and Abdulrahim; Wilkins-Laflamme). Following the 9/11 terrorist attacks, anti-immigrant sentiments escalated and stimulated anxiety and fear in the United States, which divided American-born citizens and Muslim immigrant populations (Viruell-Fuentes, Miranda, and Abdulrahim). Islamophobia also spiked in Canada (Wilkins-Laflamme) and continues to be experienced by many Muslim women (Saleem). Anti-immigrant messages, through mainstream media and broader cultural discourses, are now visible to Canadian audiences (Wilkins-Laflamme). Islamophobic attitudes include “seeing Muslims as separate from society, as Other with no values in common with Westerners and not influenced by Western culture in any way” and “seeing all of Islam and Muslims as inherently mistreating women and generally traditionalist” (Wilkins-Laflamme 90). As a result of discrimination and stigmatization, immigrant mothers with Arabic-sounding names have experienced an increase in poor birth outcomes and mental health problems (Viruell-Fuentes, Miranda, and Abdulrahim; Wilkins-Laflamme). Some Muslim women in Canada have also been discouraged from covering their faces in public (Wilkins-Laflamme).

Immigrant mothers from a diverse range of countries of origin also experience discrimination in regards to their childrearing beliefs and practices (Fleck and Fleck; Tajima and Harachi). For example, Chinese and Punjabi parenting are described as controlling or authoritative, whereas individualist culture is positioned as normative (Ochocka and Janzen). Such stereotyping may result in immigrant mothers feeling unsupported, confused, and overwhelmed in their new and unfamiliar environment (Fleck and Fleck). In addition, stress is amplified for single, immigrant mothers because immigrants’ education and skills developed in their country of origin are often discounted, which poses a barrier to economic acculturation (Sinacore, Kassan, and Lerner).

All mothers have unique life experiences that cannot be generalized under a single category. It is evident from the literature that single mothers have different experiences from partnered mothers, just as immigrant mothers face different barriers than do Canadian-born mothers. Although some research exists on these mothering experiences, there is a need for further investigation of the experiences of mothers who are subjected to multiple forms of societal oppression, particularly mothers who identify as immigrant and single.



## **Mental Health and Acculturation Challenges**

As a result of their multiple marginalization, based on discourses about motherhood and single motherhood as well as their immigration experiences, single, immigrant mothers are at risk for numerous mental health and acculturation challenges (Lenette). We explore some of the most common challenges in this section: isolation and depression; poverty, unemployment, and underemployment; loss of social support; and acculturative stress.

### ***Isolation and Depression***

Immigrant women need connection to peers and community members who share the same culture (Urindwanayo). Single, immigrant mothers risk experiencing isolation and marginalization (Aydin, Korukcu, and Kabukcuoglu), and mothers who are isolated and raising children without support are at extreme risk for anxiety and postpartum depression (Guruge et al.; Muhammad and Gagnon; Sawers and Wong; Urindwanayo). Good mother ideals and the associated guilt and shame from internal and perceived external judgment elevate the risk of perinatal mood and anxiety disorders for mothers generally (Dunford and Granger). The risk for postpartum disorder is twice as high for immigrant mothers compared to their native-born peers (Thomson et al.; Vigod et al.). Furthermore, being a single, immigrant mother, compared to those who are partnered, is the best predictor for postpartum depression (Guruge et al.), highlighting the significance of intimate partner support in decreasing postpartum anxiety in new mothers during and after pregnancy (Sawers and Wong).

These challenges are further magnified by cross-cultural transitioning, loss of social support, and lack of knowledge of resources (Guruge et al.). Furthermore, single mothers face barriers to these resources, both economic and social, because they have less time available to create connections with community members (Colton, Janzen, and Laverty). Thus, isolation and marginalization can present many challenges for immigrant mothers in receiving support from social institutions, such as schools, childcare programs, and health services (Aydin, Korukcu, and Kabukcuoglu). With weak or no partner support, immigrant women are more likely to experience depressive symptoms (Guruge et al. 2015).

### ***Poverty, Unemployment, and Underemployment***

Single, immigrant mothers face financial and structural barriers that go beyond the work-life balance dilemma faced by other mothers (Knoef & Ours, 2016; Browne et al.). There are increasingly more immigrants living in low socioeconomic conditions and shelters, who are at risk for exposure to violence and poverty (Viruell-Fuentes, Miranda, and Abdulrahim). Immigrant women

have higher unemployment rates than women born within the country (Lu, Wang, and Han) and are more likely to live below the poverty line (Khanlou et al.). The high unemployment and poverty rate in immigrant populations in general is often due to factors such as language barriers, education, culture shock, and discrimination (Dlamini, Anucha, and Wolfe; Lu, Wang, and Han). Nombuso Dlamini, Uzo Anucha, and Barat Wolfe found that immigrant women were likely to encounter the biased cultural assumption that their educational background and work experience were of less value or of lower standards when compared to those of their Canadian counterparts (Dlamini, Anucha, and Wolfe). Unemployment and job loss are contributing factors that may precede immigrant depression, postpartum depression, and other mental health problems (Urindwanayo). This is particularly true for immigrant women who are unemployed and expecting a newborn (Urindwanayo).

These acculturative and systemic challenges are debilitating for single, immigrant mothers who have no choice but to participate in the labour market (Wiegers and Chunn). They often work at low-paying jobs with limited or no employee benefits, and the social standing of single motherhood, even for nonimmigrants, has been associated with employment instability (Wiegers and Chunn). Bibhas Saha suggests that discrimination against mothers in the labour market is linked to the social construction of mothering priorities. Specifically, mothers are expected to accept the competing priorities of children and work demands; this social expectation has been linked to women's lower success in attaining meaningful and long-term employment (Saha). Women who feel societal pressure to raise children are less likely to return to the labour market (Saha).

The high costs of childcare compared to mothers' often limited financial resources are another contributing factor to their challenging experiences in the labour market (Forry). In Canada, safe, reliable, and high quality childcare is expensive (Forry). The cost of fulltime child care per month for infants across Canada can range from \$175 to \$190 in some parts of Quebec to \$1,685 in Toronto; the highest rate for toddlers is in Vancouver at \$1,407 (Macdonald and Friendly). In Alberta, the provincial norm was about \$1000 (Macdonald and Friendly). Single mothers do not have the social and financial support of a partner and are typically the sole providers for their children (Wiegers and Chunn). These mothers with one household income may feel stressed and overwhelmed, and childcare presents a barrier to job stability (Knoef and Ours).

### ***Loss of Social Support***

A common trend for immigrant populations in general is the loss of family and friends after relocating to a new country (Guruge et al.). In particular, single, immigrant mothers are at risk of losing preimmigration social support systems (Vigod et al.). For those coming from cultures that expect women to

hold the family together at all costs, becoming a single mother in the new country means risking the loss of social and financial support from relatives and extended family members (Lenette; Knoef and Ours).

Sources of social support include families, friends, ethnic communities, and networks provided by healthcare professionals and social workers (Guruge et al.). Social supports can assist in decreasing stressors that immigrant mothers tend to experience related to family responsibilities, role confusion, and maintaining family traditions (Msengi et al.). Without these social supports, single, immigrant mothers become susceptible to emotional distress and mental illness (Guruge et al.). As noted above, a lack of social support is associated with increased postpartum depression and other mental health concerns among immigrant women (Guruge et al.; Urindwanayo). Immigrant women are in need of emotional and social support during the antenatal and postpartum period and, unfortunately, do not have their family members or close friends nearby to meet their needs effectively (Morgan et al.; Urindwanayo).

### *Acculturative Stress*

The sociocultural experiences of immigration and single motherhood can result in high levels of stress and anxiety as well as other health challenges (Guruge et al.; Muhammed and Gagnon; Thomson et al.). Researchers exploring the healthy immigrant effect have suggested that migration can have a negative impact on immigrant health (Thomson et al.). Migration issues, such as language barriers, marital conflict, intergenerational conflict, and physical health problems, may increase the risk of postpartum depression for immigrant women (Morgan et al.). In examining parenthood and self-perceived stress among Canadian families, both immigrant and nonimmigrant, Ali Muhammad and Alain Gagnon indicate that single mothers experienced the highest level of stress in comparison to married or cohabiting couples and single men. The reason for this high degree of stress is due to the intersection of factors, such as education, income, and sense of belonging, that single mother experiences (Muhammad and Gagnon). Immigrant women also experience significant stress when their circumstances involve partner violence or conflict (Guruge et al.). In immigrant households with high conflict and cultural obligations to keep the family intact, relatives may minimize the issue of violence, blame the victim, and discourage mothers from leaving (Guruge et al.).

### **Counsellors and Other Healthcare Providers: Part of the Problem or Part of the Solution**

Immigrant mothers, and immigrants in general, are more likely to experience underdiagnoses of health and mental health problems, be underserved within their communities, and be mistreated by health and mental health

practitioners (Thomson et al.; Vigod et al.). Healthcare providers may exhibit similar forms of discrimination and stigmatization towards immigrants as those experienced in the community more broadly, and institutional policies and practices may reduce accessibility and responsiveness of services (Higginbottom et al.; Imel et al. 2011).

In Canada, immigrant populations face significant challenges that limit their access to mental health services. These challenges include lack of awareness of mental health services, cultural barriers to seeking mental health support, and settlement difficulties complicating the process of utilizing services (Saleem and Martin; Thomson et al.). In a review of over twenty years of relevant Canadian literature, Mary Susan Thomson has stated that immigrant new mothers are not aware of services or mental health issues, such as those related to postpartum depression: “Limited awareness of culturally appropriate community health services incapacitate refugee, asylum seeking and new immigrant mothers to cope with post-partum depression” (Thomson et al. 1897). Researchers have identified factors that can influence how immigrant mothers engage in accessing treatment, including the following: gender roles and cultural incompatibility in relationships; their reluctance to seek help due to the stigma of mental health; their preferences, acceptance of mental health issues, and belief in other cultural practices; and settlement barriers, including transportation and limited mobility (Thomson et al.; Vigod et al.).

Complicating limitations to service access, single, immigrant mothers face financial, emotional, social, and cultural barriers that increase their risk for developing mental health problems (Daryanani et al.; Dziak, Janzen, and Muhajarine; Muhammad and Gagnon). In order to help alleviate stress in immigrant populations in general, researchers have suggested a need for a more services that are culturally appropriate and available in multiple languages (Muhammad and Gagnon; Thomson et al.; Vigod et al.). Muhammad and Gagnon have also argued for support related to education, employment, and community engagement. Some authors point to the role of cultural or spiritual leaders and healers in supporting immigrant health (Saleem and Martin). However, the cultural discourses related to single mothering that we have noted throughout this article may pose barriers for some women.

Single, immigrant mothers face challenges surrounding health equity and access to health care due to language and culture (Higginbottom et al.; Urindwanayo). Language can have strong effects not only on employment and mothering experiences but also on communication with healthcare providers (Delara, 2016). Many immigrant women are from countries where the native language is not English. Therefore, language barriers may have an impact on relationships to, and interactions with, the healthcare system as well as on how these women’s needs are addressed (Urindwanayo). Additionally, culture can play an influential role in the lives of immigrant women (Delara; Urindwanayo).

Mahin Delara has proposed that culture influences “perceptions and interpretations of symptoms, help-seeking behavior, decision-making, expectations of the sick role, and coping style and communication with health providers” (3), which, in turn, affects their access to healthcare.

## Conclusion

Although there are community programs and services to address the needs of vulnerable mothers, counsellors, psychologists, and other helping professions have an ethical responsibility to consider the multiple intersecting nondominant identities of single, immigrant mothers and the ways in which these identities can influence their mental health and overall wellbeing (Curry Rodriguez). As Mego Nerses and David Paré, argue, “An intersectional view of identity reveals the complexity and variability of experience, illustrating how it takes place within contexts that can be alternately liberating or oppressive” (180). Our purpose in this article was to highlight some of these intersections with a view to drawing the attention of service providers to the unique experiences of single, immigrant mothers and the need for culturally responsive and socially just counselling, social, and other services. Additionally, this review points to the need for further research related to the intersections of gender, ethnicity, single motherhood, social class, and immigration.

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## **Indigenous Motherhood and Indian Hospitals: Exploring the Impact on Generational Indigenous Mothering Using Feminist Ethnography as a Decolonial Practice**

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*Colonialism creates dehumanizing situations and alienates those who are colonized not only from themselves but also from their culture, language, and lands. Settler colonialism is defined as “settlement over Indigenous people and land” (Hart 25). Indigenous women in Canada were faced with colonizers who interfered with their matriarchy and egalitarian community values. Patriarchal views, which were at the core of colonialism, established controlling and eradication mechanisms in the form of “institutions such as Indian hospitals” (Brant 9). Both the physical and psychological abuse that was inflicted upon Indigenous women in Indian hospitals affected the mothering role and being mothered for both Indigenous women and children, which, ultimately, caused intergenerational trauma. Ethnographic storytelling and Indigenous feminism formulate a resistance as well as an activist stance towards colonial governments but also provide resources for a formal education for non-Indigenous people as part of a decolonial movement.*

### **Preface**

“It serves to remind us that ultimately Indian hospitals isolated and treated the consequences of colonization, and operated to maintain if not widen health disparities.”—Lux 19

“Aboriginal bodies were seen as experimental materials and Aboriginal communities were kinds of laboratories to pioneer new treatments.”—Lux 113

“Those who consented to treatment had no idea what they were consenting to. Those that refused were physically and sexually assaulted.”—Meijer Drees 99



The academic and personal evolution of this paper began in the summer of 2018 while I was enrolled in a directed reading course with my dissertation supervisor Professor Ruth Koleszar-Green. For me, this course was a reintroduction to Indigenous worldviews after many years away from Indigenous research and teachings. This course was the first time I had been taught about Indigenous worldviews from the perspective of an Indigenous faculty member versus the perspective of a white faculty member, which, therefore, introduced me to ethnographic literature written by and from the perspective of Indigenous matriarchs. After reading ethnographies by Maureen Lux, Laurie Meijer Drees, Beverly Jacobs, Patricia Monture-Angus, and Audra Simpson, I was exposed to both the historical and continuing impact of colonialism on Indigenous communities, especially Indigenous women and children, in Canada. I became overwhelmed with anger at the horror contained within these firsthand accounts of the life and death of Indigenous people in Indian hospitals, which were government institutions that demonstrated the way the government felt about Indigenous people, especially women. These hospitals highlight the intensive impact of colonialism, as they were tools of marginalization and eradication. Racial and biological differences between Indigenous and non-Indigenous people were magnified to blame Indigenous people for the diseases from which they suffered—tuberculosis, for example—because they were thought to be racially and biologically inferior. This history fuelled my desire to learn about my responsibility towards Indigenous people by digging deeper into understanding the physical and psychological experiences that occurred in these hospitals. I did this through writing a reflection paper, which was intended to be a jumping off point for me to figure out a way to create awareness about the impact of colonialism on Indigenous people, especially women, in Canada, and to be able to become part of decolonial movements. This paper turned into the present article and became not only a personal journey of learning my responsibility towards decolonialization but also a method to raise awareness about the past brutality Indigenous people experience in these hospitals by and the ongoing impact of colonialism on Indigenous people in Canada.

Weaving between ethnographic stories and the Truth and Reconciliation Report's Calls to Action allowed me to contextualize the historical impact of colonialism and realize its ongoing impact on Indigenous people especially women (TRC 109-20), yet I came to realize that the government has not fully followed through on the Calls to Action. Beyond the apology for residential schools, the Canadian government has done little to help heal the intergenerational trauma among Indigenous communities. As I will further expand upon in this article, there are many Indigenous people, especially women and children, who have not healed from the trauma of the past, which has had an intergenerational impact.

The quotes cited above are from ethnographic stories highlighting the way the Canadian government felt about and treated Indigenous people. The government created and operated Indian hospitals not out of its responsibility to provide healthcare for Indigenous people, especially women and children, but rather to marginalize, control, and eradicate a population (Walter 32). Regretfully, there are no government documents even within the TRC that reference the voices and/or exact numbers regarding the brutality and trauma experienced by Indigenous people in Indian hospitals. These experiences have usually gone unnoticed with focused on residential schools. Therefore, these quotations are significant for making connections to the historical and ongoing impact of colonialism as well as for amplifying Indigenous voices.

Through this initial research, I further concluded that I must take my lead from Indigenous women to whom I am responsible and accountable. As a white woman and guest of Indigenous women in Canada, it is my responsibility to prepare this article as recognition of the historical and continuing effect of Canadian colonialism on Indigenous women. It is my hope that such an article can contribute to decolonization in two ways: first, as a formal resource of learning for other non-Indigenous women about the impact of colonization and, second, so that non-Indigenous women can learn to take their lead from Indigenous women—a tenet of Indigenous feminism, which also takes an activist stance and works towards social change.

This article has three aims. First, this article addresses how Indian hospitals were created by the Canadian government, which enacted legislation and ignored treaties outlining proper healthcare for Indigenous people. Second, this article explores the historical and continuing impact (intergenerational trauma) of Indian hospitals on Indigenous women in Canada and children with respect to being mothers and being mothered. Third, it investigates what it means to be responsible and accountable to Indigenous women as a way to educate non-Indigenous women to be part of a decolonial movement.

### **Introduction: Mothering and Maternal Health in Indigenous Communities**

For me, this article is more than just words; it is about creating awareness about the brutality Indigenous women experienced in Indian hospitals through beatings, experimentations, forced sterilizations, and death. Such experiences have created lasting intergenerational trauma. In my research, I saw the psychological impact these experiences had not only on Indigenous women who could not biologically birth children due to forced sterilization but also on Indigenous children who no longer trust female figures due to being physically and psychologically abused. Even though I am not a mother, I recognize the significance of motherhood and being mothered, and that is

why I make these connections to women and children in Indigenous communities. The colonizers did not support Indigenous communities that were matriarchal and egalitarian, as they wanted to eradicate matriarchy in favour of patriarchy.

Ethnographies such as *Separate Beds* by Maureen Lux and *Healing Histories: Stories from Canada's Indian Hospitals* by Laurie Meijer Drees showcases the experiences of Indigenous women in Indian hospitals. In these works, Indigenous women and children describe their experiences of brutality in captivity: "Indian hospitals followed the mandate of colonialism. They were small, overcrowded, dirty, and dilapidated. Institutional segregation, isolation, forced sterilization as well as physical and mental abuse were common practice in these hospitals" (Lux 41). These oppressive institutions were enacted in order to reinforce the political, legal, and social structures of a patriarchal colonial society. Indigenous women, who were the matriarchs of their communities, were deemed unacceptable by colonizing bodies. Matriarchy, which was an egalitarian form of community composition, was at the core of many Indigenous communities prior to colonization. These communities held Indigenous women in the highest regard. Prior to colonization, Indigenous women were powerful guides who were led ceremonies, formed the centre of the family, and reared children. After colonialism; Indigenous women were forced to adhere to patriarchal norms that made them submissive to white colonial society. In her paper titled "Colonialism and First Nations Women in Canada," Winona Stevenson provides a discussion of the "rationalization of the subjugation and imposition of patriarchy via federal legislation" (44). British colonizers created and attributed binary definitions to Indigenous women, which maintained that the ideal woman involved subordination to men and not individual autonomy. Power and privilege do not belong to nonwhite women under patriarchal regimes (Stevenson 47). Patriarchy normalizes the notion that women, especially Indigenous women, are to be excluded from a place in society, specifically from decision-making processes. The colonial project "defined who was/was not an Indian and who did/did not get status and who lost their status and who was ineligible to gain access to resources" (Granzow 153). Therefore, the government implemented a patriarchal system of inheritance and lineage, which systematically disqualified Indigenous women, two-spirit people, and children from claiming their rights and status.

Furthermore, the existence of gender- and race-based discriminatory practices were perpetuated by the federal government as a way to justify the developments of Indian hospitals and pave the way for the disappearance of Indigenous people who were not deemed as part of white patriarchal colonial Canadian society (Brant 100). In their paper "Decolonization Is a Not a Metaphor," Eve Tuck and Wayne Yang discuss the colonization of Indigenous

people, especially women, by identifying how white settlers used such terms as “slaves, savages and unnatural” to establish negative stereotypes about Indigenous communities, especially Indigenous women, that continue to currently impact them (Tuck and Yang 4). The intersections of race and gender are obvious when examining the exclusionary procedures that exist due to the discourses of the racialized “other.” These discourses and concepts reflect a white patriarchal homogenous state that prohibits equality. Under patriarchy, women, especially Indigenous women, are often excluded from employment and education opportunities. Currently, Indigenous women are still not given personal autonomy, are still marginalized, and are not given access to resources to help them heal from past and persisting trauma from their experiences in residential schools and/or Indian hospitals (Granzow 38).

These studies helped me to better understand the colonial desire to eliminate Indigenous communities, which always started with the destruction of women’s roles. In Indigenous communities, motherhood and being mothered go beyond biology; they are about being raised within a community and a culture as well as having a connection to the land and one another. Without these bonds between Indigenous women and children, the community connection cannot be formed properly, weakening its strength. Principles of Indigenous feminism are important to this article because I believe that the Indigenous women who were personally impacted by experiencing the brutality in captivity or are now dealing with intergenerational trauma need to tell their stories in order to heal and create strong communities that begin and end with egalitarianism and matriarchal values. These stories become a window to the ongoing impact of colonialism and take an activist stance against colonial governments. Furthermore, by listening to these stories, we, as non-Indigenous people, can better comprehend the ongoing impact of colonization and our responsibilities towards Indigenous communities. This approach will pave the way for Indigenous communities to form alliances with non-Indigenous communities to support Indigenous women in their ongoing struggle to become part of decolonial movements.

Writing, sharing, and learning from these stories is a form of decolonization. For Indigenous women, ethnographic storytelling allows for the examination of the social, political, and cultural significance of the ongoing impact of colonialism on Indigenous communities. Indigenous feminism resists the colonialization of Indigenous women: “Feminism, when linked to Indigenous women, is both a theoretical approach and activist stance” (Green and Bourgeois 7). Indigenous feminism draws on one or more elements of Indigenous cultures, “which is the connection to the land, territory through relationships framed as a sacred responsibility predicated on reciprocity and definitive ideas of culture and identity” (Green and Bourgeois 4). These stories amplify Indigenous voices, bring communities together, and formulate an

Indigenous feminist stance against the colonial state of Canada. I find it necessary to analyze these experiences alongside Indigenous feminism because it can become part of decolonial movements and provide education for non-Indigenous women.

### **Part One: Colonialism and the Roots of Indian Hospitals**

Settler colonialism in Canada is defined as “settlement over Indigenous people and lands and is rooted in domination, self-righteousness, and greed that created dehumanizing situations alienating those that are colonized not only from themselves but from their culture, language and lands” (Hart 25). The colonization of Indigenous people, especially women, in Canada has involved exclusion, marginalization, and appropriation. Colonialism has had long-term devastating effects resulting from a history of residential schools, Indian hospitals, and reserves; its goal has been the removal of Indigenous peoples from the “history and geography of Canada” (Brant 9). The Canadian federal government was able to push its agenda of control, regulation, and assimilation with the creation of Indian hospitals, which were modelled after the idea of residential schools. These hospitals existed in order to force assimilation, to marginalize Indigenous women from their respective communities by keeping them isolated from one another, even while in these hospitals, and to eradicate Indigenous people, especially Indigenous women and children.

Colonialism, therefore, played a major role in the creation and the development of Indian hospitals. Indian hospitals in Canada were an example of “state-directed projects that are places of violence ... at the root of colonial rule” (Granzow 92). Similar to residential schools, the purpose of Indian hospitals was the assimilation, marginalization, and eradication of Indigenous people in Canada. These institutions were steeped in racist ideologies that legitimized the colonial state of Canada (Granzow 92). These hospitals were painted as a humanitarian effort towards Indigenous people; however, they reflected the power exerted over Indigenous people by colonial governments. Lux’s book highlights the actual treatment methods used in these hospitals and what these methods revealed about how the federal government felt about Indigenous people. Lux outlines that the Indian epidemic of tuberculosis (TB) was linked to race and gender, as it was deemed to be a threat to non-Indigenous white people. The rate of Indigenous people who contracted TB was inflated, whereas the rate of white people who contracted TB was underreported. The colonial government misrepresented the data to justify the segregation and institutionalization of Indigenous people, especially women; they were physically forced into hospitals, whereas non-Indigenous white people were given antibiotic treatment for TB (Granzow 96-98). The military was used to remove Indigenous people from their homes all across Canada and into

hospitals, such as the Charles Camsell Indian hospital in Alberta. The number of Inuit people evacuated from the North starting in the 1930s reached its height in 1955, when over 950 Inuit were sent to southern sanatoria (Granzow 101). Segregated institutionalization was the mandate of these hospitals, which were supported by the government. The Canadian Association for the Prevention of Consumption (TB) was formed in 1897, when Canada's first sanatorium was established in Muskoka Canada. By the 1930s, twenty sanatoriums had opened, including Manitoba's Fisher River Hospital, the North Battleford Indian Hospital in Saskatchewan, the Moose Factory Indian Hospital in Northern Ontario, the Mountain Sanatorium in Hamilton, the Charles Camsell Indian hospital in Alberta, and Fort Qu'Appelle. By 1953, over 20,000 beds had been filled with Indigenous patients (Granzow 96).

Colonialism is the root of not only the racial construction of difference but the construction of biological differences between Indigenous and non-Indigenous people. These categories and classifications paved the way to blame Indigenous people for this TB because they were thought to be racially and biologically inferior. Governmental and political power established medical practices that conceptualized that the spread of TB was due to Indigenous people being unfit and unnatural (Granzow 96), which reinforced the idea that an Indian presence in society was dangerous and had to be eradicated. In *Invested Indifference: How Violence Persists in Settler Colonial Society*, Kara Granzow shows how social Darwinism was used by the colonial government as a primary framework through which to blame Indigenous people for the disease because they were thought to be primitive and uncivilized disease carriers (Granzow 98). Social Darwinism loosely argues the following: "human groups and races are subject to the same laws and the laws of natural selection. 'Survival of the fittest' is important to this theory as those that become powerful in society do so because they are thought to be innately better" (Granzow 98-101). Therefore, the colonial government felt that TB was spread by Indigenous people because of their own weakness and unfitness rather than their poor living conditions and their lack of access to proper healthcare, which were perpetuated by colonial governments and their agents.

Furthermore, I expand and use the concept of "contact zones" to address the contact between Indigenous and non-Indigenous people, which came with great friction, disease and death (Granzow). According to the idea of "Terra Nullius," colonizers felt that North America was unclaimed land, which justified their hostile takeover of it, which involved declarations of entitlement and acts of dehumanization (Granzow 144-146). Land takeovers occurred all over Canada. Between 1870 and 1876, massive lands were claimed in Western Canada, and Indigenous people there then became governed by Treaty 6 and ultimately all Indigenous people were ruled by the 1876 Indian Act.

The displacement of Indigenous people from their land was often violent:

“Territorial disputes between First Nations and settlers, the displacement of Aboriginal people as a consequence of the disputes, food shortages, and disease also contributed significantly to the high death rate” (Granzow 142). For example, between 1774 and 1839, the Cree population in Alberta neared extinction not only due to food shortages but also due to their exposure to smallpox (Granzow 142). Therefore, the contact between Indigenous and non-Indigenous settlers solidified that these unequal power relations created race and gender-based definitions that classified Indigenous people as the “other” (Granzow 2020, 33). When linking this idea back to the notion of Indian hospitals, it is worth repeating that their mandate was to isolate and segregate Indigenous people, especially women and girls, from the rest of Canada and to replace a culture rooted in matriarchy with one rooted in patriarchy.

Settler racism and discrimination are an integral part of Canadian patriarchal society; such ideas have often been used to paint Indigenous women as “hypersexual, amoral, and unorthodox” and responsible for the spread of all disease (Walter 10). I agree with Granzow, who cites the works of postcolonial scholar Ann Stoler, to show that Indigenous people were categorized as the “other” to negatively classify, externalize, and eradicate them from society. This discourse of exclusion became attached to Indigenous women; their gender and bodies were defined as being “disposable and in need of regulation through legislative means like the Indian Act” (Granzow 14). Race and gender are, therefore, linked together not only to outline the overall existence of these hospitals but also to justify the discriminatory practices that were perpetuated within. For example, the “provision of treatment was to be considered separate from acts of colonial violence, but they were not” (Lux 93). White doctors and nurses were unwilling to provide proper care to Indigenous people, especially women, while in these hospitals. As will be expanded upon in the next section, Indigenous women were not given access to either Western or traditional medicines while in these hospitals and instead were used to test experimental drugs, to conduct physical experiments, and to test medical equipment (Lux 124). Although accurate numbers were not kept, the statistical information I have found indicate that Edmonton’s Charles Camsell Hospital and Manitoba’s Fish River Hospital were the two hospitals that had the highest rates of death among Indigenous people. For example, in 1949, approximately 462 Indigenous infants and five hundred Indigenous women died in the Fish River Hospital (Lux 160).

Chelsea Vowel, a Metis legal and feminist scholar, figures prominently in my research and in this article because Vowel contextualizes the way in which colonial governments mapped out and controlled the lives, history, and homes Indigenous people, especially women in Canada, which also often involved violence. Vowel’s book *Indigenous Writes* demonstrates the intensive impact of colonization and the directives that were implemented to keep Indigenous



people geographically isolated from themselves and the rest of Canada (Vowel 89; Granzow 152). Following Vowel, Granzow understands the Canadian colonial project as one of control over Indigenous people; for her, the colonial project “defined who was/was not an Indian and who did/did not get status and who lost their status and who was ineligible to gain access to resources” (Granzow 153). For example, the Indian Act implemented a system that operationalized the fiction of the “Indian” so that the “Indian” would disappear (Granzow 155).

It was not until the 1940s that significant government attention was given to the prevention and treatment of Indigenous TB and the way that Indigenous people, especially women, were treated in these hospitals. The investigation into their treatment in Canada became a priority for the Ministry of Indian Affairs in 1945, which demanded information about the treatment and cure of TB among Indigenous groups. In 1944, drug treatment made TB manageable; however, it was not given to Indigenous people as they were still hospitalized. The lack of evidence that these hospitals cured people or developed any preventative measures for Indigenous people eventually led to their closure. The Manitoba Fish River Hospital closed in 1962 and the Charles Camsell Indian hospital followed in 1964 (Lux 199).

Vowel and Granzow both observe that even though Indigenous women have currently been given status and autonomy, there are still laws, such as the Indian Act, that restrict and confine them to reserves and also restrict their access to basic resources, such as adequate healthcare. Such inequalities demonstrate the entrenched and persisting social regulation of Indigenous people, especially women. Furthermore, due to white hegemonic colonial views, Treaty 6 from 1876, which outlines healthcare for Indigenous people, was ignored, leading to the current gaps in Indigenous healthcare in Canada. With the enactment and enforcement of the Indian Act (Section 72) health disparities and lack of access to health resources for Indigenous women are still pervasive. The Indian Act, which is racially discriminatory, was established to “discriminate against classes of Indians in the matter of status and entitlement to programs and rights” (Vowel 22). Therefore, after studying the Truth and Reconciliation report and examining the current health statistics about Indigenous women, it is obvious that the physical, mental, emotional, and spiritual elements of Indigenous health are currently still inaccessible to Indigenous women and communities on and off reserves. They have few resources to deal with the physical and psychological damage originating from colonialism. For example, the Truth and Reconciliation Commission (TRC) says the following: “Survivors are dealing with the lasting effects of wearing inappropriate clothing and living in poorly constructed buildings. These living conditions are the main reason why Indigenous people suffer from chronic bronchitis today” (206-15). Indigenous women and communities

on and off reserves are isolated from traditional and Western medicines, as there is a complete lack of funding for more holistic healthcare approaches, which are common among Indigenous communities. Traditional sweat lodges, cedar baths, smudging, lighting, and other spiritual ceremonies are still not properly supported by the federal government (Green and Bourgeois). Therefore, the impact of colonialism on Indigenous communities is ongoing and pervasive, especially relating to Indigenous maternal practices.

## **Part Two: Ethnographic Storytelling-Experiences in Indian Hospitals: The Barriers to Mothering and Motherhood**

This section will expand upon the experiences of Indigenous women in Indian hospitals and the barriers to mothering and motherhood. It will include a discussion of how Indigenous people, especially women, were viewed and treated by settler colonial governments throughout Canadian history. The historical construction of the identities of Indigenous people in Canada created an atmosphere of violence because Indigenous people were thought to be “disposable and were not part of a civilized society” (Granzow 111). Studying such works as Lux and Granzow, I garnered insight into the way that “racialized and gendered violence against Indigenous women was perpetuated and why nothing has changed over the past 100 years” (Granzow 3-4). This article uses ethnographic accounts from sources such as *Separate Beds* by Maureen Lux and *Healing Histories: Stories from Canada’s Indian Hospitals* by Laurie Meijer Drees to educate non-Indigenous women about the “poverty, overcrowded housing, contaminated water and inadequate infrastructure that was part of their lives in these hospitals and gave rise to the cycle of illness and health disparity for Indigenous women” (Meijer Drees 18-19).

The ethnographic stories found in *Separate Beds* and *Healing Histories* are crucial to this article because they include personal and ancestral stories of the experiences of survival and death of Indigenous women and children in Indian hospitals. The following passage describes the conditions in Indian hospitals all over Canada, although the worst cases were in Alberta, Manitoba, and Quebec:

The conditions of the hospitals were shocking. There were usually 3 physicians on staff for hundreds of Indigenous patients, walls were crumbling, heating and lighting were dismal, there was 3-4 functioning toilets and only 1 functioning bath/shower. These hospitals were infested with cockroaches, fleas, bedbugs, rats and/or mice. The average stay in these hospitals was almost 28 months (2.5 years) in order to accomplish the severing of family and community connections. Large Inuit populations permanently lost their families and some never learned the fate of their love ones therefore making it

impossible to grieve. Those that returned were unable to psychologically process the physical and psychological trauma that they experienced in these hospitals. (Lux 122))

Indigenous women in Indian hospitals across Canada faced similar circumstances at the hands of Indian Health Services. Many were forced into these hospitals not because they were ill but rather to control, regulate, and assimilate Indigenous women in Canada. Healthy Indigenous women were used to test dangerous medical equipment and were exposed to cancer (Lux 119). Vaccines were almost never administered, and if they were, they were not done according to standard medical practices. The bodies of Indigenous women were used to conduct experiments and test various drugs, which had unknown side effects and often long-term negative health effects (Lux 119). Many women were experimented on without their consent or knowledge. Tales of electroshock therapy and sterilization indicate these practices were frequent at these hospitals. Many women and children died in these hospitals either because they were beaten to death, were left uncured, or were shocked to death or because they were simply ignored and left in isolation (Lux 119). Several Indigenous patients spoke about their experiences of isolation at these hospitals:

“I am getting so tired of this hospital life and I am getting lonely too.”

“I am complaining of not being sick and you doctors keep me here for nothing. You doctors left me laying in my bed worried about my little girl at home.” (Lux 107)

Furthermore, these hospitals were modelled after the ideas of “civilization and Christianization” (Granzow 131). Christian practices were reinforced and fostered during the patients’ time in these hospitals, regardless of their own spiritual and/or cultural practices. Christmas festivities were forced upon Indigenous people in Indian hospitals while being abused. In Granzow’s book, an Indigenous woman, Beatrice Calliou, recounts her time in Charles Camsell Hospital as being filled with abuse, experimentation, and forced sterilization. Similarly, Alice Ironstar, an Indigenous patient in the For Qu’Appelle Indian Hospital in Quebec, describes abuse not only through experimentation but also through forced assimilation to white Christian views, leaving her with no sense of belonging (Granzow 132). Doctors and nurses in Indian hospitals did not follow similar protocols like the ones that were used on white people when treating Indigenous patients: “Doctors would be the ones to administer electro-shock therapy and they would not even give proper medicine to the patients. Nurses were restrictive and punitive” (Meijer Drees 100). For example, TB experiments involved taking five daily blood samples via painful vein punctures (Meijer Drees 101; Lux 109). Collapsed lungs, unnecessary surgeries,

the removal of ribs, confined bed rest, isolation, severe beatings, blood loss after such beatings, administering experimental medication, testing out new and dangerous equipment on Indigenous bodies, and, of course, a high mortality were all common in Indian hospitals across Canada (Brant). A former Indian hospital staff member described the following routine procedures:

“Patients who could not be disciplined to follow the highly regulated bed rest regimes were wrapped in casts, partial or fully-body to ensure their cooperation. Castes were apparently put most frequently on children. Rambunctious children were often physically restrained. Hospital policy was to place small children facedown at night, their hands tied to the side of the crib to keep them from jumping up and down. (qtd. in Granzow 126)

Another former hospital worker spoke about the time she saw some staff members let some dogs loose to attack a boy who had run away. This was his punishment. But she never saw the boy again (qtd. in Ing 125).

The powers and politics of state-directed projects, such as Indian hospitals, perpetuate methods of assimilation, marginalization and eradication all while framing these procedures as examples of healthcare (Granzow 92). The physical and psychological trauma that these hospitals caused for Indigenous communities are noted in the maternal literature. Although there are gaps in the literature, as many Indigenous people, especially women and children, do not want to discuss the traumatic events of the past, there are many that do and that have. Indigenous women and children who have discussed their personal experiences and struggles in Indian hospitals yield stories of psychological and physical trauma. These women were traumatized not only from the abuse they suffered at the hands of nurses and doctors but also from being removed from their children. Many Indigenous women had their children stolen from them and placed in these hospitals. Women and children were isolated from one another even if they were in these hospitals together, which only perpetuated the psychological abuse. Pregnant Indigenous women were forced into having abortions and those who were not pregnant were forcibly sterilized. The Indigenous children who survived these experiences often feel disconnected from their mothers and entire communities. They must deal with the ancestral trauma from their mothers and grandmothers who also survived the Indian hospital experience.

The stories referenced by Rosalind Ing in her article “Canada’s Indian Residential Schools and Indian Hospitals and Their Impacts on Mothering” outline that intergenerational trauma is connected to both those who survived their experiences in these hospitals but also the generations that came after the survivors. The four generations of Indigenous women interviewed by Ing

recount their own stories but also tell the stories of their ancestors. They share stories of intergenerational trauma and being raised by mothers and grandmothers that were unable to cope with being degraded by doctors, nurses, and, ultimately, the federal government due to colonialism (Ing 122). Intergenerational trauma, which Ing refers to as collective trauma, can refer to Indigenous women who have had their children taken away from them or can refer to those who survived the ordeal and are dealing with the aftermath and its physical or psychological trauma. As cited by Ing, generations of Indigenous families are still dealing with losing their children after they were murdered, whereas others are dealing with being unable to conceive after the abuse and sterilization that they suffered in Indian hospitals; inferiority complexes plague these Indigenous women and children. Ing uses the expression “mortification of the self” when discussing intergenerational trauma to describe the “depression, anxiety, low self-esteem, shame and/or mental health issues,” that are predominately described by Ing’s respondents (121). Ing’s respondents were poignant when summarising their intergenerational experiences:

My parents had self-esteem issues. They married young and had my brother and I at an early age, and weren’t prepared to have a family or a marriage. They never experienced a family, didn’t know how to deal with family issues, and our family fell apart. It created self-esteem issues for me, too, thinking I came from a broken home. That’s the most direct effect that it’s had [on me].” (Ing 124)

“These experiences made people unable to communicate.... My mother found it hard even to hug us ... she wasn’t always there for us.... I remember feeling lonely and unloved. An important way to nurture children was missing.” (Ing 124)

Ing expands upon the barriers that Indigenous women in the Indian hospitals faced and continue to face in terms of motherhood because of the trauma. This type of trauma presents barriers for Indigenous women and their ability to mother their own children or become maternal figures to other children in their communities. Psychological and physical trauma created fears and insecurities towards mothering for many Indigenous women. Those who could not psychologically process these traumas could not spiritually connect with children in Indigenous communities (Stevenson 44). Furthermore, children who survived their experiences dealt with barriers to being mothered. As they grew up in Indigenous communities among those family members who also survived the Indian hospitals, they experienced a lack of trust towards adults, especially women, because of their fear of further separation and because of the way they were treated by female nurses: “Indigenous children resisted being mothered because they could not

psychologically connect with an aunt, cousin and/or grandmother—out of fear” (Ing 123). This perpetuated a cycle of intergenerational trauma that began with the women who survived their ordeal and the children that eventually grew up with those who survived and/or grew up to be survivors. The impact of intergenerational trauma is felt all over Canada; however, reports from Cindy Blackstock and the TRC indicate that the most significant impact is felt in British Columbia: “In 2009, this province had the highest rate of suicide among First Nations communities whose families had survived residential school system and/or Indian hospitals. 90% percent of suicides occurred in 10% of First Nations communities” (TRC 109).

The creation and development of Indian hospitals was a strategic move by the federal government to assimilate, marginalize, and eradicate a community, culture, and people. These hospitals were a deliberate attempt to attack the strength of Indigenous women and those communities that revered women. The destruction of matriarchal communities based on egalitarian principles was the goal of the Canadian colonial government.

### **Part Three: Expanded Theoretical Frameworks**

This section identifies four theoretical frameworks and avenues of further research, which I believe are particularly valuable in drawing out the lessons we can learn from the colonial impact, both historical and ongoing, of Indian hospitals on mothering and motherhood in Indigenous communities. It is important to note that full application of each framework is beyond the scope of this short article, so my aim here is to simply to introduce each framework as a promising approach for further investigation.

#### **a. Ethnographic Research and Decolonization**

The purpose of using ethnography as a methodology is significant in both my dissertation research and this article. For the purposes of this article, ethnographic stories were used as a method of decolonization whereby the stories and voices of Indigenous women who suffered in Indian hospitals can create a discourse about the brutality of colonialism. Ethnographic stories, such as the the ones found in *Separate Beds and Healing Histories*, were examined to demonstrate the impact of Indian hospitals on Indigenous people, especially women and children, but these stories also act as a form resistance and create awareness about these experiences. Telling and retelling these stories will create a way to inspire changes in Canadian society in terms of how Indigenous communities are viewed. By using ethnography to tell the truth about the experiences in Indian hospitals and the ongoing impact of colonialism, we can remove the frameworks and ideologies that belong to the colonizer. Decolonization should not only involve the return of lands; it must

also include a rejection of race- and gender-based discrimination against Indigenous people, especially Indigenous women. This is what Tuck and Yang refer to as decolonizing schools, methods, and student thinking (3). This type of ethnographic research is linked to decolonization and to feminism because Indigenous women are reclaiming their voices, their power, and their bodies by telling their stories. Indigenous women who have survived these past traumas have reclaimed their culture and community by speaking their truth, having children, and formulating community connections despite what they have suffered. For Indigenous women, this is a form of resistance against colonization and a way to stand up to end marginalization and oppression.

Ethnography is important because it is a way to look at the history of colonialism in Canada to identify the political and legal mistakes of the Canadian government, whose laws are engrained with gender- and race-based discrimination used to control and marginalize Indigenous women. Using ethnographies will be a way to educate non-Indigenous people, especially women, on the reality of Indigenous marginalization and oppression at the hands of the federal government, which will create a better alignment between Indigenous and non-Indigenous women.

### **b. Indigenous Feminism**

The racism and discriminatory practices at the heart of colonialism need to be rethought, resisted, and removed from current Canadian consciousness by using Indigenous feminism, since “feminism, when linked to Indigenous women, is both a theoretical approach and an activist stance” (Green and Bourgeois 7). Indigenous feminism draws on one or more elements of Indigenous cultures, “which is the connection to the land, territory through relationships framed as a sacred responsibility predicated on reciprocity and definitive ideas of culture and identity” (Green and Bourgeois 4). Using Indigenous feminist theory to analyze the gender- and race-based violence perpetrated against Indigenous women is necessary for three reasons: First, it will allow for the creation of spaces for Indigenous feminism; second, it will help prevent violence towards Indigenous communities, especially Indigenous women; and, third, it will raise awareness about such violence (Green and Bourgeois 69). Indigenous feminism helps resist the Canadian judicial and legal systems that exist as barriers to the health and security of Indigenous women.

Using ethnography to examine feminism and resistance towards colonialism has allowed for Indigenous communities to be brought closer together: “Feminism has worked to remove the binary definitions that are given to Indigenous women that were/are based on white colonial attitudes” (Stevenson 46). Indigenous women who have survived residential schools and Indian hospitals have reclaimed their culture and community by not only speaking out about their survival but also by having children and educating them about



what they have been through. Indigenous feminism also helps educate non-Indigenous women and encourages them to become part of decolonial movements.

### **c. Race and Gender Intersectionality**

The theory of intersectionality will be used in this section to expand upon the way that race and gender are inextricably linked to the examination of Indian hospitals. Intersectionality understands that “social categories such as race, class and gender ... usually overlap [and] can become multiple sources of oppression” (Crenshaw 138-39). As cited by both Kimberle Crenshaw and Patricia Hill Collins, it examines the multiple ways in which people are kept in low social positions, are marginalized, and excluded from important parts of society. According to both Crenshaw and Collins, intersectionality highlights how such factors as race, gender, and class are not independent one another but rather inform one another to create complex kinds of oppressions. Socially, intersectionality describes the overlapping and intersecting social identities that impact the way people are seen by society. The theory of intersectionality informs my examination of the way that the Canadian federal government has negatively defined Indigenous people to create discriminatory practices (Crenshaw 145-47 and Hill-Collins 11).

Race- and gender-based discriminations are rooted in the white settler colonial mentality, which dictated, that Indigenous people, especially women, were the ones who spread disease and, therefore, had to be controlled, marginalized, and eradicated at any cost (Vowel 99). Race-based discrimination is linked to the white settler mentality, which defined Indigenous people as “savages” and in need of civilization (Tuck and Yang 3). The casting of Indigenous bodies as ill was used to justify the assimilation of those bodies into civilized white ones through the establishment of Indian hospitals (Granzow 121-23). Even though it was white settlers who brought introduced these diseases to North America, Indigenous people were blamed and villainized for them, which justified their brutal treatment in Indian hospitals. Indigenous people were seen as a threat to the rest of Canada, which legitimized the extreme measures taken to “cull, control and confine the Indian and by extension the Indian epidemic,” leading to “incarceration, institutionalization, and reservation” (Granzow 122).

Race- and gender-based discriminations in Canada against Indigenous people, especially women, were used by the federal government to justify the existence of these hospitals. The federal government wanted to eliminate matriarchy, the growth of the Indigenous population, and, therefore, the continuation their cultures, which led to the brutal treatment of both Indigenous women and children in these hospitals. Indigenous women were subject to forced sterilizations, abortions, and electro-shock therapies, whereas

Indigenous children were brutally beaten to the point of death (Granzow 111). The testing and treatments in the hospitals were the government's way of dealing with the larger social implication that Indigenous people were the problem and the carriers of diseases, such as TB. These hospitals were a direct consequence of colonialism and the treaty system. Lux suggests that for this reason, the federal government walks away from their responsibility to treat and prevent TB among Indigenous people; "the provision of segregated institutionalized of poorly funded Indian hospitals was a retreat from the government's responsibility. Hospitalization imposed the economic and political factors that were part of colonization and implemented harm against Aboriginal people" (Lux 121). According to Lux, social reform was cited as the reason why Indigenous people were marginalized in these hospitals. Here, social reform meant that the hospitalization of Indigenous people would be a way to cleanse society from Indigenous people who were seen as uncivilized (Lux). Based on this race- and gender-based narrative, Indigenous people were blamed for the spread of disease, such as TB, and they had to be removed from society to protect white settlers.

#### **d. Guest Responsibilities**

After reading Ruth Koleszar-Green's article "What Is a Guest? What Is a Settler?" I have learned that I am a settler but also a guest of Indigenous people. Non-Indigenous people are settlers on Indigenous lands. Settlers, also known as colonizers, are often non-Indigenous white people who settled Canada and displaced Indigenous people from their lands. According to Sarah Maddison in her book titled *The Colonial Fantasy: Why White Australia Can't Solve Black Problems*, the word "settler" it is intended to be deliberately discomforting; it underscores the nature of non-Indigenous people's relationship to the land and territory. Settlerhood is bound up with whiteness as well as with settler privilege and white privilege. Settlers benefited from colonialism in the form of land grants as well as slave labour. Settler colonial whiteness in Canada can classify and allocate value to people based on gender, class, sexuality, physical ability, and especially race.

As a white woman, I am a settler; however, being a guest is a bit more complex. Settlers are not automatically accepted as guests. For example, settlers came to the table to meet with Indigenous people, but they came with weapons, took too much from the dish, and, ultimately, spoiled the dish. Settlers did not come with the full intention of becoming a guest; they came to take Indigenous land and disrespect Indigenous people. Therefore, just because I acknowledge that I am a settler does not make automatically me accepted as a guest. I must be accepted by Indigenous people, especially women, and be made a part of the land and the community. I must actively resist colonialism. Once I am accepted, I can become a proper guest. I accomplish this by

accepting my responsibility towards Indigenous people, becoming more aware of their history and sharing what I know to non-Indigenous people, and becoming part of decolonization movements.

It is my responsibility to create education for non-Indigenous women, especially white women, about the negative colonial experiences Indigenous women and girls went through and continue to go through at the hands of the Canadian federal government. It is my responsibility to educate non-Indigenous people about the history of race- and gender-based discrimination and violence against Indigenous women in Indian hospitals because of laws such as the Indian Act. My responsibility as a guest is clear. I must educate to more white women about the gender- and race-based violence acting as barriers for Indigenous women to live more autonomous lives. Through this education, more guests will come together to disrupt colonial policies and structures that eradicate, marginalize, and oppress Indigenous women in Canada.

In *How We Come to Know*, Kathleen Absolon writes that “Research is guided by what we know and what is found within” (18). She stresses that researchers need to be self-reflexive when conducting Indigenous research; they must explain where they come from, who they are, and what their intentions are. Being a white woman, I can use my power and privilege to support Indigenous people (Koleszar-Green 169), which requires me to be more self-reflexive, to locate myself within the research, and to introduce myself “geographically, politically and genealogically” (Baskin 27). By identifying myself as a white researcher, I am acknowledging that I am willing to admit the evils of colonialism and use my power and privilege to work towards change. White researchers do not operate within a position of trust within Indigenous communities but rather within spaces of privilege; they, therefore, need to ensure that Indigenous women understand why white women are conducting their research. Personally, my desire to be a responsible guest stems from my desire to end the colonial gender- and race-based violence committed against Indigenous women daily in Canada. As a white researcher, guest, and ally, I feel strongly that Indigenous women were robbed of their lands, lives, and identities. I want Indigenous women to get back what was stolen from them and be recognized as the true people of this territory. I will eliminate power imbalances between myself and Indigenous women by removing “frustration, disappointment and sadness and exercise[ing] empathy, understanding and motivation for change as points of entry into a community” (Absolon 18). I want to end the historical and ongoing trend of gender- and race-based violence against Indigenous women in Canada.

## Conclusion

Unequal power relations were at the core of Indian hospitals. The federal government never supported the Indigenous populations of Canada. They did not listen to their needs; they ignored the treaties put in place securing the healthcare rights of the Indigenous people. Instead, the federal government wanted to eradicate the Indigenous community and make Canada a white country. Indigenous mothers and children suffered in Indian hospitals and require psychological assistance for the trauma that was inflicted upon them. Telling their stories via ethnographies, such as the ones discussed in this article, is a method of decolonization because they are stories of resistance, truth, and survival; they create and support decolonial movements. The research I conducted about Indian hospitals was extremely difficult for me to process and contextualize because I was horrified at the acts of violence that were committed against Indigenous people. I was outraged at the fact that the Canadian federal government justified these acts because of gender- and race-based discriminations. This article has been an academic and personal journey for me to produce because I want this piece to educate non-Indigenous women, especially white women, about the historical and ongoing impact of colonialism. It warrants repeating that even though I am not a mother, I recognize the significance of motherhood and being mothered in Indigenous communities. I, therefore, wrote this article to add to the literature on colonialism, decolonialism, Indigenous feminism, and motherhood and mothering as well as an act of resistance and a call for change.

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## Maternal Mental Health and Mindfulness

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*Mental health problems result in disease and disability (Afifi 385). When looking at the data across cultures, women are more likely to report mental health symptoms, access available supports, and receive treatment for mental health disorders (Lesesne and Kennedy 755). Research on maternal health has suggested that “the burden of mental health disorders peak in the child bearing and midlife periods” (Lesesne and Kennedy 756). Biology is often implicated in this presumed psychological vulnerability, given that throughout a woman’s life, she experiences pronounced hormone-driven cycles, including menstruation, pregnancy, a postpartum period, and menopause. However, even after exhaustive studies exploring a number of sex-related variables, there is a lack of consensus regarding the significance hormones have in influencing women’s mental health challenges (Hendrick et al. 93; Schiller et al. 49). Some scholars contend that the focus on biology and hormones are an easy way to discount the negative experiences that disproportionately affect girls and women. Discrimination, poverty, sexism, abuse, exploitation, and caregiving burdens work to undermine women’s mental health. Women’s mental health should, therefore, be understood by evaluating all aspects of women’s lived experiences—physical, sociocultural, economic, and interpersonal. Informed by the diathesis-stress model, this article reconsiders the social, political, and economic stress that adversely affects women’s wellbeing. Specifically, this article posits that Buddhist-derived interventions, such as mindfulness, can fortify and empower women. Evidence from neurobiology provides a meaningful framework supporting this approach to health and wellness.*

Mental health challenges often result in disease and disability throughout the world (Afifi 385). When looking at the data across cultures, women are more likely to report mental health symptoms, access available supports, and receive treatment for mental health disorders (Lesesne and Kennedy 755). Women in developed countries are more often diagnosed with a variety of emotional disorders, including mood instability, anxiety conditions, eating disorders,

and personality disorders. Research on maternal health in the United States has suggested that “the burden of mental health disorders peak in the child bearing and midlife periods” (Lesesne and Kennedy 756). Indeed, during pregnancy up to 25 per cent of women in the West may meet criteria for a mental health disorder (Swanson et al. 553); however, fewer are ultimately identified as such (Vesga-Lopez et al. 805). A recent review of the perinatal depression literature concluded that this form of depression is highly prevalent in the prenatal and postnatal period, yet it is often undiagnosed and untreated. The status of mental health exists in a socioeconomic context in which gender differences predispose females to a plethora of challenges, including economic and educational hardships (Knack 81). A number of feminist scholars have posited that “everyday aspects of contemporary culture have become potentially pathogenic for women and should be examined as ongoing sources of traumatic stress” (Berg 970). Of note, women’s rate of reported PTSD is twice that of comparable males (Berg 972). Women’s mental health should, therefore, be understood by evaluating all aspects of women’s lived experience: physical, sociocultural, economic, and interpersonal. This article explores the prevailing reasons cited for the increased mental health challenges facing women in the West, highlights conventional medicine’s inherent patriarchal bias, and, finally, considers the benefits of feminist trauma treatment, including mindfulness, in promoting the health and wellbeing of mothers.

## **Women and Mental Health**

A number of theories have been put forth to explain women’s higher rate of mental health challenges. Biology is often implicated as a main factor in this presumed psychological vulnerability, given that throughout a woman’s life, she experiences pronounced hormone-driven cycles, including menstruation, pregnancy, a postpartum period, and menopause. However, even after exhaustive studies exploring a number of sex-related variables, there is a lack of consensus regarding the significance hormones have in influencing women’s mental health challenges (Hendrick et al. 93; Schiller et al. 49). Some scholars contend that the focus on biology and hormones are an easy way to discount the negative experiences that disproportionately affect girls and women. Discrimination, poverty, sexism, ableism, abuse, exploitation, and caregiving burdens work to undermine women’s mental health (Satyanarayana, Chandra, and Vaddiparti 350). Research suggests that these hardships are central to women’s mental health struggles both immediately and in the long term as well (Rudenstine et al. 124).

Rather than a singular focus on biology as the determinant of mental and emotional vulnerability, the interplay of both genetics and the environment provides a more accurate and comprehensive picture. The diathesis stress



model is a theoretical framework which postulates that each person carries a differential genetic predisposition to a host of mental and physical health conditions (Colorado-Conde et al. 1591). However, whether the disorder is expressed is partially contingent upon the individual's life events. The ultimate stress that is experienced will either push the person towards manifesting the disorder or serve to safeguard and buffer the person, thus reducing the risk of disease expression (Monroe and Simons 407). Based upon this model, the power of negative environmental variables and their detrimental influence represent risk factors for a number of psychiatric disorders. Therefore, women's disproportionate experiences of hardship and trauma are seen as potent risk factors for mental health challenges. These risks increase when children—more often girls—are exposed to adverse events early in life, including physical abuse, sexual violation, and lack of schooling (Stewart et al. 14)

Stress is an inevitable and a predictable part of the life experience and is known to affect children's developing brain (Franke 391). Positive stress includes challenges that are appropriate for the child's cognitive and emotional level of function (Franke 391), which may include common interpersonal and school-based challenges. Tolerable stress is more intense and beyond what is considered normative, such as the death of a family member or exposure to natural disasters. The effects are more significantly felt and for a longer period of time (Franke 391). However, even these more powerful stressors can be successfully negotiated with the support of a caring and responsive family system. In contrast, toxic stress includes recurrent traumas, such as physical abuse, sexual abuse, and neglect, which are especially aversive and psychologically damaging. They are considered neurobiologically harmful to the developing child, given the negative influence on the neuroendocrine-immune network (Franke 392). This type of stress can harm the child's developing brain and result in negative emotional and physical outcomes (Freeman 546). Oftentimes, toxic stress occurs in more challenging family systems, in which there are typically lower levels of adult nurturance and support. These early life circumstances exponentially increase the potential for a lifetime of maladaptive health outcomes (Freeman 546).

All children are at risk for exposure to adverse events, but the specifics of these occurrences have been shown to differ based upon gender. Although both male and female children are victims of sexual abuse, this violation is much more common in females and, on average, occurs at a younger age (National Sexual Violence); indeed, one in four girls in the United States will be sexually abused before the age of eighteen (National Sexual Violence). Research also suggests that girls are at greater risk of being sexually abused by a family member, whereas boys' victimization more often occurs outside of the home (Maikovitch-Fong and Jaffee 431). The specifics of the traumatic event may also exert a differential effect on the abused child in both the short and

long term. Generally, it has been theorized that childhood victimization poses a significant risk for later depression, anxiety, and substance abuse (Rudenstine et al. 124). However, the abuse has the potential to be more devastating when children experience what traumatologists refer to as “complex trauma” (Godbout et al. 91). This type of trauma often occurs within what should be a secure space, such as a child’s home, by a person who is presumed to be safe, such as a family member—father, uncle, grandfather, or brother. The experience of repeated sexual abuse is universally regarded as an overwhelming and damaging traumatic event with the potential for long-standing emotional and interpersonal impairment. This abuse is consistent with the experience of interpersonal violence, which is the intentional use of aggression—both physical and sexual—by family members, partners, friends, or acquaintances. Notably, over 30 per cent of women in the United States report to being a victim of interpersonal violence (Kelly and Garland 312). Although a significant number of these women suffer this abuse prior to the age of twenty-five, epidemiological data indicate that a subset of these women experience revictimization throughout their lifetime, which results in a wide-ranging symptom profile (Kelly and Garland 312).

Childhood maltreatment potentially denies women the opportunity to establish a healthy relational template and increases the likelihood of emotional dysregulation, which is associated with the development of mental health disorders (Dvir et al. 152). Emotional dysregulation refers to the inability of a person to control or regulate their responses to material or experiences they deem to be emotionally provocative (Rudenstine et al. 125). At times, however, this emotional difficulty is outside of the current situation and is instead due to the distortion or overresponse to elements in the environment. Oftentimes, the person with emotional dysregulation reacts in an exaggerated manner to minor frustrations and interpersonal challenges; thus, the person is quick to anger, cries easily, is accusatory, demonstrates passive-aggressive behaviour, and creates chaos and conflict in environments in which they live and work. Despite current research that suggests that the majority of mental health disturbances in adults have their origins in childhood and adolescence, in clinical settings, women’s historical victimization is often not considered in attempts to understand this behaviour as well as other challenging psychological conditions (Brown 464).

### **Conventional Medicine and Patriarchy**

For the ancient Egyptians, and later the Greeks and Romans, women’s bodies, specifically the uteri, were blamed for strong emotional responsivity. The uterus was believed to have the ability to roam or migrate throughout the female’s body, causing anxiety, depression, and irritability. Therefore, medical

intervention was geared at coaxing or facilitating the uterus to return to its rightful place within the body in order to quell women's distress (Tasca 111). Noted authorities, such as Sigmund Freud, claimed that the emotional reactivity was not medical but psychological in nature. Females suffered from what Freud called "hysteria" due to the absence of a penis—a condition later termed "penis envy." This malcontent was believed to be remedied through marriage, which included frequent copulation and the birth of a child—preferably a male (Tasca 118). Hysteria continued as a mental health diagnosis found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders until 1980.

Although these practices may be understood as a misguided artifact of the past based upon misogynistic pseudoscience, there continues to be a perception that female medical complaints have a basis in emotional exaggeration or hysteria (Werner et al. 1036). Examples of this misattribution include the autoimmune disorder of multiple sclerosis (MS). Even though it afflicts many more women, up until the 1920s and the advent of the MRI, which provided clear evidence of the disease, more men were diagnosed with the disorder (Lines). Sadly, women presenting with MS symptoms were often regarded as suffering not from a real physical illness but from a psychological disorder. Although the diagnosis of hysteria was removed from the Diagnostic and Statistical Manual as a psychological disorder, the misbelief about female hyperemotionality continues. When confronted with unexplained medical complaints, women are significantly more likely to receive a diagnosis of conversion or somatoform disorder, which is modern-day nomenclature for hysteria (Cherry). Even today, women who present with vague symptomology are often left untreated and are misdiagnosed for longer periods of time before an accurate diagnosis is made. The unfortunate history of misogynistic medical theory allows for the ignoring of female suffering and instead promotes a culture of victim blaming. From a modern perspective, this thinking appears misguided and puerile; however, its application damages, demeans, and victimizes women—all in the name of medical science.

### **Feminist Treatment**

Given the gender bias prevalent in medical and psychological diagnoses and treatments, the remedy must be systemic, ongoing, and capacious. Nevertheless, we cannot wait until these overarching changes are made to address the suffering of women. Hence, we argue that one way to support women is for health practitioners to adopt a feminist treatment approach, which offers a corrective to traditional subjugating practices that dismiss female voices and experiences. Specifically, a feminist approach to healthcare is multifaceted, as it addresses a wide range of women's needs. Instead of rendering the gender

bias invisible, a feminist therapeutic approach centralizes the injury to the female psyche and respects all sites of injury (Brown 465). In so doing, women's experiences are validated through the use of an egalitarian framework. This philosophy is not prescriptive but meets the needs of individual clients. According to a relational-feminist model, empathic attunement and responding are essential components in the therapeutic relationship, which allows for healing and growth (Freedberg 253).

A central tenant of feminist therapy is the empowerment of women (Brown 465). In feminist therapy, a meaningful intervention could include a psychoeducational component, so a survivor of sexual assault, for example, would have a better understanding of the ruminative propensity and resultant body reactivity after the assault. Specifically, in a feminist trauma model, the survivor of the violence would be the focus of therapeutic attention and would receive individual or group-based support. Nonetheless, the systemic variables of patriarchy, sexism, and aggression would clearly be identified as cultural forces that damage women and society at large. This integrative model would include a priority on the raising and development of a feminist consciousness. This ideology would serve to connect the personal experience to the awareness of the overall system of inequity and fortify the woman's right to resist it. One way in which healthy and empowered resistance can be realized is by recognizing the toxicity of patriarchal institutions that have circumscribed women's lives and, in so doing, create independent ways of valuing the self.

### **Feminism and Mindfulness**

A particularly effective way to foster female empowerment is through the development of a mindfulness practice. Mindfulness serves as an antidote to the damaging effects of hegemonic systems, given that it allows women to shift the terrain of power and harness their own strength (Davis and Hayes 200). This is not to suggest that mindfulness alone can counter the power of these structures, but it does maintain that women's collective empowerment, gained through the practice of mindfulness, can shift the balance of power in their own lives. Consistent with feminist trauma treatment, the adoption of Buddhist-inspired practices, such as mindfulness, has gained currency in the treatment of many mental health disorders in the West. Mental health professionals, influenced by this treatment philosophy, are charged with translating and adopting these lessons and practices to promote wellness.

Regarded as a religion, philosophy, and psychology, Buddhism is appreciated as a powerful instrument for healing (Lee et al. 113). Some even regard the Buddha as a psychotherapist of sorts, having provided therapy to millions of adherents throughout the centuries. The introduction of Buddhism to modern Western psychology began in 1900 by Rhys Davids, who translated Buddhist

texts into English. Subsequent exposure occurred with renowned Buddhist teachers and mental health clinicians and scholars, including Jung, Fromm, and Kornfield (Aich 167). Later, Chogyam Trungpa was recognized for drawing the connection between the teaching of Buddhism and Western psychology. More recently, in the 1990s, Kabat-Zinn popularized select Eastern practices for their relevance to mental healthcare in the Western world (Lee 218). Since that time, there has been a significant increase of Buddhist thought and practice in mainstream mental health treatment (Lee et al. 114).

Due to increased research funding, meditation and mindfulness have become integral treatment in fostering emotional wellness. These and other Buddhist-derived interventions (BDIs) have received considerable clinical attention. BDIs have been shown to be beneficial in clinical studies for the treatment of depression, anxiety, bipolar disorder, sleep disorder, and substance-use disorders (Nagy and Baer 353). The basis of BDIs is to teach clients effective management of difficult thoughts, perceptions, and experiences. When used therapeutically, mindfulness interventions can increase a person's capacity to manage negative emotions and foster mental wellness (Davis and Hayes 198), which is especially relevant for women, as the healing occurs within her control and outside systems that may patronize or misconstrue her symptoms and concerns.

Both mindfulness as a Buddhist practice and feminist philosophy are similar in that they share a commitment to the transformation of society by increasing social justice and decreasing "senseless suffering" (Keefe 62). The practice of mindfulness may be used independently or incorporated with other treatments to serve as a therapeutic intervention to enhance women's coping repertoire and fortify their resilience. Mindfulness practice is sometimes paired with cognitive behavioral therapy (CBT), but each is unique in terms of process and treatment. The practice of mindfulness focuses on teaching participants to carefully attend to their own moment-to-moment experiences, bringing into awareness their emotional reactivity, which may precipitate ineffective or maladaptive responding (Bauer 327). It is theorized that through awareness of the circumstance and the emotional response that follows, the most effective and self-preserving behavior may be chosen. CBT intervention also focuses on becoming aware of the circumstance. However, this treatment uses the material gained from this stage of awareness to evaluate the accuracy of what is perceived and refute dysfunctional or negative thoughts and self-statements. It is through this therapeutic process that thinking about the circumstance and perceptions of the self are transformed. By contrast, in mindfulness, there is no attempt to change or refute the experience but to recognize it and respond as deemed appropriate.

## The Neurobiology of Mindfulness

The effectiveness of BDIs has been explained through the framework of neurobiology. Specifically, the way in which the brain responds to emotionally provocative stimuli is important in understanding the therapeutic value of BDIs. Stated simply, the awareness of life events—stimuli in the environment—sends information for processing to two distinct regions of the brain: to the hippocampus for a quick appraisal and to the prefrontal cortex for a more thorough assessment (Hanson and Mendius 34; Tabibnia and Radecki 61). Brain-based research suggests that the “automatic processes of the brain tend to be fast, spontaneous, and largely sensory, [whereas] controlled processes tend to be slow, effortful, often language-based, and intentional in nature, such as problem-solving and self-control” (Tabibnia and Radecki 60). Thus, information that is perceived to be potentially threatening elicits an emotionally charged response summoned by the amygdala—that is, the emotional brain speaks first (van Marle, et al. 649; Phelps and LeDoux 179). After further consideration, however, a more dispassionate, logical brain center is activated to analyze the situation, connect relevant material, and direct future action (Hatchard et al. 43). Ultimate resilience and functionality rest on the interaction between these two systems: the limbic or immediately responding emotional brain and the prefrontal cortex that offers the final and most reasoned assessment of the information (Hanson and Mendius; Tabibnia and Radecki 60).

The logical brain center can provide a disinhibiting function; it can reduce emotionality and impulsivity and support greater emotional regulation. Nevertheless, the more primitive, emotional brain is necessary, as well as adaptive, when faced with novel, stressful, and emotionally provocative stimuli (Tabibnia and Radecki 63). Painful memories are uniquely powerful: they are emotionally laden, explicit, and devoid of associated content. When distressing remembrances are triggered by stimuli or brought to the fore through memories, emotional distress is reignited and perpetually reexperienced (LaBar and Cabeza 54; Tambini, et al 276.).

Given this neurobiological reality, many people strive for equilibrium by avoiding or ignoring the difficult material presented by life events. As a result, distraction from the self and related material can come to be regarded as a useful and necessary mode of living. This distancing from the self is a limiting and perilous option. With this mental disconnect, a person’s thoughts and actions become driven by a reactive process, which is the desperate attempt to repress, overlook, or squelch uncomfortable thoughts and experiences. Some researchers have proposed that specific forms of psychopathology may be associated with this unhealthy reactive process (McCormack and Thomson 157). One’s neurobiological system may become impaired by the experience of adverse early life events. Given that women disproportionately endure

traumatic experiences, for some, there is the potential for resultant emotional dysregulation. This presentation may result in the diagnosis of more severe and challenging conditions with limited attention paid to the historical antecedents.

Eastern philosophy holds that emotional suffering may be the result of two separate but uniquely related conditions. The first, as previously referenced, is the unwillingness to face difficult material in life, and hence ignoring and avoiding it at all cost: “Pain comes and goes in life. But that is not suffering. Suffering is the product of pain and our resistance to it” (Bien 87). The second source of pain is, in essence, the opposite. Rumi postulated that “the cure for the pain is in the pain” (Rumai 205). Instead of running away, a person must see, feel, and experience the difficulties of life. Through such deliberate, nonreactive contemplation, the situation is faced, accepted, processed, and worked through (Hanson and Mendius 60). When mental equanimity exists and is accompanied by insight and awareness of the feeling tone, one is better able to understand relevant choices and take subsequent actions with intentionality (Young 54). Moreover, there is the potential to experience greater insight, wellbeing, and, ultimately, freedom from suffering (Nagy and Baer 353; National Institute of Health). Although this is certainly an aspiration goal, it is imperative to recognize the ongoing oppressive institutions and practices that exist both inside the domestic sphere and in medical and psychological institutions at large.

### **Mothers and Multitasking**

Although the practice of mindfulness—directing attention to the present experience—is believed to be essential for improving mental health, it is nonetheless a challenging skill to master. This is especially true given how media-rich the current culture is, with its infinite distractions encouraging disconnection from the here and now. Even within moments of quiet reflection, cultural conditioning may lead us to seek extraneous stimuli. It is within this media context that there is increased pressure on the work-home balance, given the ease by which communication flows from the workspace to home. For mothers, the demands of negotiating multiple life spaces and tasks represent a significant form of gender inequality. In dual income families, for example, mothers, when compared to fathers, spend on average ten additional hours weekly engaged in childcare and household activities (Offer and Schneider 828). Interestingly, in many cultures, there is a false assumption that multitasking, either serially or concurrently, is more easily performed by women. This gender stereotype flies in the face of research that has found there is no specific sex difference in multitasking proclivity and performance (Hirnstain et al. 292). Nonetheless, mothers are typically enduring more



responsibility for the care of their young in addition to other household activities (Offer and Schneider 823). This expectation for multitasking increases parenting stress and negatively affects the wellbeing of mothers.

Although some regard multitasking as a sign of cognitive strength, it is a misguided presumption. People—regardless of gender—can only effectively process and manage one task at a time. In her study, Suzanne Powell finds that multitasking was associated with a 40 per cent reduction in the participants' productivity, intellectual capability, and even the volume of grey matter in the brain (61). Importantly, a consistent mindfulness practice may help ameliorate some of the more damaging effects of a highly distractive environment.<sup>2</sup> Britta Holzel et al. show that mindfulness may increase gray matter in the brain and improve functions involved with learning and memory, modulation of emotional control, and the process of awareness (41). Additionally, it is hypothesized that mindfulness facilitates the connectivity and synergy of the brain, mind, and body, which benefits both mental and physical health (Carlson et al. 479; Creswell et al. 187). For example, several studies have found these practices influence aspects of psychological wellbeing by improving mood, increasing positive emotions, and decreasing anxiety (Spijkerman, Pots, and Bohlmeijer 111; Vollestad, Morton, and Nielsen 242). Recent studies suggest that mindfulness may positively influence heart and brain health and immune system functioning (Carlson et al. 479; Creswell et al. 187).

Mindfulness is a practice of conscious living in an effort “to raise awareness of the self in the present moment” (Lee et al. 123). Mindfulness practice, in fact, is increasingly integrated into mental health treatment due to research that has shown it to be effective. For example, mindfulness-based stress reduction is now a standard approach for helping clients manage life's demands. Mindfulness-based cognitive therapy and other approaches target specific treatment areas, such as depression, anxiety, substance abuse, eating challenges, and self-harming behaviours, all of which are seen more frequently in women. As previously mentioned, the fact that women experience these mental health challenges at a higher rate is likely due to gender-based violence and oppression.

In its purest form, mindfulness involves a nonjudgmental appraisal of events in the here and now, with the goal of increasing an accepting attitude towards these experiences and the capacity and willingness to stay in contact with them, even when they are aversive (Farb et al. 71). As a result, it becomes possible to reduce overidentification with avoidance through greater acceptance of the situation as it is, without judging it according to one's expectations (Bergomi et al. 22). Through this increased clarity, there is the potential for healthy and life-enhancing decisions. Mindfulness practice, in fact, is increasingly integrated into mental health treatment due to its focus on self-efficacy, healing, and resilience. As described by Laura Brown, women's

individual experiences of trauma are representative of larger, systemic and institutional forms of oppression (468). It is within this context that mental health treatment for women should comprehensively support consciousness-raising efforts to engender insight and promote the assertion of individual power and control. Within this paradigm of feminist awakening and empowerment, the practice of mindfulness may be especially useful to women during pregnancy and as mothers. Mindfulness interventions during pregnancy have been shown to decrease levels of depression and anxiety and to improve women's capacity to manage stress (Snyder et al. 714).

## Conclusion

The maltreatment and traumatic experiences of girls and women in sexist and oppressive institutions may result in emotional suffering and the manifestation of mental health challenges. Instead of medical and physical health professionals appreciating the oppressive dynamics of women's lived experiences as contributing factors to their psychopathology, diagnosis is often rendered absent the context of this systemic and institutionalized victimization.

The effects of oppressive medical, psychological, sociocultural, and economic institutions must be recognized and ameliorated; nonetheless, it is also imperative to focus on daily support to women. This is where healthy interventions, such as mindfulness, may have efficacy. Mindfulness—a strategy for empowerment that alleviates suffering in part by reducing ruminative thinking and advancing coping mechanisms—allows for women to wrest some measure of control from these patriarchal macro institutions, which can increase their physical and emotional health and wellbeing.

## Endnotes

1. As with all treatment plans, the licensed mental health practitioner would evaluate the client and ascertain the appropriate treatment intervention.
2. This is not an easy task, however, as mothers receive a lot messages about self-care and managing their own mental health while the gender imbalance in caregiving and multi-tasking continues, which mitigates against prioritizing such practice of self-care (Yavorsky 674).

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## Does the Place Where We Are Born Matter?

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*Until the middle of the twentieth century, most births in rural Ireland took place in the home. From then on, childbirth increasingly took place in hospital settings. Not only did this physical relocation of birth from home to hospital affect women's lived experiences of childbirth and traditional midwifery practices, but both were also inextricably bound up with the complex relationship to women's bodies and place within the evolving postcolonial Irish state.*

*This article is an historical overview of the uprooting of birth from home to hospital in Ireland. It documents the main policy changes that led to the current obstetric-led, institutionally based maternity system. It highlights how this postcolonial state effectively erased traditional midwifery practices and eventually removed midwifery services from local communities. The subsequent centralization of maternity services led to a huge reduction in maternity units from 108 in 1973 to nineteen today; consequently, there is a very limited obstetrically driven maternity service, which is almost entirely hospital based.*

*This research is part of my PhD, which is an interdisciplinary art practice-as-research project that uses methodologies employed by feminist ecocritical thinkers, new materialists, cultural geographers, and socially engaged art practitioners; it incorporates oral testimonies, archival material, film, drawings, paintings, and found objects. This complex layered reading of the interrelationships between place, birth, and memory will contribute to a shared knowledge, placing it at the intersection of international research in medical humanities and collaborative, participatory socially engaged arts practices.*

“Imagining human corporeality as trans-corporeality, in which the human is always intermeshed with the more-than-human world, underlines the extent to which the substance of the human is ultimately inseparable from ‘the environment.’” —Stacy Alaimo 2

## Introduction

Tracing the historical trajectory of birth in Ireland from local communities to institutional settings has largely drawn on social and historical contextual readings (Delay; Clear; Gelis, Kennedy; Devane et al.; Murphy-Lawless; O’Boyle). However, what of the spectral traces embedded within the places associated with childbirth? A different understanding of birth practices emerges from a rereading of the history of the place where birth happens; thus, it is possible to reemphasize the importance of community and environment in connection with the birthing body.

The politics of birth space in Ireland that led to the shift from home to hospital birth is immersed in a long colonial and postcolonial history of place and women’s bodies (Cronin; Howe; Lloyd). The current maternity system is inextricably bound up with legacies associated with church, state, and medical interpretations of the birthing body, which are reflected in the current policies and places where birth takes place (Earner-Byrne; Kennedy; O’Connor; Murphy-Lawless).

In mapping places of birth in Ireland, and County Clare in particular, I explore how the entanglements of place, birth, and memory have changed over time and consider how the lived experience of being born and of giving birth has been affected by the transition from home to hospital birth, focusing on those living in rural Ireland (Biggs; Rose; Hawkins and Straughan; Lacy; Reckitt). My work documents this move and charts the shifting perceptions and experiences of place during labour and childbirth.

The main reason for concentrating my research on County Clare is because there are no maternity services in this area. The last maternity unit there closed in 1987, since that time, women have had to travel to either Limerick or Galway for all appointments during their pregnancy and when in labour. This can mean journeys of up to two hours each way, which is one of the changes resulting from a series of health policy changes. Intergenerational oral testimonies, primarily with women who have given birth while living in County Clare from the 1950s onwards form the crucial primary source material and inform this research as it progresses.

## Theoretical Framework for This Research

Feminist theorists in conjunction with new materialist thinkers allows for a reimagining of the historical legacy of midwifery and maternity services in Ireland—one that offers a different understanding of the relationship between the current obstetric-led, institutionally based maternity services (Alaimo; Bennett; Barad, Braidotti; Coole and Samantha; Dolphijn). The work of new materialist theorists, such as Stacy Alaimo and her theory of transcorporeality,

situates the event of childbirth within a complex exchange between the body, place, and matter. In the opening quote, Alaimo suggests that “‘the environment’ is not located somewhere out there, but is always the very substance of ourselves” (5). The entanglement of the birthing body with the place where birth takes place aligns with Alaimo’s theorisation of transcorporeality.

Sociologist Barbara Katz Rothman looks at the birthplace from a different perspective. She points out that “the location of birth is one of the hotly contested issues of contemporary motherhood” and that “birth means very different things in different locations; it is not simply the same event in a different space. A politics of space underlies ideology and practice” (87). Yet another way of interpreting place in relation to birth can be found in the influential text *The Poetics of Space*, by French philosopher Gaston Bachelard, which asserts that “the house we were born in is physically inscribed in us. It is a group of organic habits” (36). For Bachelard, the materiality of place is imprinted on us emotionally, psychically, as well as bodily. If this is so, then how has the change from home to hospital birth affected both our relationship with place and the lived experience of giving birth?

Another perspective on the significance of birthplace in Ireland has been expressed by curator Mary Grehan. In 1994, The National Maternity Hospital in Dublin hosted a centenary art exhibition curated by Grehan. Reflecting on this experience Grehan acknowledges that “we are born into places” and that this “can determine a number of socio-economic and cultural factors in our lives” (51).

Each of the theorists and thinkers referred to above bring a different perspective to the intersection of place with birth. In the context of the evolution of the maternity services in Ireland, the entanglement between place and birth is complex.

### **A Historical Overview of the Hospital Development Program in Ireland**

In 1971, Erskine Childers, the minister of health, noted that “We have the highest proportion of hospital beds to population in Western Europe” (Daly 2). When the minister made this comment, hospital development in Ireland was at a critical juncture. The evolution of the hospital system, and specifically maternity services in Ireland, contributed to the formation of the current obstetric-led system dominating maternity services. The role of hospitals is bound up with the history of the evolving postcolonial Irish state during the twentieth century. Architectural historian Gary Boyd and architect John McLaughlin consider the significance that modernism played during the infrastructural growth in Ireland during the twentieth century:

The absorption of modernity in twentieth-century Ireland was characterised and experienced not by heavy industrial development, the mass production of housing and the emergence of a fully-fledged Welfare State—as for example in Britain—but rather a dispersed and decentralised modernism that was effected at different but no less pervasive scales and intensities ... the sites of architecture here were as much invisible systems as physical places in Ireland. (5)

For Boyd and McLaughlin, Ireland's decentralized architectural growth generated both visible and invisible networks and systems, including maternity hospitals and units around the country.

The expansion of the hospital system from the 1930s onwards contributed to a normalization of hospitalization for many illnesses. Historian Mary Daly notes that this period saw the development of “a hospital system, not a health system” (1). In the early 1970s, the average time spent in the National Maternity Hospital was 8.9 days, and in Waterford Maternity Hospital, it was 12.9 days (Daly 3). It became the norm for a woman to spend approximately ten days in hospital after giving birth—an experience many relished, as it gave them time away from family duties (Clear).

### **Health Policies affecting the Irish Maternity Services, 1950s to 1970s**

Sociologist Patricia Kennedy highlights that in 1955, just over 33 per cent of all births in Ireland took place in the home. By 1970, home births made up 2.92 per cent of all births (11). In 2016, less than 1 per cent of births took place in the home (Meaney et al. 11).

There were several key policy changes that took place in Ireland between 1950 and 1970 that affected a woman's choice of where she could birth. Dr. Noel Browne was the minister for health in Ireland from 1948 to 1951. His name is synonymous with the Mother and Child Scheme (1950), in which he proposes that mothers and children up to the age of sixteen should have free medical care: “As a doctor, I believed that a free health service was an essential pre-requisite to an effective and a just health service” (159). This scheme was condemned by both the Church and the medical professionals. The former feared that it would lead to education surrounding childbirth and possibly abortion and contraceptive services being established in the country that was contrary to their social teaching policy (Fahey). The latter feared that it would lead to state control of the medical profession—a form of socialized medicine that would potentially affect their income and, more importantly, make them answerable to the state.

Browne's motivation for promoting the Mother and Child Scheme went hand in glove with his vision of creating more hospital services for the people of Ireland. Having worked in the National Health Services system in England,

he felt that Ireland deserved its own healthcare system, one capable of providing healthcare for a population beleaguered with poverty. As part of the national hospital building program, women were encouraged to give birth in hospital settings. There was a growing belief that hospital was the best and safest place to give birth, and given the levels of poverty in the country in the early 1950s, there is a strong case to be made for this assertion. For example, the infant mortality rates in Dublin were very high, whereas counties, such as Roscommon, had much lower infant mortality rates (Breathnach and Gurrin).

The Catholic hierarchy's vehement disapproval of the Mother and Child Scheme reveals three key points. First, families should pay for their healthcare; second, the social teaching provided by the Catholic Church on sex education was to be the source of knowledge women and their families were given, and, third, they did not want doctors from other faiths or nonfaiths attending women during pregnancy. The informal Church-state alliance was powerful and pervasive (Powell). Browne concluded that "the Church thrived on mass illiteracy and that the welfare and care in the bodily sense of the bulk of our people was a secondary consideration to the need to maintain the religious orders in the health service" (141).

The growth in the number of hospitals around the country as part of the development of the health service in Ireland during the 1950s normalized hospital births. From the late 1960s onwards, the centralization of maternity services led to the reduction of the number of maternity units from 108 in 1973 to nineteen in 2019 (O'Connor, "Maternity Closures"; "Maternity Care"). Centralization was proposed in two reports: the 1968 Fitzgerald Report and the 1976 Discussion Document (Development of Hospital Maternity Services). Both recommended that all women should give birth in obstetric-staffed units, a system that continues to this day (O'Connor, "Maternity Closures"; Murphy-Lawless).

The 1970 Health Act led to the creation of Comhairle na n-Ospidéal (the Hospital's Council), which oversaw the implementation of the 1968 Fitzgerald Report and the 1976 Discussion Document (Development of Hospital Maternity Services), as well as to policies that led to the closure of smaller maternity units around the country (Murphy-Lawless).

A further crucial policy ensuring that women give birth in the hospital setting was the introduction, and continued use, of the Active Management of Labour (AML), which was initiated in the early 1960s at the National Maternity Hospital, Dublin (O'Driscoll et al.; Murphy-Lawless). Its main objective is to manage the length of a woman's labour and to supervise it if prolonged. The definition of prolonged labour has dropped from thirty-six hours in 1963 to twelve hours in 1972 ("May I Break Your Waters?"). This drop highlights the focus and privileging of time over place, which is at the core of the AML system.

Exponents of this system believe that birth can be controlled by regulating the length of time that a woman is in labour through the use of medication and interventions. However, this form of control lies in the hands largely of obstetricians and not the birthing woman. AML controls the duration of labour, and when this is combined with other policy changes—such as the fact that each maternity hospital has to have minimum production levels of two thousand births a year, based on a bed occupancy of “three women per labour ward bed per 24 hours” (O’Connor, “Maternity Closures”)—one can begin to see how policies that focus on time have come to dominate the system.

These policies persist within the maternity services today in Ireland. Homebirth midwife and activist, Philomena Canning, spoke at The Convention on the Elimination of all Forms of Discrimination against Women, (CEDAW), the United Nations’ Women’s Committee, in Geneva in February 2017. In 2019, writing Philomena Canning’s obituary, Marie O’Connor said at the event, Canning argued the following:

“Active management” is premised on the denial of women’s human rights, viz., self-determination, bodily integrity and personal autonomy. In its quasi-judicial concluding observations, CEDAW expressed concern at Ireland’s reported policy ‘of having three births per 24 hours for every bed in maternity wards’, and called on the State to respect the natural birth process. (“Obituary of Philomena Canning”)

## **Uprooting Birth**

Behind these data lies multilayered social, political, and cultural readings of women’s birthing bodies by the state, church, and medical professionals. The current maternity system in Ireland is the living embodiment of these changes, and women have had to adjust their experience and expectations accordingly.

One key element that has been part of these adjustments is the relationship with place. The rupture from home-place to hospital-space birthing experiences necessitates uprooting women during labour. The result of these changes means that women have little choice about where they can give birth. One of the consequences of the changes to this obstetrically driven maternity model and the huge reduction in maternity units is that women are expected to travel greater distances during pregnancy and labour than in the past. Currently, when a woman is in labour, she has the additional consideration of not just leaving her home but also of leaving her locality to give birth.

One further crucial change that directly affects where a woman can give birth came with the changing role of the midwife. The regulation of midwifery in Ireland has effectively removed midwives from local communities and

embedded them within institutional obstetric-led maternity services. Therefore, not only did the physical relocation of birth from home to hospital affect women's experiences of childbirth, it also directly affected traditional midwifery practices. Both were inextricably bound up with the complex relationship to women's bodies and place within the evolving Irish state.

Historian Ciara Breathnach acknowledges that the role of the traditional midwife had survived well into the twentieth century, particularly in rural areas, as "handywomen were deeply embedded in rural communities and difficult to uproot" (34). In her book, *The Need for Roots*, philosopher Simone Weil asserts that "To be rooted is perhaps the most important and least recognized need of the human soul" (43). Conversely, the uprooting of midwives from local communities in Ireland ignores the need for the roots that Weil identifies.

The extent to which this uprooting has taken place is exemplified by recent conferences organized to celebrate the regulation of midwifery, and 2018 was the centenary of the Midwives Act in Ireland, which saw the establishment of the regulatory authority, the Central Midwives Board, that oversaw the regulation of midwifery practices (Barrington 79). The first of the conferences was held on 1 October, 2018, at the Rotunda Maternity Hospital, Dublin. The second was on 22 November, 2018, hosted by the Nursing and Midwifery Board of Ireland, and it took place in the Thomas Prior Hall, former mason orphan girls school and now a hotel.

I attended the above conferences, and Simon Harris, the minister of health, spoke at both, and on each occasion, he applauded the fact that the practice of "handy-women" was "outlawed" (3). The choice of the word "outlaw" to describe traditional midwifery practices by the minister for health suggests a lack of appreciation for the skills and tacit knowledge of traditional midwives, often called *Bean Ghlúine* (midwife) or *Bean Feasa* (wise woman) in the Irish language. It also suggests that he considers such traditional midwifery practices to have been dangerous (Breathnach).

However, it was the places/sites that were chosen to host the conferences that I would like to consider for a moment. Both places are historically linked with women's and children's bodies through memories and through their associations. As cultural geographer and ethnographer Karen Till points out, "Central to the ways that people create meaning about themselves and their pasts is how they expect places to work emotionally, socially, culturally, and politically" (Till, *The New Berlin* 11). In light of Till's work, how then does the Rotunda Hospital work emotionally, socially, culturally, and politically? The Rotunda Hospital was the first purpose-built teaching maternity hospital in the world (A. Browne; Curran; Harrison). From its inception in the mid-eighteenth century, this hospital set the tone for all subsequent maternity hospitals both in Ireland and abroad. Despite the breadth of political changes



that occurred in Ireland's history since the hospital was created, it has persistently used its institutional authority to cultivate an obstetrically driven maternity system. Harris stated that for him that "It is only fitting that—the Rotunda—as the first lying-in hospital in the world ... should still lead out on innovations to improve health and outcomes for mothers and babies (2).

Till's explorations of memory, place, and public space reveals a complex reading of the power dynamics at play in public spaces. The minister's speech belies the complex history of power that is rooted in the very fabric of the Rotunda Hospital building itself (Till, "Wounded Cities" 3-13). Urban policy analyst and psychiatrist Mandy Fullilove uses the term "root shock" to explore the emotional implications of being forced to move and the erasure of places to people's "emotional ecosystem" (qtd. in Till, "Wounded Cities" 7).

The role of midwifery within the current maternity system in Ireland has been uprooted from local communities and now largely takes place in institutional settings, which is similar to the experience of pregnant women. As I gather the birth stories from women of different ages and who live in different places in County Clare, themes are beginning to emerge. One of them is "root shock," as described by Fullilove. The displacement that women experience during labour and in childbirth often echoes the emphasis of time over place that pervades the current obstetrically dominated maternity system in Ireland.

Women are uprooted during pregnancy and birth, but we also need to uproot "space," as Doreen Massey puts it, and move it from where it is "embedded (statis; closure; representation) and ... settle it among another set of ideas (heterogeneity; relationality) ... where it releases a more challenging political landscape" (13).

The politics of being uprooted must also consider the distance that women are expected to travel to give birth. Geographically, Ireland is a small country (e.g. Canada is 140 times larger than Ireland, and the province of Ontario, Canada, is fifteen times larger than Ireland); therefore, it can appear reasonable to ask women to travel one or two hours while in labour. However, because of such policies as AML, the tension between time and distance is crucial when in labour. Many of the women I interviewed described the anxiety of trying to time their arrival at the hospital so that they could labour without intervention. They were fearful that if their labour did not progress at the recommended rate, determined by the hospital's AML policy, they would be induced. They, therefore, felt under pressure to time their arrival at the hospital, which added considerably to their anxiety during pregnancy. A detailed analysis of these experiences is central to this PhD research project, which will be published in due course.

## Conclusion

“Given that colonialism works not only by violence against the community whose land it occupies, but also by seeking to erase the traces of a native culture, the reassertion of the primacy of everyday values takes on a defiant cast.”

—Kiberd (3)

Tracing the history of the maternity services in postcolonial Ireland highlights a growing disregard of the significance of place during pregnancy, particularly at the time of birth. Between the 1930s and 1980s, Ireland effectively erased traditional midwifery practices and largely removed midwifery care from local communities; instead, an enforced dependence on an obstetrically driven maternity service developed.

The uprooting of the everyday event of childbirth from local communities raises many questions about Irish people’s relationship with place and also with authority. The authorial voice of the obstetrician dominates debates surrounding maternity services and reinforces the institutional control over women’s birthing bodies in Ireland. However, the tacit acceptance of this system by the vast majority of people highlights a complex relationship with the intersection of authority, birth, and place.

I contend that the erasure of traditional midwifery has contributed significantly to the rupture of the event of birth from birthplace in the Irish context. The disappearance of midwives whose tacit knowledge rooted them within the community is a great loss.

Yet midwifery has survived in other colonized countries, such as Australia and Canada (Olson and Couchie). When one considers the incredible work being undertaken to draw attention to the “birth evacuation policy” used to force Indigenous pregnant women in Canada to leave their home place to give birth in maternity hospitals often far from their homes, questions about the dominance of obstetric and medical models of maternity care are raised (Neufeld). Nevertheless, it is heartening to think that such midwifery and birth practices still exist among many communities and that work is being undertaken to find ways to support them.

In Ireland, a form of internalized colonization has been an important aspect of the development of the current relationship with childbirth. The valuing of the everyday event of childbirth has been hampered by policy changes that led to the erasure of traditional midwifery practices (O’Cruaíoch; Breathnach). The centralization of hospital births, which led to the drastic reduction of maternity units in the country, added a layer of anxiety for women and their families, who now have to travel longer distances to access maternity services; however, conversely, this has also reinforced a reliance on the hospital system.

It is time to reinstate the importance of place in birth and in maternity care. In her work, Till identifies the need for a “place-based ethics of care” (“Wounded Cities” 8). It is my firm hope that as this research grows and deepens, it will provide the opportunity to consider what a “place-based ethics of care” for birthing women in the West of Ireland could be. By focusing on the role that birthplace has played in the politics of birth in postcolonial Ireland, this historical overview contributes to a reimagining of the entanglements between place and birth. Working closely with feminist ecocritical thinkers and activists, this research seeks to reroot our interrelationships with childbirth and birthplace.

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## **Birth Pleasure: Meanings, Politics, and Praxis**

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*Little research has directly focused on the spectrum of pleasure experienced in birth, which until now has lacked a scholarly description or definition. In this article, I present the concept of birth pleasure and offer an introduction and preliminary definition synthesized from published experiential accounts, existing research and scholarship, and relevant lay literature. Through an intersectional and matricentric feminist lens, I offer implications of including birth pleasure in birth justice praxis.*

“What was that?” I recall thinking, still reeling in an unexpected tsunami. How to describe it? A life-swallowing sensation? A cellular-level magnetic reorientation? Something pulled all of my exhausted, trampled pieces back together in a warm wave of light and colour. I was made whole by this—a pleasure beyond comprehension. I felt immense gratitude and aliveness. This baby, this shimmering little lifeforce looking me in the eye, transformed me. When it came time to share about my birth experience, I was at once at a loss for words and conflicted to tell the truth of that moment, particularly with other mothers. As an intersectional feminist scholar, a public health professional, a woman, and a new mother, I grappled with naming and integrating this experience as well as its meanings and politics. This article is the result of this inquiry. I will present birth pleasure first as a paradox, a popularized taboo. I then offer clarifications of the key terms thus far used for birth pleasure, explore published experiential accounts, and review the modest research literature that has directly addressed pleasure as experienced in birth. From these components, I synthesize a definition of birth pleasure. To conclude, I offer some preliminary implications of birth pleasure in the movement for birth justice.

## Pleasure in Birth: The Paradox of a Popularized Taboo

Birth pleasure could read as a paradox to some. Pain surely remains the dominant frame in the modern Western construction of birth. Despite a few higher profile publications that have drawn considerable media and academic attention and criticism, pleasure experienced in birth remains largely invisible, ignored, or actively ridiculed. Several authors—mostly in the midwifery, childbirth education, and childbirth preparation realms directed towards lay pregnant women—have documented pleasurable birth. They have asserted that orgasmic and ecstatic pleasure in birth not only exist but are possible for many (if not most) birthing people under supportive circumstances (Buckley; Davis and Pascali-Bonaro; Davis-Floyd; Gaskin; Kitzinger). Midwifery scholarship has long acknowledged the possibility of pleasure in birth, based largely on practical observation across the field. Midwifery texts, for example Denis Walsh and Soo Downe’s *Intrapartum Care*, cover pleasurable and sexual aspects of birth typically omitted from obstetrics textbooks focused primarily on pathogenesis. Still, laypersons and health professionals alike do not typically receive messages about pleasure in birth at all.

Often, experiential accounts expose an intuited sense that the pleasure experienced in birth is in some way taboo, inappropriate, and dangerous to share with others. Virginia W. Bath’s account, as quoted by Elizabeth Davis and Debra Pascali-Bonaro, highlights layers of social construction in birth but especially illustrates the felt sense that one should censor the experience, for fear of the judgment or estrangement that would follow:

The orgasmic sensations during second stage were completely unexpected and took me weeks to discuss with anyone. My husband was relieved when I told him—he was shocked at how sensual the experience had been and was happy it had been so for me. Still, I edit out the orgasmic element when telling my story, as most people are not aware of it as a possibility and would think I was completely insane! (vii)

Media, the blogosphere, news coverage, and other public commentaries have either ignored the issue or castigated the concept of pleasure in birth and women’s interest as “hedonistic” and as expecting birth to be “like a spa treatment,” “superficial,” and “self-indulgent” (“Natural Childbirth”). Women have been informed that “childbirth is not like Burger King” that “you can’t have it your way” (Larimore). National Public Radio did not participate in the flurry of coverage of Ina May Gaskin’s work or her observations about ecstatic birth in 2009. They did, however, publish a commentary from a mother titled “MSNBC Makes Me Click Headline about ‘Orgasmic Birth,’” wherein she declares “orgasmic birth makes a great headline,” and via photographic

evidence, she conveys the trauma of her experience (McKinney).

This kind of “not me” shout-down is not uncommon online. Some who have reported experiencing pleasure during labour and birth in online forums have been called “perverted” and “liars” (Caffrey 19). It would appear that pleasure in birth remains scandalous, as it was in the Victorian era when some British obstetricians went so far as to argue against the development of analgesia for birth to prevent inappropriate sexual sensations from arising in the birthing mother:

May it not be, that the physical pain neutralizes the sexual emotions, which would otherwise probably be present, but which would tend very much to alter our estimation of the modesty and retiredness proper to the sex.... Chastity of feeling, and above all, emotional self-control, at a time when women are receiving much assistance as the accoucheur can render, are of far more importance than insensibility to pain. They would scarcely submit to the possibility of a sexual act in which their unborn offspring would take the part of the excitor. (Dr. Smith in 1847, qtd. in Poovey 142)

Such thinking persists, it would seem, as pleasure is seldom discussed or studied in scientific fields dealing with birth. There has been some recent theorizing about socially constructed discourses and narratives around orgasmic birth, specifically as found in white and upper-class home birth and natural birth spheres. Some authors challenge natural and orgasmic birth narratives as problematic insofar as they create oppressive norms for new mothers to achieve under a guise of female liberation (Vissing; McClintock; Rossiter). Kate Rossiter critiques an orgasmic birth ideal popularized, marketed, and sold to pregnant women as a problematic product of neoliberal ideology, and I am prone to agree.

Although the power situated in hierarchical constructions of so-called good birth deserve interrogation, birth pleasure and its potential relationships to maternal or newborn health outcomes deserve investigation. To date, no representative population-level studies have examined the incidence or prevalence of pleasurable birth. I recall the invisibility of my own experience when it happened. As a researcher, I was struck by the fact that my experience of birth pleasure was absent from my medical chart, where much maternal health research data originates. My actual experience was a nonfactor. In the literature on maternal health at large, pleasure is all but absent. A handful of peer-reviewed and unrefereed scholarly articles have addressed pleasure in birth directly by many names—notably, “orgasmic birth” (Caffrey), “ecstatic birth” (Buckley; Caffrey; Tanzer; Vaughan and Maliszewski), “childbirth climax,” “obstetric orgasm,” and “obstetric pleasure” (Postel), and “birthgasm” (Mayberry and Daniel).

## Clarifying Terms: Orgasmic Birth, Ecstatic Birth, and Beyond

Currently, the dominant framing of pleasure experienced in birth is orgasm. There are several definitions, or rather explanations of orgasmic birth, none of which are especially clear. In their popular birth preparation guide *Orgasmic Birth*, Davis and Pascali-Bonaro offer the following semidefinition: “Whenever a woman can look back on these [birth] moments with joy, when physical and emotional aspects of birth are fully experienced as pleasurable, we call this orgasmic birth.” (xi). Thierry Postel uses such terms as “childbirth climax” and “obstetrical orgasm” without offering definitions, but in reference to “physical pleasure experienced by mothers during obstetrical labor” and childbirth (e89). However, pleasure and orgasm are not synonymous. In her 2007 dissertation on sexual experiences of women in childbirth, Danielle Harel drew the term “birthgasm” from an informant and used it to develop the terms “unexpected birthgasm” and “passionate birth” to distinguish unintentional and spontaneous orgasmic sensations from intentional sexual stimulation during birth. Lorel Mayberry and Jacqueline Daniel use birthgasm in title only, and do not define it; instead, they rely on a definition of coital orgasm and apply that to birth. There is much more that could be said about the politics embedded in the literature around female orgasm itself—especially the ways male blueprints of sexuality are superimposed on the female body, including in birth—but that is beyond the scope of this paper.

Another key conceptualization of pleasure in birth is ecstatic birth. Ecstasy has been defined as “a state of being beyond reason and self-control; a state of overwhelming emotion; especially rapturous delight; a trance; especially a mystic or prophetic trance” (“Ecstasy”). In her work on ecstatic birth published in 2002 and 2003, Sarah Buckley offers no definition but provides a dissection of the word ecstasy: “ec” meaning outside, and “stasis” meaning usual state. Deborah Tanzer used the term “peak experience” to convey a similar concept in 1968. In their study of ecstatic and mystical birth psychology and phenomenology published in 1982, Barbara Vaughan and Michael Maliszewski define ecstatic states as “states of consciousness that are characterized by an overwhelming sense of joy or rapture” (115).

Mystical experiences are “intense momentary periods in consciousness lying beyond the limits of ordinary experience which are characterized by the expansion of consciousness or awareness that exceed an individual’s customary known or familiar concept of self-identity” (115-16). Birth pleasure is a broader concept that can be thought to incorporate the ecstatic and orgasmic. The experiential accounts to follow will help to illustrate the multifaceted, nuanced, and diverse spectrum of experiences of pleasure in birth.

## Experiential Accounts

Many of the authors who have written about pleasure in birth have featured the voices of those who have experienced it, and I am thankful to coalesce their rich testimonies here to construct this concept I call “birth pleasure.” In Shelia Kitzinger’s *Birth & Sex*, pleasure in birth is conceptualized as predominantly orgasmic in nature, on the paradoxical “almost razor-edged separation, between intense pleasure and pain” (15). She provides snippets of interviews in which this edge is explored by her informants: “Orgasm is like a pain, a sweet pain that gets bigger and fills you up. Then as it ebbs you are left feeling content and throbbing,” and “Sometimes the pleasure is so acute it is almost too much to bear, almost painful” (15). These descriptions are consistent with those of others who report a concurrence of both pleasure and pain in birth, as opposed to some who have reported painless birth with pleasure or orgasm, as discussed below.

Robbie Davis-Floyd presents vivid accounts of childbirth based on one hundred interviews in her classic and highly cited work, *Childbirth as an American Rite of Passage*: Here is the experience of one woman:

Labor for me was a total turn-on. Yes, there was pain—a lot of pain, and the most effective relief for it was stimulation of my clitoris. Larry rubbed my breasts and my clitoris and kissed me deeply and passionately for hours until the baby came. And when he had to go out of the room, I masturbated myself until he came back. I had lots of orgasms. They seemed to flow with the contractions. Even when I was pushing I wanted clitoral stimulation. It was the sexiest birth ever! And I loved every minute of it. I was completely alive and alove [sic]—turned on in every cell of my body. I felt that the totality of Larry and me—the fullness of everything we were individually and together – was giving birth to our child. (69)

Davis-Floyd complicates the desexualization of birth further and explores the continuity birth as an expression of one’s sexual life-course. She quotes Jeanine Parvati-Baker’s vivid birthing account from 1988:

I feel the baby come down. The sensation is ecstatic. I had prepared somewhat for this being as painful as my last delivery had been. Yet this time the pulse of birth feels wonderful! I am building up to the birth climax after nine months of pleasurable foreplay. With one push the babe is in the canal. The next push brings him down, down into that space just before orgasm when we women know how God must have felt creating this planet. The water supports my birth outlet. I feel connected to the mainland, to my source. These midwife hands know just what to do to support the now crowning head, coming so fast.

How glad I am for all those years of orgasms! Slow orgasms, fast ones, those which build and subside and peak again and again. That practice aids my baby's gentle emergence so that he doesn't spurt out too quickly. He comes, as do I. (71)

Others describe it differently, of course. From seven interviews with women who reported pleasurable experiences of birth (all white upper-class English women recruited online), Anna Caffrey distilled three main categories of experience: pleasure, orgasm, and euphoria. Some of the women denied the sexuality of these pleasurable sensations; others drew parallels between sexuality and the pleasure they experienced while maintaining a difference between the two. Others emphasized the sexuality of their birth pleasure sensations. Regarding the balance of pleasure and pain, one informant described their experience as follows: "I don't think it was that it didn't hurt, it was probably more that there were other things, overriding feelings that were, um, more important, which is that, I just had this real sense of purpose and just being able to get on and do what I needed to do.... I think I did feel pain, it just didn't feel bad" (qtd. in Caffrey 21).

The physicality of the birth process was experienced and interpreted in different ways. Now, I will excerpt several interviews from Caffrey's work that exemplify powerfully the different ways that birth pleasure is described.

I could feel, um, my son descending, and as he descended he sort of stimulated as he went down, and I could feel his head. And there was still no pain at all, and all I could feel was, it was just this really weird primal state where it just felt like it was just me and him together.... I felt really, sort of filled up, really complete, sort of sexual, but it wasn't, because he was only going one way and I knew that, you know, I was in labour and this was a baby. (qtd. in Caffrey 21)

But it was definitely stimulation, and it was definitely pleasurable, but it wasn't sexual. It was sort of, a stretching and a massaging, um, of the inside of me, and I didn't orgasm and there was no, I didn't feel him touch G spots, or anything, inside, it was just a feeling of being stretched and stimulated that was pleasant. (22)

I'm a very physical person, I think, I just, I love the physicality of it. I love the stretching. And the, the, sort of like a big yawn. Like a big, stretchy yawn. It felt like that. (25)

Whereas some authors highlight orgasm as a central defining typology of sensation in birth pleasure (Davis and Pascali-Bonaro; Kitzinger 15-17), orgasmic sensations were not the highlight of even the interview captions categorized as "orgasmic" in Caffrey's study. Rather, the use of the term "orgasmic" served as a conceptual anchor to make sense of a completely new experience:

The wiggling thing is what ... was probably the first sign that there was something physically pleasurable about the whole thing, because I know that, um, a wiggle like that, I'm about to have an orgasm. (qtd. in Caffrey 23)

[It] was very much more like sort of the long build up you get to an orgasm, more than the actual orgasm itself.... It wasn't exactly the same, it's just that it's the closest parallel. (24)

The “euphoric” headspace these women experienced involved psychological and spiritual aspects:

[The] hour after they were born I was as high as a kite. (qtd. in Caffrey 25)

[It] was just ... it was euphoric. Yes, euphoric. And so there was ... it was painful, but it was euphoric in, in a sort of deeper sense.... And it, in some ways, it was like swimming. Nothing to do with being in water, but swimming in a ... deep down, deep, deep, dark blue river, sense. (25)

Um. It felt ... like ... it felt like I was giving something really brilliant to somebody. To me. Um. To the world. I don't know. To God. I don't know. Ah. I felt like I was producing a really, really brilliant sculpture. Um. If you ... it feels like ... it felt like a fusion. It feels like a fusion of nature and humanness. A fusion of love of my husband and me, I guess. Um, a fusion of me and, and the world, in a, um, you know, all these kind of things that sound quite hippy. Um. Cheesy. It, but it is, it does feel like that. Like a big ocean, like, ah. Just trying to find, probably, I don't know, words to just help you understand what it's like. It's like a universal kind of thing, like, like the whole universe comes together in that moment. It is wonderful. (25)

Such minimizing of the magnitude of the experience with diminutive language about the “hippiness” or “cheesiness” of their experiences speaks to some of the social values and beliefs constructing birth—that pain is more grounded and real than pleasure or joy and that pleasure is in some way frivolous, detached, or even delusional.

One woman emphasized the difference between her first birth, which had left her traumatized and her second pleasurable birth. She reflected on its impact on her relationship with the new baby:

I just felt this massive rush of hormones, and I just could not keep a smile off my face. Ah, they sent me to have a shower, and I was just grinning and grinning and grinning in the shower, and I just sort of, couldn't believe that I'd had such a wonderful experience.... I carried

him in a sling because I didn't want to be apart from him, and just, it was a much better bonding experience, and that I felt like he was my son, and he was my, sort of, special gift, and I just wanted to just smother him in love, in a way that I never felt with my daughter. (qtd. in Caffrey 23)

It is notable that none of Caffrey's informants reported that births which were in some way pleasurable were in any way negative or traumatic. Several categorized their pleasurable birth as healing or empowering in some way, particularly if a previous birth was a traumatic or negative experience (Caffrey 18).

By acknowledging the importance and authority of their lived experience and knowledge, I prioritize birthing people in knowledge production around birth. Though by no means representative of all experiences of birth, these accounts serve to ground the concept of "birth pleasure" in its textured, three-dimensional realness in the lives of these mothers. As an intersectional feminist (Crenshaw; Cho; Denis) and matricentric feminist (O'Reilly), with a commitment to research justice (Data Center), I aim to uplift the knowledge of those impacted—in this case, birthing mothers and gender nonconforming birthing people. The studies cited above have significant limitations. They involve mostly white and high socioeconomic status informants. We must hear from women of colour as well other women with diverse identities, including low-income, lesbian and/or queer, teenage or advanced age, disabled, immigrant, incarcerated, gender nonconforming, and transgender people.

### **Studies of Pleasure in Birth**

Few refereed studies have directly examined phenomena associated with what I have collectively refer to here as "birth pleasure." These studies tend to draw heavily on similar sources regarding the hormonal, neurological, and anatomical underpinnings of birth pleasure in their efforts to document and affirm its objective existence. Postel's study from 2013 draws attention to "obstetrical orgasm" or "childbirth climax" in a survey of 109 midwives about their practices and reports they had received about obstetric pleasure as well as in the accounts of nine birthing women. Although "obstetric orgasm" is not defined in Postel's study, she synthesizes the responses into a more generalized description of "obstetric pleasure" as "a physical sensation with no accompanying erotic ideation," which "lasts from a few seconds to a few minutes and occurs during fetal expulsion" and is marked by a "complete desensitization to pain" (e90). Out of the nine women who provided testimony, seven reported such pleasure without an epidural and two with "ineffective epidural anesthesia" (e90). Not all of the incidents of obstetric orgasm reported by midwives were corroborated by the mother. There was no distinction made



between pleasure or orgasm stimulated intentionally (via clitoral contact for example) versus spontaneously arising sensations. Postel considers the experience of obstetric pleasure to be “unpredictable” and rare, and idealization or sexualization of birth based on this study is discouraged (e91).

Mayberry and Daniel headline their 2016 paper with the term “birthgasm”; their paper examines orgasm as a potential complementary and alternative therapy for pain in childbirth. They mostly draw on physiological studies based on the neuroendocrine pathways of oxytocin and beta-endorphin as well as some qualitative reporting. Their analysis presents orgasmic birth as free of pain early in the paper, yet they do not examine nonorgasmic kinds of pleasure or the concurrent experiences of pain and pleasure present in several experiential accounts. They propose more institutional support for orgasm in birth as a therapy for pain while suggesting further study. There is an interventionist point of view inherent in the proposal that birth pleasure should be used as a treatment for pain, as it is reflective of the biomedical model of birth.

Few studies have examined or tried to approximate how common pleasure in birth is. No representative population-level studies exist. Most studies done on the topic have also involved predominantly white women of middle or high socioeconomic status, and many of these studies are well over thirty or even forty years old. In 1977, Kathleen Norr et al. published a study of 249 postpartum mothers on their relative experiences of pain and enjoyment in birth, but it conflated the concepts of “enjoyment” and “pleasure” in their instruments. They did not publish the raw data regarding how many women reported experiencing enjoyable births. Their findings do not tease apart experiences of pleasure from a generalized sense of enjoyment of the birth process (due to total blockage of pain by epidural analgesia, for example). Through regression analysis they found that difficulty in delivery was the strongest inhibitor of birth enjoyment, even more so than pain.

In 1982, Vaughan and Maliszewski conducted a study of birth ecstasy involving fifty-nine women in the first twelve to eighteen months postpartum using validated instruments and their birth experiences inventory. Twenty-four respondents reported one to two ecstatic states or mystical experiences during birth, and nineteen reported three or more. The authors conclude that women experience such ecstatic or mystical states in birth more commonly than is recognized but offer no further estimations of frequency. They also did not include any measures of physical pleasure, such as orgasmic or other pleasurable bodily sensations.

Meanwhile, more recently, non-obstetric female sexual dysfunction has been estimated to be commonplace, affecting between 22 per cent and 43 per cent of women (Goldstein S152). There is, perhaps, a connection between such sexual dysfunction and the absence of birth pleasure. But no studies have

examined this, beyond Baxter's study in 1974 that found anorgasmia prior to first birth was related to more difficult births and increased likelihood of forceps delivery. Social determinants also likely play a role. Given the widespread population incidence of sexual dysfunction in females, it would be important to not only focus on the individual-level biological etiology but also on the psychological and social etiology as well. A complete account of the relevant literature related to this topic in terms of biology, psychology, and sociology is beyond the scope of this paper, but I look forward to expanding on this work to present those dimensions of the birth pleasure concept, which could be viewed as a biopsychosocial phenomenon (Engel).

### **Birth Pleasure: Synthesizing a Definition**

Birth pleasure is the presence of enjoyable somatic, mental, and/or emotional states and/or sensations, including sensual, sexual, and nonsexual sensations, orgasm or orgasmlike sensations, joy, ecstasy, and/or euphoria, regardless of the presence of pain or other states, emotions, sensations typically considered unpleasant, in the process of a person giving birth, including all stages of labour, parturition, and the immediate postpartum period.

### **Concluding Thoughts: Pleasure and Birth Justice Praxis**

Many scholars and activists have argued that childbirth should be studied differently. Mothers and birthing people should be at the centre of analysis; research should start with their voices and be motivated by their concerns (Oparah and Bonaparte; Davis-Floyd; Gaskin; Kitzinger; Jordan; Data Center). Childbirth scholarship can and should directly examine birthing people's experiences to incorporate the embodied and social realities of birth in research and practice efforts, thereby improving birth outcomes (Oparah and Bonaparte). Maternal health research overwhelmingly focuses on pain and pathogenesis, or the causes of disease. Salutogenesis, or the causes of health, are also a worthy focus for the field (Mittelmark). Examining the kinds of pleasure that are experienced in labour and what impact they have, if any, on labour and health outcomes is warranted. Such data may illuminate practice and policy opportunities for improved care delivery and health outcomes, particularly for those most at risk of maternal morbidity and mortality within the current maternal care paradigm, due to the compounding oppressions of race, class, gender, and beyond—including, Black and Indigenous women and queer/gender-nonconforming people, low-income people, younger and older people, and those with cultural and religious beliefs about birth that are inconsistent with the biomedical model of birth management (Oparah and Bonaparte).

However, movements for birth rights and birth justice are not waiting for published studies from the ivory tower to operationalize and leverage pleasure in transforming birth (Oparah and Bonaparte; Paltrow and Flavin; Ross and Solinger; Silliman et al.). Karen Scott, for example, highlights sexuality and pleasure in her SACRED birth model and calls for participatory reimaginings of birth care by and for Black birthing people as well as an end to “obstetric racism” (a term coined by Dána-Ain Davis). Pleasure has recently been highlighted for its radical and revolutionary potential in its own right (brown). Struggle and resistance are the keystone concepts in the rhetoric of social justice, but what brown and colleagues point out is that there is political power in pleasure—it moves us towards things we need and want. I offer this preliminary definition of birth pleasure to advance and expand the scholarship around this spectrum of experience to build salutogenic maternal health knowledge and achieve birth justice. Understanding birth pleasure can shed light on the path towards a just birth culture for people bringing forth life.

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## **“Good Mothers” Breastfeed: Discursive Constructions of “Good Motherhood” in Infant Feeding Health Promotional Material in Ireland**

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*This paper focuses on discursive constructions of “good motherhood” in discourses of infant feeding in contemporary health promotional material in Ireland. The study examines the multisemiotic composition of two pamphlets on breast and formula feeding, routinely given to mothers in Ireland after having a baby. These pamphlets are analysed using a model of multimodal critical discourse analysis (MCDA) in order to produce a comprehensive examination of the key discursive strategies and semiotic choices employed by the producers of these texts to influence parents’ decisions about infant feeding. The paper examines how mothers’ choices with regard to infant feeding are constrained by the positioning of breastfeeding as the optimal choice, and the discursive legitimisation of correlations between the practice of breastfeeding and the ideal of good motherhood. It also highlights that these discursive strategies and semiotic choices are underpinned by discourses of attachment parenting, total motherhood and neoliberal risk culture.*

*The paper argues that the health promotional texts which form the basis of this study, are part of a wider discourse of breastfeeding which is an ideologically infused moral discourse about what it means to be a good mother in an advanced capitalist society. It further concludes that the question of choice, which is central to so many women’s issues, is notably absent from the discourse of infant feeding, a factor that can have a strong negative impact on the wellbeing of new mothers.*

## Introduction

Societal practices with regard to infant feeding have changed considerably over time. When infant formula was created in the early twentieth century, it provided a safe alternative to breastfeeding in countries with access to clean drinking water. In the 1970s, approximately 75 per cent of babies in the United States were being fed exclusively or in part by infant formula (Wolf). However, since the late twentieth century, there has been a major shift in practice back towards breastfeeding. The benefits of breastfeeding are well established in publications in the fields of medicine, midwifery and, public health, with the “breast is best” mantra permeating the majority of these studies (Williams et al. 340). Medical and health care practitioners assert that breastmilk has nutritional properties which protect infants from various health risks and promote developmental and psychological wellbeing (Schmied and Lupton; Brookes, Harvey, and Mullany 342). The World Health Organization recommends exclusive breastfeeding up to six months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond. This recommendation has become the optimal goal of healthcare systems around the world, with antenatal classes, healthcare professionals, advice books, government health policies, magazines and websites all promoting breastfeeding as the supremely superior way of feeding infants (Knaak; Símonardóttir and Gíslason).

## Breastfeeding in Ireland

In Ireland, breastfeeding rates are currently among the lowest in the world. Approximately 60 per cent of mothers in Ireland report breastfeeding at discharge from hospital (49 per cent exclusively) and just 35 per cent at three months (UNICEF). The promotion and support of breastfeeding has become an important feature of public health policy in Ireland, with breastfeeding initiatives largely driven by the Irish Government’s Health Service Executive (HSE). The National Health Service Breastfeeding Action Plan 2016–2021 describes its vision as to achieve “a society where breastfeeding is the norm for individuals, families and communities in Ireland resulting in improved child and maternal health outcomes, where all women receive the support that they need to enable them to breastfeed for longer” (*Report 8*). On a practical level, its aim is “to increase breastfeeding initiation and duration rates” (*Report 8*). The national governmental agenda to promote breastfeeding in Ireland is, thus, clear and is in line with the aims of health promotion around infant feeding in other Western countries (Head 1).



## Aims and Objectives

This study seeks to determine if, and to what extent, infant feeding health promotional material in Ireland attempts to influence mothers’ decisions about how to feed their babies. It explores the discursive strategies and semiotic choices used in this material to present the practices of breast and bottle feeding to mothers and further questions whether the discourse of this material allows women to make meaningful choices with regard to feeding their babies. The findings are discussed against the backdrop of wider ideological discourses underpinning the discourse of infant feeding in contemporary Irish society.

## Ideological Background

Significant cultural shifts have taken place in the institutions of motherhood and public health in the course of the late twentieth and early twenty-first centuries, and their resulting ideologies form an important backdrop to the discourse of infant feeding.

### *Breastfeeding, Motherhood, and Public Health in a Neoliberal Risk Society*

The discourse of breastfeeding intersects with broader discourses on motherhood and expected behaviour from mothers (Símonardóttir and Gíslason 666). Gavin Brookes, Kevin Harvey, and Louise Mullany further argue that the widespread promotion of breastfeeding can be closely aligned to societal beliefs about what it means to be a successful or a good mother” (342). The concept of a “good mother” has undergone a strong cultural shift since the first half of the twentieth century, as motherhood has consistently intensified over time (Hays). The notion of being a mother in contemporary times is, thus, characterized by what Sharon Hays refers to as “intensive mothering” or Susan Douglas and Meredith Michaels refer to as “the new momism” or Joan Wolf describes as “total motherhood.” The latter can be defined as “a moral code in which mothers are exhorted to optimize every aspect of children’s lives, beginning with the womb” (Wolf xv). In addition, total motherhood stipulates that mothers’ primary occupation is “to predict and prevent all less-than-optimal social, emotional, cognitive, and physical outcomes; that mothers are responsible for anticipating and eradicating every imaginable risk to their children” (Wolf 71-2). Breastfeeding is central to the discourse of “total motherhood” due to its supposed role in promoting bonding between mother and baby and the protection afforded by breastmilk against health risks.

The ideology of total motherhood is, thus, embedded in neoliberal risk culture, which Wolf defines as “a pervasive anxiety about the future that drives

many people to build their lives around reducing all conceivable risks” (xvi). In terms of risk management, breastfeeding can be perceived as the ultimate means of controlling health risks for infants: “Breastfeeding, in which mothers are personally responsible for reducing health risks for babies by controlling the production of their food, is the epitome of total motherhood in a neoliberal risk culture (xvii). The movement towards a neoliberal model of public health in Western societies is based on the idea that rates of illness will be reduced if individuals modify their lifestyles in accordance with healthy living advice (Brookes and Harvey 59). This emphasis on assuming personal responsibility for health can arguably mean that every mother becomes accountable for the health of her babies (Wolf 66).

### *Science and Breastfeeding Advocacy*

The prevalence of this type of parenting culture in Western societies has redefined successful parenting as an activity where mothers are expected to take full responsibility for their children’s development under the guidance of experts and science (Símonardóttir 106). Motherhood has become an experience regulated by external authorities (Kanieski 335) and informed and guided by experts (Knaak 348). The message for women that “breast is best” is relentlessly present in discourses surrounding pregnancy, childbirth, and infant feeding, and it has become one of the scientific truths that is rarely questioned or contested (Símonardóttir and Gíslason 674). The claim that “science says” for sociocultural reasons arguably constrains infant feeding decisions (Lee, “Breast-Feeding Advocacy” 1061).

Intensive mothering, total motherhood, risk culture, and the ubiquity of science are, therefore, all elements that interact in the ideology of contemporary motherhood and that shape the social practice of breastfeeding in Ireland. Breastfeeding discourse does not only emphasize the health benefits of breastfeeding but also systematically positions breastfeeding as “the proper and moral choice” for mothers (Knaak 346). The question arises, therefore, as to whether women can really be expected to be capable of making meaningful choices around infant feeding within these constraints.

### **Data**

The dataset for this study is comprised of two pamphlets routinely given to mothers in Ireland after having a baby—*Breastfeeding. A Good Start in Life* (BRF) and *How to Prepare Your Baby’s Bottle* (BOF). Both texts form a key element of the pack of informational leaflets distributed by public health nurses to new mothers in Ireland and are also readily available in maternity hospitals, doctor offices, and public health clinics. The pamphlet on breastfeeding is produced by Ireland’s HSE in conjunction with La Leche

League, Cuidiú, the Baby Friendly Hospital Initiative, the Association of Lactation Consultants in Ireland, and Friends of Breastfeeding. The pamphlet on bottle feeding is also produced by the HSE in conjunction with SafeFood.<sup>1</sup> The pamphlet on breastfeeding consists of twenty-four pages, which, in general, promote the health benefits of breastfeeding and provide advice in relation to how to breastfeed and how to determine if baby is feeding well. The pamphlet on bottle feeding is a much shorter document of thirteen pages, which provides information on formula feeding and describes its aim as to “help you to prepare your baby’s bottle feeds safely.” Both pamphlets therefore, position themselves as authoritative sources of help for new mothers.

These pamphlets fall into the genre of health promotion discourse, which can broadly be defined as a form of communication that seeks “to inform and persuade intended audiences to change habits or adopt new routines” (Finan 16). In line with the aforementioned neoliberal model of public health dominating Western societies, “health promotion has changed its emphasis from curing and containing disease to inciting people to take personal responsibility for maintaining their health” (Brookes and Harvey 59). Mothers are, thus, incited to take responsibility for their health and that of their babies; they are reminded frequently that “breastfeeding protects your baby’s health and your health too” (BRF 21) and that following breastfeeding guidance “is the safest and best way of making sure your baby grows and develops as healthily as possible” (BOF 1).

Health promoters draw on a variety of persuasive strategies to encourage the public to adopt certain behaviours, the most common of which are appeals to fear and the “unvarnished” presentation of facts (Monahan 81). Gavin Brookes and Kevin Harvey highlight the use of fear-inducing strategies in public health promotion and question their moral legitimacy. In reality, health promotion increasingly relies on persuasive commercial advertising techniques (Chouliaraki and Fairclough; Lupton). In particular, the use of arresting and visceral visual imagery is increasingly common, “since such semiotic elements have been shown to influence the public’s uptake of a particular promotional message, and help to send people along a more emotive pathway than might be accomplished by health promotion texts which are strictly verbal in communication” (Brookes and Harvey 61). The analysis in this study, thus, combines both visual and textual analysis in an effort to take into account the key role played by images and other semiotic modes in creating meaning and inducing interpretations.

## Methodology

This study examines these pamphlets using a multimodal critical discourse analysis (MCDA) approach. This approach essentially derives from critical discourse analysis (CDA), which emphasizes the social and constitutive nature of discourse (Fairclough, *Discourse and Social Change* 3). In accordance with CDA theory, discourse is governed by rules that extend beyond grammar, of which people are not necessarily conscious; CDA seeks to expose realities hidden behind elements that have become naturalized (Fairclough, *Critical Discourse Analysis*). It is an approach often dedicated to uncovering power asymmetries and hierarchies in societies as well as the oppression of particular groups (Benwell and Stokoe; Litosseliti and Sunderland; Wodak). CDA theory considers the grammar and vocabulary in texts as systems of choice from which text producers select. In this way “language is treated as a system of lexico-grammatical options from which texts/authors make their choices about what to include or exclude and how to arrange them” (Benwell and Stokoe 108). Although these choices may not necessarily be consciously motivated, they are still meaningful (Fairclough *Discourse and Social Change*), or according to David Machin, Carmen Rosa Caldas-Coulthard and Tommaso M. Milani, they are “linguistic materialisations of the ideologically-laden interests of the writer or speaker” (302).

Essentially, MCDA follows the same principles of CDA, but its main innovation is that it includes not just language but all of the semiotic modes that make up a social context (Machin et al. 303). This study, therefore, looks at how images, photographs, diagrams, and graphics also work to create meaning. In accordance with MCDA theory, visual as well as linguistic strategies that appear normal or neutral on the surface may actually be ideological (Machin and Mayr 9). Language, images, layouts, fonts, etc. are all semiotic modes available to text producers, and meaning is the product of the interplay between these various semiotic modes (Brookes and Harvey). Brookes and Harvey emphasize that health promotion texts are essentially multimodal, “harnessing in their designs not only language but also visual elements, thereby making meaning over more than one level of semiosis” (76). MCDA is, hence, an appropriate approach for the analysis of health promotion texts. It is, however, important to remember that MCDA has the same limitations as CDA. Although it can show what semiotic resources have been used in text, and the meaning potential they have, it cannot say how readers will receive these texts or make any conclusions about the intentions of the authors. This study can only, therefore, highlight meaning potential and how these texts may be interpreted by those who read them.

The analysis will focus predominantly on the linguistic and visual categories of lexis, images, photographs, layout, and colour, and how they are used to

represent the practices of breast and bottle feeding to mothers in Ireland. It further examines to what extent these linguistic and visual categories are used to influence mothers’ decisions about how to feed their babies, and it questions whether these discursive strategies ultimately constrain women’s choices regarding infant feeding.

## Results and Discussion

The analysis reveals that these pamphlets represent a key attempt by the text producers to influence mothers’ decision making regarding how to feed their babies. Essentially, these pamphlets aim to persuade mothers to breastfeed regardless of their social, economic, or personal circumstances, and they promote a specific health promotional agenda. The analysis shows that this persuasion is achieved by simultaneously positioning breastfeeding as the supreme method of infant feeding and using fear-inducing strategies and tactics to convince them not to bottle feed. The combination of these strategies effectively establishes correlations between the practice of breastfeeding and the ideal of good motherhood, rendering it impossible for mothers in Ireland to make meaningful choices in this area.

### *Breastfeeding as the Supreme Method of Infant Feeding*

Breastfeeding is clearly established in both pamphlets as the supreme method of infant feeding. This is most apparent in the manner in which mothers are linguistically indexed (or not) in both pamphlets, in the use of confessional narratives and apparent statements of fact, and in the choice of photos, colours, and layout.

### *Linguistic indexing of mothers*

The linguistic indexing of mothers is strikingly different in the two pamphlets. In the BRF pamphlet, breastfeeding mothers are addressed and referred to as “mums.” Brookes, Harvey and Mullany recorded a similar finding in their analysis of breast and bottle feeding materials in the United Kingdom and described the term “mum” as a “loaded lexical choice that arguably serves to strengthen the connection between the act of breastfeeding and the social role of motherhood” (346). The term “mum” is used recurrently throughout the pamphlet, and the choice of this lexical item (in bold for emphasis) personalizes breastfeeding mothers and humanizes them.

- More and more **mums** in Ireland breastfeed their babies. (BRF 3)
- Almost all **mums** can breastfeed and make enough milk if their baby is feeding often enough. (BRF 3)

In the bottle feeding pamphlet, however, bottle feeding mothers are not named in any form. The word “mother,” or any derivatives, is notably absent.

Instead, the pronoun “you” and the possessive adjective “your” are used, and although it can be assumed that these words are linguistically indexing parents, this is not made explicitly clear:

- If **you** have decided to bottle feed your baby, this booklet is for you. (BOF 1)
- It is very important that **you** clean and sterilise all the equipment **you** used to feed **your** baby, such as bottles, teats and lids. (BOF 3)

Norman Fairclough (*Analysing Discourse*, 136) emphasizes that what is missing from a text is just as important as what is present. The suppression of the terms “mother” or “mum,” which are consistently used throughout the pamphlet on breastfeeding, raises the question as to why these terms are being omitted in the discourse of bottle feeding. The suppression of these items arguably creates an emotional distance between readers and bottle feeding mothers.

### *Images*

There are thirteen photographic images in the pamphlet on breastfeeding and eight in the pamphlet on bottle feeding. Based on the work of Roland Barthes (*Image and Methodologies*), David Machin and Andrea Mayr argue that there is probably never any neutral denotation when images are concerned—all images denote something(49-50). Thus, the meaning potential of these visual semiotic choices must be addressed.

A close examination of the thirteen photographs in the pamphlet on breastfeeding shows that these photographs depict mothers and babies in a variety of settings: a hospital room, a park, a domestic setting, a bedroom, a café, a waiting room, and a support group. Other photos do not depict any clear background but are close-up shots of mothers and babies. All of the photographs depict smiling mothers and content babies, and they have been taken in a combination of indoor and outdoor settings with plenty of natural light, which provides a bright visual image of the breastfeeding mother. Breastfeeding is represented as a positive and an enjoyable experience, and the inclusion of a variety of settings also represents breastfeeding as a socially engaging activity. In each instance, the mother is either engaged with the baby (depicting a close bond between the mother and baby) or directly with the camera. In photo three, for example, the viewers see the mother in a close-up shot at eye level, a semiotic choice that creates a feeling of shared space and intimacy between social actor and reader (Kress and van Leeuwen, *Reading Images* 114-16).



Figure 1: Breastfeeding mother relaxing with her baby (BRF 4)

Several photos are also taken from a side angle but from a close-up position, which according to Machin and Mayr “can [also] connote a close alignment and sharedness of position” (99). The viewer is, thus, encouraged to align with these mothers’ thoughts and concerns and to identify with them.

The favourable visual depictions of breastfed babies accentuate their health and happiness. They appear in each photo, closely held by their mothers, and are content and visually healthy. The infant on the final page with the heading “Every breastfeed makes a difference” is presented in warm colours and is laughing while looking into their mother’s eyes.

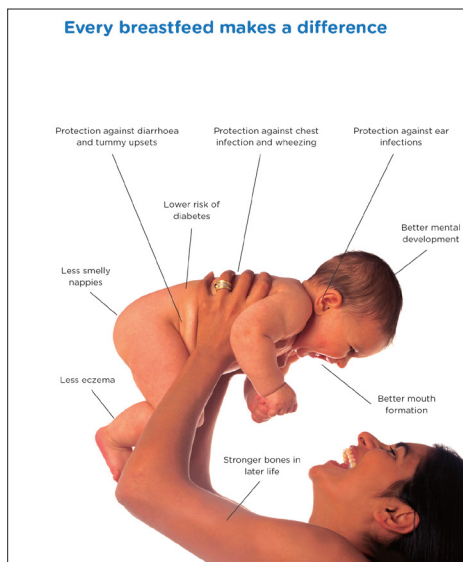


Figure 2: Image of laughing mother and happy baby to illustrate the benefits of breastfeeding (BRF 24)



Brookes, Harvey and Mullany argue that in their study, “the most emotive discursive realisations of conflating the act of breastfeeding with motherhood ... reside in the photographs of babies and breastfeeding mothers which recur throughout the pamphlet” (355). The same can be said here, with the images all following the same semiotic pattern: they represent the breastfeeding mother and baby as participating in moments of bonding, closeness, and happiness.

There are eight photographic images in the pamphlet on bottle feeding, and the striking difference between the images in both pamphlets is the absence of mothers from these images. The only parental figure depicted in the bottle feeding booklet is in a diagram relating to “10 steps to prepare a bottle feed.” And in the visual illustration of step five, (“pour the correct amount of water into as sterilised bottle”), a female face in animated version appears to be checking the correct amount of water. Exclusions from images are extremely important in MCDA, as Machin and Mayr emphasize that “just as it is revealing to ask who is backgrounded or excluded visually from a text, so it is important to ask the same visually” (102). The eight photographs depict babies photographed alone, without any parents. They also appear to be several months older than the newborn babies featured in the breastfeeding pamphlet. Four are lying down but are supporting themselves on their hands and smiling, whereas the remaining four are sitting up unsupported. The nature of these images implies that bottle feeding is a practice more suited to older babies.



Figure 3: Bottle-fed baby sitting alone (BOF 3)



The visual exclusion of mothers from this discourse in comparison to those featured in the pamphlet on breastfeeding suggests that there is lack of a close relationship between mother and baby; the pamphlet, thus, dehumanizes the practice of bottle feeding. It is arguable a visually sterile depiction of bottle feeding infants, as it is presented as an isolating and socially disengaging activity when compared with the presentation of breastfeeding.

### *Colour and Layout*

It is evident in both pamphlets that there has been a series of coordinated visual choices involving colours and layout. Colour is a key resource in visual communication (Kress and van Leeuwen, “Colour” 347) and can be a key factor in adding salience to texts (Machin and Mayr 54-55). In the pamphlet on breastfeeding, each page has a border in a bright colour, in yellow, pink, or green. On each page, headings are printed in a bright blue font, and quotations also appear in the same blue font. Blue shaded boxes incorporating text in a white font are used to highlight key information, and the text is continuously broken up by intermittent photographs of happy babies and mothers. It is evident that this pamphlet uses a broad palette of bright, striking colours and that these visual colour choices add a sense of fun, vigour, and positivity to the breastfeeding experience.

In contrast, however, the pamphlet on bottle feeding uses a much smaller palette of neutral, pastel, and almost sterile colours, such as cream, green, and pale blue. Whereas information on breastfeeding is offset by bright and lively colours and hues, information on bottle feeding is set against a much plainer and duller backdrop. Although the typeface in both is similar, the layout is quite different. The bottle feeding leaflet is presented almost in the style of a scientific manual with five sets of animated diagrams on equipment, cleaning, sterilizing, putting bottles together, and how to prepare a bottle feed. This scientific manual style, together with the choice of neutral colours, is in stark contrast to the bright warmth of the colour and layout choices in the breastfeeding pamphlet.

### *Confessional Narratives*

Confessional narratives are also a key persuasive strategy to promote the supremacy of breastfeeding. This can also be termed “mythopoesis,” which is legitimation through the telling of stories (van Leeuwen and Wodak 104-11). These stories legitimate the authority of the “experts” who have produced these texts by affirming the supremacy of breastfeeding through what appear to be mothers’ voices. Theo van Leeuwen and Ruth Wodak distinguish between two types of stories, moral and cautionary tales: “In *moral tales* the hero or heroes follow socially legitimate practices and are rewarded for this with a happy ending. In *cautionary tales* the hero or heroes engage in socially

deviant behaviour that results in an unhappy ending” (100). There are a total of six moral tales in the pamphlet on breastfeeding. In fact, the pamphlet opens with the following narrative: “When I was pregnant I thought about breastfeeding but I wasn’t sure if it was right for me. I wondered if I’d be able to make enough milk. It turns out that nearly all mothers can make enough milk for their babies and can feed as long as they want to. My son is growing so well now” (BRF 1).

This narrative begins with a story of individual experience, and the use of the verbs “I thought,” “I wondered,” and the negative verbal structure “I wasn’t sure” allows readers to identify with this mother who is unsure about whether to breastfeed. The use of modal verbs in this narrative is important, as Machin and Mayr remind us that modals encode probabilities and certainties but conceal power (191). In this instance, the reader is confronted with an epistemic modality, in which the mother in the narrative wonders if “she would be able” to breastfeed. This story is then generalized through the reference to “nearly all mothers,” who “can” both make enough milk for their babies and feed as long as they want to. Breastfeeding is represented as something that is a possibility for “nearly all mothers.” The declarative sentence at the end of the narrative—“my son is growing so well now”—implies a correlation between breastfeeding and children growing well. Any reader unsure about whether or not to breastfeed is reassured that this is something “almost all” mothers “can” do and almost should do.

The practice of feeding on demand, which represents a core value in attachment parenting and total motherhood ideologies, is also legitimated using a moral tale: “Coming home with my baby was a busy time. From six in the evening he fed really often. I just went with it, got comfortable and used it as a time to relax with him” (BRF 7). The socially legitimate practice here is feeding on demand, and the reward was receiving time to relax with the baby. Likewise, the issue of feeding in front of others was also resolved using this strategy. “Breastfeeding in front of other people was something I worried about. I felt embarrassed and no-one in my family had ever breastfed. I went to the antenatal classes and breastfeeding group when I was expecting. It really helped to see how other mums fed their babies. I’ve got a lot more confident now” (BRF 17). In this instance, the practice of feeding in front of other people was problematic, but success was achieved by attending antenatal classes and breastfeeding groups. The happy ending was that the mother in question felt confident. These short narratives, thus, serve to legitimate breastfeeding as the supreme means of feeding babies and further present success in breastfeeding as achievable for almost all women.

### *Apparent Statements of Facts*

The use of apparent statements of facts is also a key persuasive device used in the pamphlet on breastfeeding. These appear mostly in the form of declarative statements, which present breastfeeding as the incontestably supreme form of infant feeding.

- The longer you breastfeed the greater the **health protection** for you and your baby. (BRF 3)
- Breastfeeding is also **convenient** and **cost-free**, and mums enjoy the feeling of **closeness** breastfeeding creates. (BRF 3)
- Breastmilk is **important** for your baby’s **healthy growth** and **development** and it **protects** his digestive system. It contains antibodies to **protect** your baby from illness and build his immune system. (BRF 21)
- Breastfeeding is **important** for mothers’ health too as it **protects** against ovarian and breast cancer as well as helping you to **achieve** and maintain a healthy post pregnancy weight. Breastfeeding is **cost-free**, **convenient** for you and your baby and always at the right temperature. (BRF 21)

These short declarative statements embody apparent statements of fact, even though no evidence or references are produced to support them. The verb to “protect” is used recurrently with the prepositions “against” and “from,” thus reinforcing the notion of “risk” and the need to protect infants from it. The declarative structure “breastfeeding/milk **is important for...**” is used extensively to persuade mothers of the importance of this practice. The use of the nominalization “breastfeeding” is also significant, as it places the focus on the process of breastfeeding as opposed to the social actors involved. Women are persuaded that the practice of breastfeeding will be beneficial, not just to their babies but also to themselves as mothers, and that it is important in terms of their babies’ healthy growth and development, their protection from illness, building their immune system, and even their brain development.

### **Fear-Inducing Strategies**

The notion of risk, undoubtedly underpinned by neoliberal risk culture, is omnipresent in both pamphlets. Both pamphlets use visual and lexical items to encourage parents to breastfeed their infants by inducing fear of not doing so. These strategies include the use of bullet points, bold typefaces, and diagrams, together with recurrent lexical items from the lexical fields of illness, infection, and safety.

In the pamphlet on breastfeeding, these strategies are particularly evident in a section entitled “Good Health Begins with Breastfeeding”:

Research shows that children who are not breastfed have a greater risk of:

- Developing ear, nose and throat infections
- Gastroenteritis (vomiting & diarrhoea)
- Kidney and chest infections
- Asthma and obesity
- Obesity and diabetes, and
- Sudden infant death syndrome (BRF 21)

These bullet points, in a bold typeface, highlight the negative consequences of bottle feeding infants. The choice to display these consequences in bullet points turns them into a list which has an important semiotic function, as it suggests that “we are being presented with the fundamental, essential technical details of the particular social practice” (Ledin and Machin 470). The lexical choices throughout the booklet also draw on an underlying discourse of risk with the verb “to protect” and the noun “protection” used recurrently:

- Breastfeeding **protects** your baby’s health and your health too. (BRF 21)
- Breastmilk ... **protects** his digestive system. It contains antibodies to **protect** your baby from illness. (BRF 21)
- Breastfeeding ... **protects** against ovarian and breast cancer as well. (BRF 21)
- It helps **protect** your baby from infection and other illnesses. (BRF 3)

The meaning potential of these semiotic choices is that if mothers do not breastfeed their children, they are exposing them to risk, which is against the ideology of total motherhood.

Fear inducing strategies are also present in the lexis of the leaflet on bottle feeding. In fact, the opening sentence of this leaflet situates the practice of bottle feeding immediately in a context of risk: “If you have decided to bottle feed your baby, this booklet is for you. Like any food, powdered infant formula is not sterile. It may contain bacteria like *E. sakazakii* and *Salmonella*—that could make your baby sick, causing vomiting, diarrhoea and, in rare cases, meningitis” (BOF 1). The use of the conditional clause “if you have decided to bottle feed your baby,” combined with the modal auxiliary verbs “[powdered infant formula] **may** contain bacteria ... that **could** make your baby sick,” establishes causality between the decision to bottle feed and your baby getting sick, even to the extent of them contracting meningitis. The declarative sentence “Like any food, powdered infant formula is not sterile” is authoritative and immediately positions formula feeding as risky, almost dangerous. The first page of the booklet also contains a footnote, which reminds readers that breastfeeding is still the “safest” form of feeding, immediately positioning formula feeding as a less satisfactory and riskier option:

The Department of Health and Children recommends that babies should be fed on breast milk for the first six months and then continue to be fed with breast milk in combination with suitable nutritious foods for up to two years of age or beyond.

Following this guidance is the **safest** and **best** way of making sure your baby grows and develops as healthily as possible. (BOF 1)

Relentless emphasis is placed on the risk of infection throughout this pamphlet. The adverb “safely,” the adjective “safe,” and the comparative and superlative forms “safer” and “safest” feature recurrently throughout the booklet, which again implies that there is some form of danger associated with bottle feeding:

- This leaflet will help you to prepare your baby’s bottle **safely**. (BOF 1)
- It is **safest** to prepare a fresh feed each time you need one. (BOF 8)

Other lexical items, such as the noun “bacteria” and the adjectives “harmful” and “sterile,” also occur frequently and further situate bottle feeding within a risk context:


- Cleaning and sterilising removes **harmful bacteria** that could grow in the feed and make your baby sick. (BOF 3)
- Because even washed hands can have **bacteria** on them, do not touch the bottle neck. (BOF 5)
- At this temperature it is hot enough to kill **harmful bacteria** that may be in the formula powder. (BOF 6)


The adjective “sterile” is used a total of ten times in this booklet, and its recurrent use underlines the risky dimension to bottle feeding:


- If you are not making up feeds, you will need to put the sterilised bottles together immediately to keep the teat and inside of the bottle **sterile**. (BOF 5)


The notion of risk is present not just in the lexis of this pamphlet but also in the visual arrangement of diagrams and their accompanying text. The configurations in all diagrams are highly schematic. Each stage of the cleaning, sterilizing, or bottle preparation operations appears as a step in numerical order and is conveyed using clear imperative commands. Certain essential points are also highlighted using a bold typeface and diagrams also complement the directives given. Readers are expected to follow each step carefully to avoid the risk of infection.

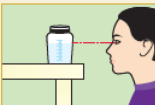
**10 steps to prepare a bottle feed**

**Step 1**  
 Empty your kettle and fill it with one litre (1L) of freshly drawn cold tap water and boil. Alternatively, boil one litre (1L) of water in a clean pan.

**Step 2**  
 Leave the boiled water to cool in the kettle or pan. **Cool it for 30 minutes, but no longer.** This will make sure that the water is not too hot, but also that it is no less than 70°C.

**Step 3**  
 Clean the work surface well. Wash your hands with soap and warm water and dry them on a clean towel.

**Step 4**  
 Read the instructions on the formula's label carefully to find out how much water and powder you need.

**Step 5**  
 Pour the **correct** amount of water into a sterilised bottle. **Water that is 70°C is still hot enough to scald, so be careful.**


**Step 6**  
 Add the exact amount of formula to the boiled water using the clean scoop provided. Reseal the packaging to protect it from germs and moisture. **Adding too much or too little formula could make your baby sick.**

Figure 4: Schematic representation of bottle preparation (BOF 6)

These semiotic choices imply that mothers should be aware of the high risk of infection and health problems if they choose to bottle feed as opposed to breastfeed and be fearful of the consequences of not breastfeeding.

### Conclusion

The Irish governmental agenda to promote breastfeeding is clearly set out in key policy documents and is in line with the aims of health promotion in other Western countries. The infant feeding health promotional material examined in this study clearly follows this agenda by propagating assumptions as to the superiority of breastfeeding and the risks associated with bottle feeding. These assumptions are linked to a neoliberal model of public health and risk culture, together with idealized notions of good motherhood based on ideologies of total motherhood. The pamphlets studied represent a key attempt to influence mothers' decisions about feeding their babies by aligning breastfeeding with ideals of good motherhood. To choose not to breastfeed is to risk your baby's health and your own, thus implying a moral obligation to breastfeed and,

consequently, constraining women’s abilities to make meaningful choices in this domain. Infant feeding decisions are deeply complex with a wide range of circumstances at play (Murphy, Parker, and Phipps; Lee, “Infant Feeding”). Social and economic factors, familial and social networks, interactions with health professionals, and cultural contexts can all play a role in shaping how mothers negotiate infant feeding (Head). The simplistic accounts of infant feeding decisions implicit in these materials do not account of the complexity of mothers’ experiences. The power of this material cannot be underestimated, and the deliberate attempt by text producers to position breastfeeding as the optimal or right choice constrains women’s choices and raises the question as to why the language of choice, which is central to so many women’s issues, is so blatantly absent from this particular form of discourse.

### Endnotes

1. SafeFood is an implementation body with a general remit to promote awareness and knowledge of food safety and nutrition issues in Ireland.

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## Artist Mothers and Virtual Collectives: Making Art and Community from Home

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*Artists who are mothers are still disadvantaged in the trajectory of their careers by the patriarchal institutions of motherhood and the art world as well as by the physical realities of mothering that may prevent them from pursuing their professional creative practices. Despite the contemporary discourse around equality in the home and the workplace, women still carry the burden of the majority of domestic chores. The transformative experiences of pregnancy, giving birth, and mothering are often dismissed by professionals in the art world, a disavowal that may exaggerate the split between one's artistic and maternal selves. This failure of recognition within the art world may be deleterious to a mother artist's sense of wellbeing. Conversely, art that embodies maternal experience may be beneficial to the wellbeing of mothers who may otherwise only be exposed to images of idealized motherhood in mainstream visual culture. This article examines the ways in which technology and the Internet are changing and expanding the ways mother artists can connect and form communities as well as how this shapes their art and may increase their sense of wellbeing. It will explore in particular An Artist Residency in Motherhood, an "open source artist residency to empower and inspire" mother artists (Clayton).*

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This article examines the strategies mothers may use in overcoming gender and structural bias in the art world to practice empowered mothering and making. These strategies include working within physical and virtual collectives and networks and employing collaborative practices. These strategies have implications for maternal health and wellbeing, as they offer mother artists possibilities for ongoing creative practice and agency. Although

it has been shown that ongoing creative practice and engagement in the visual arts is beneficial to mental health and wellbeing (Davies, Knuiman, and Rosenberg), for mother artists, maternal work may impede professional creative practice. The split between a woman's prematernal and maternal identities may be intensified for artists whose motherwork is devalued by the patriarchal structures of the art world. Thus, mother artists may be doubly affected by the failures of the feminist revolution in both the domestic sphere, where women continue to take responsibility for most of the care and maintenance work, and the professional world of the creative arts, where a belief still exists that mothers cannot be serious artists. However, art that embodies maternal experience may also be beneficial to nonartist mothers, as it offers alternatives to the images of perfect, idealized motherhood, which are perpetuated in mainstream visual culture (Betterton 5; C. Johnson; Douglas and Michaels 7).

This article explores sites of mother artists' creativity, connectivity, and collaboration, especially Lenka Clayton's innovative project, *An Artist Residency in Motherhood (ARiM)*. Clayton describes ARiM as an "open source artist residency (designed) to empower and inspire" mother artists. Contemporary art historian and cultural theorist Andrea Liss argues that Clayton's revolutionary strategy dissolves "hard borders—real geographic and economic borders as well as psychic limits—[these] are replaced with tender embraces that complicate simple binary oppositions and where spaces of public and private collide and coalesce" (Liss, "Lenka Clayton's Maternal Economy" 130). Art historian Clare Johnson has also found that artworks that embody ambivalent maternal experiences are also important in opening up discussions beyond the binaries of good and bad mother and providing "an alternative visual repertoire to popular narratives of failed or achieved maternal femininity" (C. Johnson 3). This article discusses the historical precedence for Clayton's model, including the work of Mierle Laderman Ukeles, whose works focus attention on labour and undervalued care work, and the women's art movement of the 1970s, as well as other feminist art organizations in Australia and internationally that empower women artists through collectivity and community. Finally, this article explores the potentially detrimental aspects of connecting online, including the "momification of the internet" (Dewey), the feminization of Facebook, the monetization of our care networks, and the shadow work that insidiously adds to our already overwhelming burdens of labour (van Cleef 459; Hartley).

Artists who are mothers are still disadvantaged in the trajectory of their careers by the patriarchal institutions of motherhood and the art world as well as the physical, emotional, and financial realities of mothering, which are, of course, variable for all women. Despite the contemporary discourse around equality in the home and the workplace, women are still burdened with the

majority of domestic chores (Wilkins and Lass 82). Women are still paid less than men, generally and in the art world, which makes it difficult to justify maintaining an art practice when outsourcing care work is so expensive, financially and emotionally (Jean Hailes for Women's Health 4). The myth that women cannot excel while being both a mother and an artist is perpetuated by, for example, successful artists Marina Abramovich, Tracey Emin, and Judy Chicago, who have variously stated they chose their art careers over motherhood (Brady). Every woman should have the right to choose whether or not to have children, but the statements of these artists perpetuate the masculinist idea that women cannot do both and, most damagingly, also devalue the creative and empowering potential of experiential knowledge that maternal thinking can engender (Liss, *Feminist Art and the Maternal* xix). Johnson finds that artworks offering alternative views of mothering to those prevalent in mainstream visual culture can increase a new mother's sense of wellbeing by allowing new conversations to occur outside of medicalized care and the judgment of peer groups (3).

Clayton began ARiM on a private and personal scale to counter the exclusions she felt as a mother artist by returning to familiar ways of working. In doing so, she “directly engages the devaluation of carework by framing motherhood as a valuable site, rather than an invisible labour, for exploration and artistic production” (van Cleaf 452). During the period of her three-year residency at home in motherhood, Clayton posted on her website about her practice and was contacted by many women in similar situations. Thus, since 2015, she has made available on her website the materials required to undertake an ARiM—a manifesto, business cards, and the website itself—through which mother artists can connect with others across the world. These physical artefacts of work constitute a personal and political statement and connect mothers to their professional identities even within the domestic space, where caring and professional roles compete.

Clayton's model of residency—as well as other support networks and artworks she has developed, such as her collaborative performance, *Two Itinerant Quilters* (2015)—is based on ideas of maternal ethics (Liss, “Lenka Clayton's Maternal Economy” 128). Liss writes that it is in enacting this “loving respect for the labour of others” (128) that Clayton's work is linked to a tradition that includes Ukeles's ground-breaking work from the 1970s. Ukeles maintenance works focus attention on the repetitive, invisible labour of mothering as well as the work of “nurturing and maintaining natural and psychic life systems [and] the undervalued labor of people who keep those systems alive” (Liss, *Feminist Art and the Maternal* 44). This focus on labour exemplifies philosopher Sara Ruddick's belief in the need to strip away the idealization of the mother and metaphors of mothering as well as D.W. Winicott's ideas of “ordinary devotion,” wherein ideologies of motherwork

and the selfless sacrifice of the mother are described as the very banal work that ensures the preservation of children (van Cleef 452). In her foundational text Ruddick describes how the reflective practice of motherhood—with its regular, repetitive, and cyclical work—structures our thinking and holds that maternal thinking can, in fact, be creative and empowering (22). These modes of working and thinking may alleviate the anxiety and stress related to women’s sense of individualized success or failure in the project of motherhood (Douglas and Michaels 5; Littler 5).

Collaborative feminist art practices of the 1960s and 1970s were deliberately “democratic, supportive and anti-hierarchical” and sought to break down patriarchal structures of art working and gendered workforces (Adams). In her article “Looking from With/In: Feminist Art Projects of the 70s,” in the *Outskirts Online Journal*, Australian artist Jude Adams describes her participation in the collaborative practices of the 1970s women’s liberation and women’s art movement (WAM) as “an exciting, intense and empowering time.” She says working with groups of women formed “an implicit critique of the figure of the heroic male artist who is central to traditional art history.” Although much of her work depicts the private, domestic sphere of a mother’s life at home and the “transformative potential of mothers’ quotidian experiences” (Freney), at the same time, she was active in “consciousness raising groups, WAMs and feminist collective projects that place value on conversation, connectivity and women-to-women relationships” (Adams).

Despite feminist activism in the arts in the 1970s and beyond, exclusions and discriminations are still experienced by mother artists, as concluded by a 2017 Australian survey, “Culture of Silence: Arts Parents Accepting, Rejecting or Adapting to, an Unfriendly Workplace,” by Jessie Scott, Nina Ross, and Lizzy Sampson. The survey of artist parents, of which over 90 per cent were women, found that access to galleries, studios, and arts opportunities were limited for carers of children. Furthermore, the respondents reported that they “were immediately excluded from a huge amount of networking opportunities.” The survey also added the following: “Despite a lack of availability and access, most of the respondents said that they did not experience a lack of desire to make art after having children. In many cases, they were finding ways to adapt their parenthood to their practice and vice versa” (Scott, Ross, and Sampson).

The isolation of motherhood is further exacerbated by exclusions from professional and creative practices, such as those mentioned above. When I became a mother many of my peers seemed to assume I was dropping out of the art world. Today, my best friends are the mothers of my sons’ friends. One is a meteorologist, the other a Spanish teacher. We may initially have had little in common, but what we do have in common dominates much of our lives. These women are what Rebecca Tardy calls my “back-backstage”—we wait in

each other's wings to listen, advise, pick up the pieces on any topic, and speak openly together about taboos that may not be shared elsewhere (Tardy qtd in S.A. Johnson 245). Together, we constitute an "intimate mothering public, a forum through which women gather experiential information and practical support." Such places "are particularly useful for thinking about the meaning-making practices and learning experiences that occur during intimate online and face-to-face interactions" (S.A. Johnson 247).

It was not until my eldest son was around thirteen that I found similar support from arts industry peers, when an old art school friend who had recently had a baby initiated a "lounge room studio," a kind of a mums' group for artists. These evening get-togethers were important and valuable as a means of support, as we worked on our own small artworks while mulling over our joys and travails in maternal work. This group inspired the Fight for Self (FFS) forum that took place in Adelaide in 2017 and invited mothers as well as artists and curators to respond to the question "What are you fighting for?" The responses were later manifested as a mind map shown as part of the exhibition, *Good Mother*, at the Central Gallery in Adelaide in 2018. This collaborative work was "driven by an agenda to make visible the experiences of mother-artists, the work itself is a site of creative empowerment that is both democratic and supportive in its creation and conceptualisation" (Lane). The forum was a lively, intergenerational conversation about the bias against mothers in the art world and finding collective and collaborative solutions. But by the time the FFS mind map work was shown, I had drifted away from the lounge room studio mums' group. It was too late for me. While the other mothers compared colicky babies and hours of sleep (or not) per night, I was often absent, standing on the side of a soccer pitch watching tweens gallop about or driving teenagers home from work. Intimate mothering publics, face to face and online, attract women who are going through the same problems and milestones together. Our mother identities and concerns change as our families grow up and we seek out women who are encountering similar shifts. Connections that value and recognize the changing nature of maternal identity are beneficial for mothers in a society that still idealizes motherhood and simplifies mothers' experiences.

Today, women may have more opportunities than ever before to find intimate mothering publics, where we can make meaning of maternal work and learn from one another's experiential knowledge, without even leaving home. So many mothers today make connections online—via Facebook, mummy blogs, special interest blogs, and other forums—that there is now evidence for the "momification of the internet," as mothers incorporate digital media into their daily lives at a more and more intimate level (van Cleef 449). Sociologist Kara van Cleef describes mothering blogs as "real time manuals of motherhood, detailing both how to do motherhood as well as how to interpret

the shifts in identity that accompany it” (449). Mothers are using these online platforms to share their experiences with one another to create more democratized models of knowledge and expertise.

A good example of how such networks are beneficial to maternal wellbeing can be seen in researcher Alison Mayne’s study of how connectivity can alleviate isolation and loneliness. Her study shows how members of an amateur crafters’ Facebook group support each other and “highlights how both the acts of making and of sharing making online contribute to participants’ sense of positive wellbeing” (Mayne). By sharing images of their textile works, the members of the group receive “positive strokes,” which improve their self-esteem and link them to a community of makers with shared interests (Mayne). But aspects of women’s online networks replicate patterns of patriarchal culture in the real world. The crafters in Mayne’s study, and the women seeking and offering advice on mummy blogs, often adopt a self-deprecating tone, which “extends constructs of feminine non-competitiveness and non-technicality” (van Cleaf 456-57). Although this self-deprecating tone may constitute a form of care among community members, it is stereotypical of women’s culture and femininity, and undermines the abilities of group members to have agency and authority in the real world (Morrison 38).

Ruddick’s description of a mothers’ group remains relevant for online groups—a “mother’s group is a set of people with whom she identifies to the degree that she would count failure to meet their criteria of acceptability as her failure” (21). Yet the relative anonymity of the Internet means women may be more open discussing taboos and perceived failures online than in face-to-face groups (S.A. Johnson 241). Importantly, the structuring of behaviour of the mothers’ group, as well as the stereotypically feminine self-deprecating tone, is not present in Clayton’s ARiM model—a model that gives mothers agency to develop and participate in a residency within motherhood on their own terms, supported by the noncommercialized resources available on the ARiM website. Women set the parameters of the residency as well as its duration and outcomes, and although it is like participating in a kind of virtual network, the residency is not solely reliant on Internet connectivity. Although continuing one’s art practice is often essential for the wellbeing of mother artists, other mothers may also benefit from the artworks that emerge from this process. Johnson finds that when new mothers are invited to discuss artworks that explore alternative experiences of maternal femininity they open up to discuss otherwise taboo topics, such as loneliness, boredom, and ambivalence, without fearing the judgment of peer groups (C. Johnson). Thus, it is essential that mother artists have the means to articulate their experiences of motherhood, which so often counter the flattened versions of motherhood that proliferate in popular visual culture (Douglas and Michaels 7).

Although it is clear that online connections have benefits for many women,



the maintenance of these networks may also have detrimental effects. As was noted in the 1980s by Ruth Schwarz Cowan, carework is closely linked to a society's prevailing technology, and now "the latest implements in care and housework include the screen, network, and social media platforms" (van Cleaf 455). It has long been claimed technology will alleviate the time spent working, yet the opposite seems true for many mothers, who bear increasing loads of shadow work. Although the Internet is a useful resource in many ways, not least in sharing taboo topics and concerns with supportive anonymous others, digital work is still work (Gregory 3). Many scholars believe mummy blogs and Internet groups may constitute carework, being unpaid and seemingly motivated by love; others, however, warn that the constant necessity to check in and be caring is an increasingly unmanageable economy of care, in which mothers must always "keep an eye on their networks as part of their caregiving work" (van Cleaf 454).

Mothers must also manage the physical, behavioural, and cultural effects of our digital work hours. For example, the new term "brexting" describes the practice of texting while breastfeeding, a practice that has been criticized for its perceived effects on infant development (Malcolm). The idea that mothers endanger their children's wellbeing through their Internet connectivity may be used as a backlash against the new possibilities for mothers' connected, collective empowerment. A cartoon by Michael Leunig published recently in Melbourne's *The Age* Newspaper motivated mothers to take to social media to express their outrage at its stereotyping of their Internet use as harmful to their children. The image depicts a woman so focused on the screen of her smartphone that she does not notice her baby has fallen out of its pram. Feminist author Clementine Ford writes that the cartoon amounts to "condescending judgement" and that most of her screen time, and that of other women she knows, is for work and for connecting with other mothers for support (Ford qtd. in "Leunig Cartoon Criticising Mothers").

Mothers' online behaviours stand out compared to other Internet users (van Cleaf 451). The very thing that draws women to these intimate collectivities—sharing, supporting and commenting—make them susceptible to marketing and monetization by Internet corporations and advertisers. Although these mothers overwhelmingly use the Internet to gain support from online connections, their online activities and real-life spending habits have been targeted and have generated profits for viral content mills that make money from clicks on their sites (Dewey). This reality problematizes the carework undertaken on online platforms, whose operators may denigrate and undermine maternal work through constant advertising and exploitation (Dewey). At the same time as researchers celebrate the democratization of maternal knowledge, targeted advertising—visual media that idealizes particular forms of maternal femininity—constantly tells mothers they lack

the skills, means, and materials to mother effectively.

Clayton's residency structure in ARiM is revolutionary compared to other online platforms. Hers is an open structure that women can adapt to their own mutable and diverse circumstances. There is no jury, no selection process, and no marketing. Reinstating the mantra of second-wave feminist artists, it is a platform that recognizes the political act inherent in mothers bringing their private labour into public awareness. The Internet has certainly been instrumental in the accessibility of Clayton's model, as it has grown from a small, individual practice used to alleviate her own obstacles to practicing her art in motherhood to having over seven hundred women across the world participating in their own residencies since 2013 (Liss, "Lenka Clayton's Maternal Economy" 128-29). In an interview, Clayton says, "The big part of the residency is reminding people that whatever their circumstances are, they can still have their own agency" ("Dialogues"). Feeling empowered, or having agency, within one's mothering and art practices is important in the maintenance of maternal health and wellbeing.

I am not a sociologist but have approached the problem of mothers' isolation and connectivity from the perspective of a mother artist who has now been working in this sticky milieu for over sixteen years. It is this experiential, nonexpert approach that is validated by online communities and intimate mothering publics. Yet mother artists still find their carework is disdained and their maternal work is seen to preclude them from making serious art. For me, the most useful, caring, and revolutionary model in making art from within motherhood has been Lenka Clayton's (ARiM). It is this model that has allowed me to reimagine the domestic as a novel site for art making and to begin to reconcile my roles of mother and artist. In producing artwork that embodies my maternal experiences, I contribute to growing field of visual culture that questions, critiques, and challenges the idealized images of motherhood perpetuated in mainstream visual media.

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## Care/Giving

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### Artist Statement

Opening the creaky door to my room with a laundry basket balanced on one hip, I walked into the room and plopped the basket down on the bed. Startled by the noises, my infant daughter woke and started crying. I had forgotten that she was there.

Lost in my own thoughts, I had momentarily wandered from my constant stream of thoughts about her. Has she eaten recently? When was her last diaper change? Is she happy? Becoming upset? In need of a nap? Children make themselves hard to forget—they have endless needs. Like a baton in a relay, someone must always take the responsibility for care.

“Take a baby, leave a baby?” my husband jokingly asks as he hands her to me so he can Zoom into a meeting. Yes, I’ll take her. And I’ll leave her when it’s my turn to work again. Especially in this time of quarantine when we’re both working from home and childcare isn’t an option, we care for one another by trading off Baby.

These images depict mundane everyday moments of caregiving. Using personal family photos as a starting point, I create line drawings with an image transfer process. The drawings are then painted in watercolor. Much like the way memories become muddled over time, the process used imperfectly replicates the images and introduces visual noise.



“Care/Giving #1” (2020), image transfer with watercolor paint, 7.5x5.5”, photo by the artist



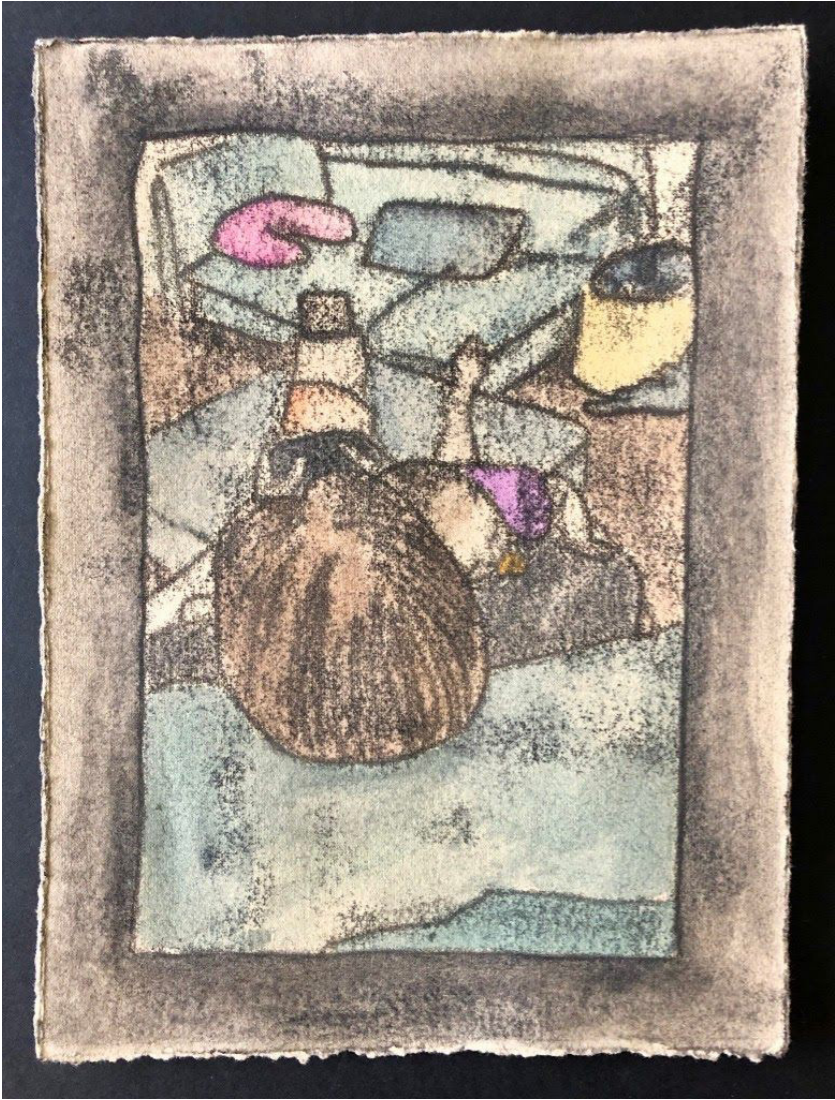


“Care/Giving #2” (2020), image transfer with watercolor paint, 5.5x7.5”, photo by the artist



“Care/Giving #3” (2020), image transfer with watercolor paint, 7.5x5.5”, photo by the artist





“Care/Giving #4” (2020), image transfer with watercolor paint, 5.5x7.5”, photo by the artist



## Professional Challenges to Women as Educators and as Mothers

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*This article explores the dynamic between the professional roles of women working in early childhood education and their maternal skills and identities. This dynamic reveals a blurring of the boundaries between motherhood and career, which have similar requirements to provide protection, care, and concern. This study sheds light on the perspectives of mothers working in early childhood education regarding their personal and professional lives. It highlights not only the conflicts raised and prices paid by the women and their children but also the extent to which female educators bring their profession home with them, including their theoretical and practical knowledge. These women continue to act as educators at home, but the demands on them are multiplied in the private sphere, where they are also mothers. Moreover, the demands they place on their children can also be influenced by the private domain, making this relationship complex and conflictual. Oftentimes, the private life and children of a female educator are seen as significant aspects of the “business card” she is expected to present to the world in order to gain respect in her professional life. Specifically, this article explores how female educators who are also mothers experience the relationships existing between the professional and personal realms.*

### Introduction

#### *Private and Public Spheres*

Hannah Herzog claims that the idea of two separate spheres of life—public and private—existing in isolation from each other is based on cultural assumptions. Each sphere has its own set of principles, social functions, and goals. According to this understanding, the public sphere is intended to meet

economic and political needs; it is based on the principles of rationality, practicality, competitiveness, and utilitarian connections. Relations are primarily contractual, formal, and identified with masculine qualities. In contrast, the private sphere is perceived as intimate and conducted according to the principles of reciprocity, compromise, concern, and emotions. It is identified with feminine traits. The private sphere is associated with traditional rules of behaviour, whereas the public sphere is identified with modern codes of conduct and enjoys greater power and prestige. This distinction reflects a gender-based dichotomy in which the private sphere is perceived as the realm of women and the public sphere is seen the realm of men. There is a prevailing social assumption that women's development both within and outside the family unit is contradictory and requires sacrificing one or the other. Thus, the entry of women into the labour market conflicted with the social expectations of their domestic role (Herzog; Pasta-Schubert). The literature on academic motherhood discusses the dilemma of choosing the best time to start a family, since both an academic career and motherhood require a large time investment (Dickson).

According to Luce Irigaray, women need a social existence separate from their role as mothers. However, Venitha Pillay claims that the distinction between these two life spheres is fundamentally incorrect because it reinforces the designation of intellectual work to the masculine realm, and Anat Pasta-Schubert suggests women investigate how the knowledge to which they are exposed in the public sphere colours their private world. Through surveying a group of female educators, the current study describes their perceptions of these two spheres as well as their relationship to them. Hence, this study aims to investigate how the public sphere influences the private lives of these women and how the private sphere shapes their public, professional ones.

### *The Private Sphere: Motherhood*

Donald Winnicott promotes the concept of a "good enough mother," who adapts to her children's active lifestyle and their needs, and gives them a solid emotional basis that enables them to interact with the world. Moreover, he asserts that maternal care in infancy and early childhood is a necessary condition for mental health. In other words, the good enough mother helps her children develop and fulfill their potential. According to Edna Katzenelson, a good enough mother controls feelings of frustration about her children's demands without turning those feelings against them. She further instructs mothers not to impose their own needs or agenda on their children but to focus on their needs. Thus, these psychologists place the children as the central subject in the family relationship and see the mother as an object bestowing love and care (Pelgi-Hecker).

***Blaming the Mother***

Our perceptions of so-called good mothers are not the result of experience or in-depth examination, and there is little connection between them and real life. Rather, our views are a matter of faith and religion; they have their own life and internal logic (Warner). In modern culture, the mother figure is responsible for her children's proper development and their ability to love and cope with the world. According to this view, many mental disorders stem from not having good enough mothers (Peronni). Linking children's developmental difficulties to deficient maternal care can cause educated and intelligent women to see themselves as inadequate mothers who carry the blame for their children's imperfect behaviour (Ladd-Taylor and Umansky); researchers define this as "working mothers' guilt" (McCutcheon and Morrison). Thus, many mothers who have been influenced by psychoanalytic theory blame themselves for failing, in their own view, to meet the challenges of motherhood (Birns and Hay), despite their awareness that ideal motherhood requires unreasonable self-sacrifice (Stone).

Ayelet Waldman criticizes the myth of the good mother and calls herself a "bad mother," but she admits that if women had not internalized this image of the good mother, they would not write so many articles, books, memoirs, and blogs on the subject. For example, Adrienne Rich in her book *Of Woman Born* describes a period in her life in which she was haunted by the stereotype of the "unconditionally" loving mother and by the visual and literary images of motherhood as the highest form of identity.

***The Good Mother–Bad Mother Dichotomy***

In the prevalent societal image, a good mother is altruistic, patient, loving, devoted, well groomed, and cheerful; she puts her children's needs before her own. Even if she works outside the home, her children, not her career, are the center of her life (Coll, Surrey, and Weingarten; Katznelson; O'Reilly). According to Shiran, a mother who feels this mythical image of the good mother hovering over her silences her self-awareness. The impossibility of the attempt to realize the ideal of the good mother causes women to feel they are missing out on life, and when they realize at mid-life that the ideal is impossible to achieve, they do not have the tools or means to change it. May Friedman finds that daughters consistently portray their mothers in either in very positive terms—such as loving, supportive, and strong—or in very negative ones, such as they never provide the warmth and care that the daughter expects and needs.

Molly Ladd-Taylor and Lauri Umansky argue that in modern society, ordinary women are held up against the images of the perfect or the bad mother, and this comparison leads to blaming mothers who do not live meet the standards of the ideal mother. The authors compare mothers' guilt to air

pollution and argue that women who distance themselves from this guilt can breathe more freely. To avoid such guilt, Cynthia Garcia Coll, Janet L. Surrey, and Kathy Weingarten suggest that women should not accept the cultural marginalization of motherhood. They argue that a more varied image of a good mother should be created. Rich asserts that when a woman achieves maternal power, the patriarchal institution labels her as evil, but a bold and courageous mother who gives her daughter a legacy of creating her own destiny and having faith in herself is actually a good mother. Martina Dickson's study of academic mothers finds that children who see their mother succeed at multiple tasks are more likely to perceive her as a role model. Tova Hartman Halbertal's study of mother-daughter relationships in orthodox religious cultures notes the challenge mothers face in preparing their daughters for life. Becoming a so-called good girl in more orthodox environments necessitates suppressing her individuality, as it may jeopardize her place in their culture. Fiona Green finds that mothers debating how to raise their children must be able to negotiate between the institution of motherhood and their experiences as mothers. Some oppose living according to the patriarchal image of a good mother, whereas others use their respected social role to raise their children's awareness and criticism of various forms of oppression and challenges. . defines good mothers as those trying to find internal balance.

### ***The Connection between Motherhood and Early Childhood Education***

The concept of “kindergarten” developed in parallel to social perceptions of women’s place in society. In particular, the feminist-ideological approach of “spiritual motherhood”—which saw women as possessing special, feminine abilities in raising children—claimed that women can best contribute to society and realize themselves as caretakers and educators for young children. The teachings of pedagogue Johann Heinrich Pestalozzi and Friedrich Fröbel, founder of kindergarten, contributed to the concept of spiritual motherhood. Their theories were based on the perception that alongside therapeutic physical activity, it is important to emphasize children’s social and moral education. Therefore, children need educated women to provide them with institutionalized education. Women who worked as preschool teachers in Fröbel kindergartens were part of an educational revolution that affected women’s education as well as children’s education. The teachers received pedagogical training according to Fröbel’s teachings, alongside a comprehensive curriculum including science and philosophy studies. This cultural revolution was fuelled by women’s aspirations to acquire higher education, a profession, and the means to support themselves in a field in which their status was equal to that of men (Seaton). However, in modern Western society and in Israeli society (the site of the current study), early education has become an almost exclusively feminine profession, as educators earn low prestige and meagre wages



(Fishbein; Herzog). Nevertheless, female educators' desire for respect, recognition, and pride in their work has prompted them to establish professional organizations that contribute to their sense of professional pride and self-determination (Seaton).

### *The Public's Perception of the Teaching Profession*

Many people view teaching as a profession most appropriate for women (Herzog). There are two common reasons for this. One is that the hours are convenient for women trying to balance their roles as wives and mothers with their roles as workers in the labour market. The second is that teaching is seen as an extension of the home into the public domain, and the skills required of teachers, especially establishing relationships with the children, are feminine skills. However, the widespread perception that education is a nondemanding profession and that teachers have a lot of free time—enabling women to easily fulfill their roles as wives and mothers without conflict—is not supported by the facts (Fishbein).

According to Herzog, the view that early education is related to the private sphere damages its status. Teaching is often treated as a job rather than a profession (Walden). It is not uncommon for teachers to be referred to as babysitters. As shown by Ditzia Maskit and Naomi Dickman, novice teachers' descriptions of the paths characterizing their entry stage into the teaching profession indicate there is a need for them to receive recognition from the “clients”—that is, parents and the wider community—of education. Similarly, Tsvia Walden states that these clients of education are not aware of the professional side of education, and this leads to professional and personal difficulties affecting those entering the field of education.

## **Research Aims**

This study aims to explore the experiences of women in the teaching profession. It will provide a stage for the voices of women who, until now, have been the objects of research but not active participants in it. It considers the relationships between the roles of mother and educator, as reflected in their professional experiences—a subject which has not yet been examined in depth.

## **Methodology**

### *Study Population*

The study population included twenty-two mothers who teach in kindergarten or in an elementary school. The interviewees are in heterosexual marriages. They range in age between thirty and sixty. All of the interviewees have two to four children between the ages of three and twenty. All of them live in the



central regions of Israel and hold teaching certificates and bachelor degrees in education from a recognized college of education in Israel. Half of the interviewees also hold a master's degree. Their years of teaching range from seven to twenty-two years. At the time of the study, seventeen of the interviewees worked in kindergartens. Of these, six taught children between ages three and four; five taught children between ages five and six; four were special education teachers; and two were substitute teachers. The other five taught first or second grade in elementary schools.

### ***Research Tool: Semistructured Interviews***

Semistructured interviews were selected as the data collection tool due to their suitability as a basis for interpreting the field of study, as outlined in the research aims. Furthermore, semistructured interviews are appropriate for collecting data in feminism-based research, since they allow for an examination of ideas, thoughts, perceptions, memories, and experiences using the words of the interviewed women and not the researcher's terms (Reinharz and Davidman). At the end of each interview, I asked the interviewee whether there were other issues she wanted to raise. This enabled those who wished to expand the discussion to issues that had not yet been raised. I also asked each interviewee to sign an informed consent form, giving permission to use the content of the conversation in this research.

### ***Data Analysis***

This study combines a thematic-analytic approach with analytic reading, according to the listening guide method developed by feminist researcher Carol Gilligan. Gilligan's listening guide involves four readings of the text of an interview. Each reading deepens understanding in a different way and leads to the next reading. The first reading focuses on the interviewee and the context from which she is speaking. The second reading focuses on relationships that arise in the content of the interview. In the third reading, the researcher examines her own sensory memories from the interview, based on notes taken during the interview and afterwards. In the fourth reading, analysis focuses on the language of the interview, especially metaphors and repeated words and phrases.

The insights raised in the subsequent, attentive readings for each interview were analyzed by dividing them according to the themes raised repeatedly in each interview and across all of the interviews. From these themes, the researcher can deduce the meanings that various topics have in the world of the interviewees and the ways that they construct their world. The advantage of this method of thematic analysis is the creation of general, overarching meanings that arise naturally during the analytic process instead of being predetermined by the researcher (Strauss and Corbin).

In the process of selection, the categories were narrowed, and a “category tree” was designed (Shkedi), which schematically represents the final categories and the relationships between them, as discussed in the results section.

## Results and Discussion

In this article, various relationships were noted between the interviewed women’s identities as mothers and as educators. The interplay and reciprocal relationships between maternal and educational roles are strongly present in the lives of the interviewees. This is expressed by one interviewee, Revital<sup>1</sup>: “These two worlds are really mixed up... Sometimes I catch myself asking, ‘Wait a minute; from which one am I talking right now?’”

The findings reveal the mutual influences and complex relationships between the role of mother and that of early childhood educator as well as their impacts on the identity of women working in education. Below are the categories identified, whose meanings will be discussed in detail:

1. The impact of female teachers’ educational training on their maternal identities and functioning;
2. The implications of working in the education system on coping with the maternal role;
3. The need for disengagement as a mechanism to help female educators connect to their maternal role.
4. Variation in the intensity and management of emotions regarding the women’s own children as compared with their students; and
5. Role duality as a symbol of the maternal and professional roles.

### The Impact of Female Teachers’ Educational Training on Their Maternal Identities and Functioning

Female educators acquire knowledge and professional tools during their training in colleges of education and throughout their years on the job, including in ongoing training courses, staff meetings, and more. The findings of this study indicate that the impact of this education extends beyond the professional sphere. The acquisition of theoretical and applied tools in the field of education and child development affects female educators’ perceptions regarding their maternal role and their functioning in the private sphere. In Revital’s words: “All the teachers at the training course said, ‘We leave here with pangs of conscience, with feelings of guilt... At home, you’re checking all the research you’ve been exposed to.’”

Most interviewees said that the knowledge they acquired in their professional training is often applied in their roles as mothers in the private sphere. This knowledge serves as a basis for examining their maternal functioning, even

before it becomes a basis for examining their professional work—the purpose for which it was originally acquired. Revital's quote indicates mother educators point an accusing finger inward, leading to guilt and frustration. Acquisition of knowledge on subjects related to early childhood becomes intertwined with the mother's sole (or almost sole) responsibility for her children's education. It also reflects the myth of mothers' magical control over their children's development and functioning.

Theoretical knowledge, tools, and content meant to be integrated into their work are often first and foremost used with their own children, as expressed by Sivan: "Whenever I was exposed to some theory, or some kind of way to work, ... I would try it out first with my own children before I used it with the kids in the kindergarten." Female educators are involved in an internal dialogue about the relationship between their professional knowledge and their functioning as mothers.

It is interesting to note that this internal dialogue even goes on among women who oppose mixing the professional and the personal, and try to create a boundary between them. They, too, assess themselves and their children in light of their professional experience and knowledge. As Betty explained, "If I learned about problems ... I looked at my children to see if they had these problems.... If they talked about giftedness among children, yes, I tried to see this in my children. It affects me, even if it doesn't always cause me to change my actions."

Opposition to using professional knowledge and tools with their own children may prevent these mother educators from taking action, but they still think about it. This indissoluble interface between the roles of mother and educator sets the stage for a powerful inner struggle about when to bring professional knowledge into the home and when not to. This struggle is ongoing and evolves over time. Kokhi explained that over the years, her internal dialogue has become more relaxed and transformed from a conflict to an informed position: "Today, at school, I bring in what I think is appropriate, but at home I am more liberated. I used to be a nag.... Today I know how to brush things off." Professional and maternal experience contribute to Kochi's confidence and enable her to examine critically the knowledge she acquires and to decide what she will use in her professional life and what, if anything, will make its way into her private life. Thus, as women gain experience and maturity, they feel more secure in their own knowledge and in their ability to adjust the use of their professional and theoretical knowledge. This represents an ability to filter what is perceived by the women as positive, enriching, and liberating.

## **The Implications of Working in the Education System on Coping with the Maternal Role**

Fishbein discusses teachers' frustration at the lack of recognition and payment for the work they must do after school hours. However, this research finds that lack of payment for these hours is not the most significant problem. More problematic is the intrusion of the public sphere into the private sphere. In the participants' assessment, this harms their relationship with their own children. Their free time becomes an illusion, and the emotional burden harms their functioning in the private sphere. Contrary to the popular myth, early childhood educators do not work limited hours.

When Shilat, a kindergarten teacher, discussed doing work-related tasks after school hours, she did not even mention that she does them without pay. The main difficulty she raised is emotional and relates to her own children: "If I have to write an assessment or evaluation ... organize the room, prepare a lesson, I come to the kindergarten in the afternoons and do it. This is at my own children's expense." She expressed doubts regarding her choices and called the overflow of work into the private sphere "unrealistic," but she did not indicate any intention to change her habits.

Although teaching is widely perceived as an undemanding profession that does not conflict with the roles of mother and wife (Fishbein), the interviewees asserted that the fact that their career is an extension of their maternal role creates difficulties in their ability to function as mothers after school hours. In the words of Ilanit: "It comes at the expense of my children ... It's frustrating ... to get home and not be able to tell a story to a child ... You do it all day at the kindergarten, but at night have to make an effort to do it with your own child." Ilanit's frustration is clarified by Irit, who explained that not only are the teaching skills and nurturing abilities of female educators and mothers similar but so are the energetic resources required for the two roles: "A mother who works in an office comes home and she is not a secretary anymore; she is a mother.... From the second I get up in the morning until ... nine-thirty at night, I am a mother.... At some point it becomes exhausting.... Some days, at the end of the evening, I think, 'I did not say one nice word to the children today.'"

Irit felt exhausted by the requirement that she is a mother all the time; she thought her children suffer because she is not emotionally free to function at home in the same way as a mother who works in an office. Female educators carry a burden of frustration and guilt about their functioning as mothers. This begins with physically bringing tasks home from work and continually affects their lives and their children, which exposes the myth that teachers have especially convenient work hours.

## **The Need for Disengagement as a Mechanism to Help Female Educators Connect to Their Maternal Role**

Female educators searching for a practical way to better integrate their two roles find that they need ways to disengage from their work. Dana noted that an afternoon nap has a significant impact on her ability to function as a mother and does wonders for the home atmosphere: “The whole schedule of songs and stories, science and math, acting and drama ... It’s a storm.... So, I come home and rest ... I stop ... You could say that I take a few deep breaths, then I am the mother of this house.” Dana compared her afternoon nap to breathing air that allows her to continue functioning at home.

Betty said that she also needs a few minutes to herself after work, but her partner expects her to start caring for their children as soon as comes home. To illustrate her difficulty when entering the messy living room where their three children are, she used a metaphor from his partner’s work as a pilot: “It’s like if you come in after you’ve worked on a plane all day, found the problems, made repairs, then you come home, open the door, and whoop! You’ve got a plane in the living room.” Betty had to explain to her partner what she goes through emotionally by making a parallel to his life in order to highlight what often remains invisible to him and others.

It is interesting that the women did not note the opposite effect: they do not feel their level of professionalism is impaired or affected by the fact it requires similar skills or energies as motherhood.

## **Variation in the Intensity and Management of Emotions Regarding the Women’s Own Children as Compared with Their Students**

In this section, I present the significantly different ways female educators manage their emotions in the private and public spheres. Deganit explained that despite her unshakable love for her kindergarten students, her conduct with them is professional and not motivated by maternal feelings: “In the kindergarten, you do things professionally.... Of course I do love the children.... But there are no maternal feelings there. Being a mother makes me a completely different person at home.” Emotions can be a positive part of relational systems, as long as people are able to manage them and separate them as necessary. Thus, the use of maternal skills in kindergarten or school does not interfere with teaching in the education system, whereas the use of professional tools in the home often goes awry due to the intensity of feelings associated with the private sphere.

Deganit’s sentiments are reinforced by Dana, who claims that kindergarten teachers require professional skills not used in the home: “If a kindergarten teacher comes to kindergarten convinced that her maternal instinct is a major

part of her work, then she is a bad kindergarten teacher. Education is a profession. You have to know how to educate children!” Dana’s opposes the comparison between the roles of teacher and mother because, in her view, this undermines the professional value of the teacher.

Parallel to the discourse on the appropriate and professional regulation of emotions in the education system is the inability to properly channel them at home. Erit said that when facing a crisis with her own children, she forgets her professional tools. Emotions overcome her, preventing her from applying the knowledge she utilizes in the public sphere when advising parents of her students: “When there is some problem with my children, I’m not moved by theories. I do not think about them. I do not remember them.... I feel like a shoemaker walking barefoot.” It seems that in routine situations, the professional skills of female educators cross the boundary and can be integrated into the private sphere, but in times of crisis, the intensity of emotions overwhelms their professionalism. When dealing with students, they can make rational decisions regarding when to express affection. When necessary, they can separate their feelings from the situation, and manage in a professional manner. Therefore, the term “maternal feelings” in relation to a female educator’s work is imprecise language. I propose we should instead use the term “tender feelings” when interacting with children who are not part of a woman’s past, present, and future life as a mother.

### **Role Duality as a Symbol of the Maternal and Professional Roles**

Women who accept Emilia Peronni’s perception that mothers are responsible for all their children’s actions would likely agree that in reference to mothers who work as educators, the term “good enough mother” should be upgraded to “good mother who is a role model.” Women who object to Peronni’s conceptualization are aware of this social perception but refuse to be held captive by it.

Betty shared a story about successfully advising the mother of one of her students. Following this, she felt she had to explain to her young son how the child of a kindergarten teacher should behave: “When I finished the conversation, I told him: ‘I just spoke with a mother from the kindergarten.’ Then he said to me, ‘I don’t give a shit about the mother from that kindergarten.’ While I still felt I was wearing the ‘crown and mantle’ of being an educator, my son, who is supposed to be my ‘diploma’ talks this way?” Betty felt her son’s behaviour could confirm or negate the aura hovering over her. His words were so troubling and threatening to her that she imagined they could pass through the closed telephone line and undo her accomplishment: “If a parent from kindergarten hears this, he will say that I cannot educate my own children” and will not resist his own children for her kindergarten class.

Betty's story again illustrates the crossing of public and private spheres. It is important for her son to understand that his behaviour reflects both her ability to educate her children and her ability to educate the students in her classroom. The parents who register their children for her kindergarten are looking for a good teacher to educate them properly. If they find that her children are not well educated, they will think she will not be able to educate their children. Therefore, I suggest that the perception of the equation good children = good mother needs another factor: good children = good mother = good educator. If a woman's children deviate from the accepted norm, she feels that she has failed twice: first as a mother and then as an educator.

Some women undergo an internal process so that in some situations they succeed in making a separation and in other situations they apply means to cope with personal difficulties as part of their professional responsibility to assist their students' parents. Shilat's story shows that today, when she is more secure in her motherhood and her reputation as a kindergarten teacher, she is freed from the need to present her children as perfect: "I give this message to the parents that not everything is because of us. There are also traits children are born with. This is something that I did not do in the past.... My children had to be perfect."

The complexity and difficulty of upholding both roles and connecting the public and private spheres reveals a reality that is far more varied and multifaceted than what has been presented in previous literature on teacher-mother relationships.

### **Summary, Insights, and Conclusions**

The study examines the relationships between the professional (public) and the personal (private) spheres among mothers working in early childhood education in order to hear the voices of these women and to understand the complex feelings and prejudices associated with the ostensibly natural connection between these two roles. The current study confirms some of the findings from previous studies, disputes some of their conclusions, and contributes original results.

The female educators interviewed in this study discussed the difficulties they have in separating their identities as mothers from their identities as educators. The separation between their personal and public spheres became blurred. This finding is consistent with and enriches Herzog's claim that the public views the teaching profession as an extension of the private sphere because of its requirement for so-called feminine skills. One primary contribution of this research lies in its assertion that female educators create an inverted space by applying their professional skills at home.

Judith Warren explains that identities in postmodern times are complex,



multiple, dynamic, and not easily defined or recognized, since postmodern identities are negotiated through social interactions. In light of this, it seems that the women I interviewed have not succeeded in defining their separate identities. However, despite this complexity, their identities as mothers and educators have a special relationship that contains both pride and conflict.

The participants also raised the issue of the invisible work they do after school hours. Female educators do return home relatively early, but they bring home tasks that they must complete during their supposed leisure time in the private sphere (Fishbein; Herzog; Walden). According to the participants in this study, applying the same skills in the public and private spheres can lead to mental exhaustion that harms their ability to function as mothers, even when they are at home and have completed all the tasks from the public sphere. They struggle with feelings of guilt for not being able to use what Herzog defines as “feminine” skills with their own children. These guilty feelings stem from the perception that a good mother portrayed is always loving, patient, nurturing, and dedicated; she places her children’s needs before her own (Coll, Surrey, and Weingarten; O’Reilly). The interviewees explained they can often express these traits almost naturally with their students, but sometimes their energy reserves are so depleted that they cannot do so with their own children. The times that these female educators are with their children but are mentally and psychologically unavailable to them are conceptualized in the present study as the “myth of convenient hours.” The findings of this research disprove the prevailing, yet factually incorrect societal perception (see Fishbein) that elementary school and kindergarten teachers have a lot of free time and can easily fulfill the roles of educator and mother. The quotes from the interviewees express their feelings that the shadow of their kindergarten work follows them home, undermining their mental stability. The difficulty begins with physically bringing tasks from the public space into the private one, which leads to dual mental coping needs. First, interviewees are unable to continue to act as they did previously with their children in the public sphere, and second, they experience pangs of guilt at being unable to use their skills optimally.

Some interviewees said that resting in the afternoon helps them to separate their role as a kindergarten teacher from their role as a mother, as it positively influences their mental wellbeing. This physical and mental timeout enables them to successfully deal with the vicious circle of performing these two roles.

The participants also emphasized that the love they feel for their students is not the same as the love they feel for their own children. The interviewees clearly differentiated between their maternal feelings towards their own children and their affectionate feelings towards their students. I propose separating this dual identity according to intensity of the emotions experienced and suggest that use of the term “maternal feelings” in the public is imprecise

and should be replaced with the term “tender feelings.” Separating profession and maternal feelings may lead to significant changes in perception, to a reexamination of the nature of the role, and, hence, to several changes. The first change is dismantling the natural link between teaching and raising children (Fishbein; Herzog). If it is more widely understood that female educators do not behave the same way at home and at school, because the intensity of emotions at home is qualitatively different, it is possible to break down this apparently natural link. A second change pertains to the assumption that the inferior status attributed to the teaching profession stems from the belief that it is the same as motherhood and does not require special skills or knowledge (Fishbein; Herzog). Once we differentiate between maternal feelings and affection, and raise awareness that the profession of early education is not a direct or natural continuation of motherhood, it becomes obvious that even if some of same skills are required, considerable professional training is needed to become an educator in a given field.

Even this separation between the roles of motherhood and education is based on their duality. Therefore, the need to use maternal skills with students and to use professional tools with one’s own children is not questioned in most previous research but is seen as self-evident. Given this duality of the maternal and professional role, the interviewees felt they are supposed to portray to the world the abilities of a good mother, who is, therefore, worthy of educating students in the school system. Gilligan notes that society does not see a mother as a real person, only through the image of the ideal mother. According to Peronni, this is the image of someone who guides and shapes her children’s lives, and provides hope and security; she is responsible for all of her children’s actions. By connecting the works of Gilligan with those of Peronni, the current research offers a new contribution: it shows that the motherhood of female educators takes yet another step towards impossible realization. As with Gilligan, who says the image of the good mother is an illusion, this research shows that female educators feel they need to be seen as ideal educators and worthy of teaching students. Additionally, the female educators in this study expanded upon Peronni’s description of a mother as responsible for all or her children’s actions, in that these mothers see the behavior of their own children in the private sphere as proof that they are worthy of educating children in the public sphere. On this issue, too, a price is paid by their children, who are given the message, directly or indirectly, that they must behave as representatives of their mother as an educator.

It should be noted that some of the female educators, with maturity and increasing confidence, succeeded in freeing themselves from this burden of proof. Even then, they acted as educators and explained their insights to their students’ parents in order to relieve them of the responsibility for their children’s behaviour or skills. The professional challenges facing a woman who

is both an educator and a mother are at the junction where her two life spheres intersect and separate. At this intersection are the points of friction, suitability, and conflict that a mother who works as an early childhood educator continually experiences.

## Endnotes

1. Pseudonyms are used to protect the anonymity of study participants. Hebrew translations were provided by academic language experts.

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SHERRI ROSE

## Are You Looking for Madame or Maman? Role Playing the French Professor and the Mother in Academia

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*Since becoming a parent, the last six years have been the most exhilarating and exhausting in the personal and professional spheres of my life. My heart was brimming with love following the birth of my first daughter while my brain was sending me stress signals to begin preparing for a tenure-track position in French at a small liberal arts college the next month. After the birth of my second daughter, and a year marked by injury, illness, and applying for tenure, I began to feel a growing sense of urgency to connect with other academic mothers.*

*In this article, I share my personal journey as a female academic and mother with the aim of contributing to a wider discussion about maternal health and parenting in the academy. I reflect on the tensions originating from the roles I inhabit as both professor and mother—roles that have appeared to be at odds with one another from my job search through the tenure process. I have come to realize that I am happiest when I am able to see the various facets of my identity overlap in ways that invite knowledge and experience to nurture each other. I have sought to make my dual roles as professor and parent visible to my students by narrating various experiences raising my daughters in a bilingual home, by bringing my daughters regularly to campus, and by living in France together as a family while working with study abroad programs.*

### **Vignette: The Job Interview**

It was a three-and-a-half-hour white-knuckle journey. I was driving a little blue car through the falling snow amid SUVs and semis on my way to the second of four campus interviews. Too stressed to embrace the beauty that the



white snow brought to the gray flatlands of northern Indiana and southern Michigan, I gripped the steering wheel tighter, my thoughts spiraling like panicked snowflakes caught in the Arctic wind. The road before me felt unsettlingly familiar. Commutes had been an irritating part of my routine as a visiting assistant professor, though not as troubling as the signs of psychological burnout I was harbouring after multiple seasons of my life lost to the job market. Thankfully, the support and flexibility of my colleagues had enabled me to teach my French courses Monday through Thursday. Each Thursday night for three semesters, I had eagerly driven two hours across Indiana to spend the weekend with my husband, who was finishing his doctoral coursework, and each Sunday afternoon I had reluctantly driven the two hours back. The hours I had clocked on the road piled up in my head like wobbly pieces of a Jenga tower. I often spent that time behind the wheel worrying about my lack of job stability and strategizing about future career plans. But that chapter of our lives had ended, and we were once again living in the same city as he began preparing for his comprehensive exams. I remembered how the setting sun was always framed in the rear window on my return drives Sunday, the flamboyant symbolism causing my heart to sink, slipping into hibernation with a silent scream—wait, just wait, it’s only temporary. It is amazing what the mind can push the body to accomplish with the beguiling words that the pain is ephemeral, that life will get easier.

Focus on the interview. Should I practice explaining my research interests again? Would I succeed in connecting with the students during my class demonstration? How would I get through all those interviews without someone noticing? Yet even though it terrified me, the thought that I was not going through the campus interview alone also grounded me: my baby was with me. What did it really matter if I did not get the job? I was four months pregnant with my first child and was about to find out if “ghost baby” was a boy or a girl. I tried to channel my excitement and the second trimester surge of energy I was feeling towards the gruelling two days ahead. My identities as professor and mother already felt at odds. Was it misleading not to mention I would be giving birth one month before starting this tenure-track position? I was putting my mind on display during the interview—hoping my body, especially my swelling belly wrapped snugly in the last pair of dress pants that fit, would pass unnoticed. I knew that having only a month to recover from childbirth, move to a new state, and prepare classes would be rough. But I am a hard worker, and I felt so lucky for the timing: a July due date was the last month of my pregnancy window for that summer. Anyway, who knew if my job situation would be any more stable the following year? I was fortunate to have a visiting position rather than to be adjuncting. My husband and I now lived in the same city, an emotional triumph in itself, and interviews had been going well. Maybe interviewing with an all-female French department would

work in my favour, I thought, as my focus returned to avoiding sliding into the semi in front of me.

### **Merging the Parent Track and the Tenure Track: Building Bridges**

Since becoming a parent, the last six years have been the most exhilarating and exhausting in the personal and professional spheres of my life. My heart was brimming with love following the birth of my first daughter while my brain was sending me stress signals to begin preparing for a tenure-track position the following month. In spite of the anxiety and guilt I experienced early on when leaving my daughter for campus each day, my perspective on the world had changed. I felt deeply joyful for the opportunity to continue doing what I had loved most for the past decade—teaching French language and literature—while also growing in my new role as parent. In some ways, these sentiments resembled the highs and lows of the emotional roller coaster I rode while pregnant and on the job market. The future course of my life was wildly out of my control, yet I was able to tap into a sense of tranquility in thinking about the new life developing in my body as I journeyed from interview to interview. Nearly six years later, I now have a second daughter who is two, and a year ago, I received the favourable news regarding my tenure application. The internal and external pressures in my daily life have only continued to increase from year to year, and many days, I sense that my precariously balanced schedule might collapse if one more item is thrown on top. Despite these tensions, I have also developed more confidence in the coping strategies I have learned, the most basic of which is to be present in the moment, attending to each day with gratitude.

In this article, I reflect on the rewards and challenges I face as a female academic and parent sharing my time between professional development and family life. In particular, I consider why maternal health and wellbeing in the academic workplace appeared to me as elusive ideals towards which I seemed always to be grasping only to emerge empty handed. I will discuss the pressures that parenting places on a dual-academic couple, my desire to see university policies put into place that more fully support motherhood, and several positive experiences I have had in which my roles as parent and professor have been able to intertwine. What does it look like to play the roles of both the professor (“Madame,” the term my French students use when addressing me) and mother (“Maman” to my daughters), and how can I be authentically engaged in each of them?

To be honest, I have been so completely immersed in the day-to-day struggle of staying afloat in academia and caring for small children that, until recently, I had not been able to give myself the time or space to process how I have been approaching these roles. It is certainly ironic, though perhaps also fitting, that

this issue of maternal health and wellbeing coincides with a global health pandemic during which the boundaries between the roles that mothers assume in their families and in their jobs have imploded. COVID-19 has brought to the forefront a real sense of urgency to the issue of maternal wellbeing, as many mothers have taken on additional responsibilities of childcare and education while also working from home. Andrea O'Reilly has aptly noted that during this pandemic, the work and stress mothers experience have risen exponentially yet remain largely invisible. Sharing our experiences as mothers, though, is one way to render mothering more visible. The reflections in this article predate my experiences teaching remotely during the coronavirus pandemic. On many levels, however, they echo similar emotional responses of frustration, isolation, and uncertainty—all of which I have surely struggled with during the past few months of confinement. My hope is that this narrative resonates with the experiences of others and contributes to a broader conversation regarding maternal health and wellbeing.

In response to the sense of isolation I felt during the months directly after the birth of my second daughter, I decided to seek out the stories of other mothers in academia. I began spending my evenings and nursing sessions reading the narratives in Elrena Evans and Caroline Grant's *Mamma PhD*, Rachel Connelly and Kristen Ghodsee's *Professor Mommy*, Lynn O'Brien Hallstein and Andrea O'Reilly's *Academic Motherhood in a Post-Second Wave Context*, and Mari Castañeda and Kirsten Isgro's *Mothers in Academia*. This encounter with an entirely new community of women's voices struck a chord with me and facilitated a surprisingly strong connection with women whom I had never met. It also reminded me that I have had several wonderful female role models as department chairs, dissertation committee members, and directors of study abroad programs. The encouragement from these women inspires me to engage with my students not just as a professor but also as a woman and a mother. Rather than silencing the female and maternal sides of my identity while on campus, I strive to give them a voice. This may be in the form of relating my lived experiences to literary or cultural topics the class is discussing, bringing my daughters to certain events on campus, or even bringing the family to France with me while I work with study abroad programs.

This is not my default mode: it is much easier for me to model the professor than the mother. The professor is cleaner, respected, and completely dedicated to their discipline. Indeed, the professor mystique seems to vanish when a baby is thrown into the mix. After all, the stereotypical image of the professor—tucked away in the office on campus or at home, reading books, delving into important research questions, writing or grading papers—never involves multitasking with a breast pump, a last minute outfit change due to a baby spitting up (oh no, not the beloved tweed jacket), or an interruption to

deal with a poopy diaper. I find that a male professor sharing pictures or anecdotes of his children renders him more human in a way that does not damage his intellectual persona but rather gives it a warmer hue. When a female professor does the same, however, there is a greater risk: her priorities are perhaps silently called into question, as if she could not inhabit both the ivory tower and the domestic sphere. These insecurities still linger in my mind, a generation after the women I view as role models fought their battles. Clearly, there is still more work to be done in normalizing mothering in academia. Yet by making both my roles visible and by being open about the tensions between them, I am affirming their joint value.

My ability to thrive professionally, however, has been dependent on the support of my partner. He is the “anchor parent” who stayed home with my first daughter the year I began the tenure-track position before we secured a place for her in daycare. Knowing that my baby was being well cared for in our home during my first months at the new job was integral to my establishing a sense of emotional stability and also to my ability to focus on my work. Over the past few years, when one of the girls was sick and had to stay home from daycare, he was the one to lose hours of work on his dissertation. We are fortunate that he will teach in the fall as a visiting assistant professor in the English department at my college after having adjuncted for several years while finishing his dissertation, although we are still unsure if a tenure line will open up and if he would be hired. He extended his years in the PhD program beyond his original plan to care for our children with limited support from his department (a doctoral fellowship the last summer and fall before his defence). He successfully defended his dissertation last December just before his PhD clock expired. Although his dissertation director was encouraging, there was no discussion within the graduate school about lengthening his timeline due to caregiving responsibilities. I am grateful for his sacrifices but anxious about his future job opportunities (within the academy or outside of it) in our rural setting. With student loans to repay, it would not be a viable option for him to stay home with the kids, nor is it what he desires. Perhaps, in the end, we will look back and be grateful that we were not both working towards tenure while raising two small children at the same time. Nevertheless, I find myself wanting more flexibility for accommodating work-family issues from both sides: the college where I work and the graduate school with which my husband was affiliated.

Family-friendly university policies needed at my workplace span paid maternity leave to creating nursing-friendly spaces on campus and including changing tables in bathrooms connected to event halls. I was assigned to a shared office my first year as a tenure-track professor, and when I vocalized my need for a private space to pump, I was given a key to a maintenance closet across the hallway. Naturally, I found the idea of maintenance workers banging

on the door while I was in there to be extremely alarming. I ended up sharing my concerns with my two male office mates and was able to secure the shared office at noon each day to pump. One of my office mates was a father of four and very sympathetic, although sometimes I would have to remind him it was noon, which, of course, could be a little awkward. I would put my “Office in use—please do not disturb” sign on the door and would sit frustrated in silence when the occasional student knocked. There are still numerous changes to be made in shifting academic mentalities towards a more equitable and holistic vision of the professor-parent. When my orientation week training began with a nine-to-four day without any breaks—which led to an engorged mama because I did not want to rock the boat on the first day—I knew it was not organized that way out of malice: it simply reflected the expectation that we be free from family constraints. After several rounds of mastitis during that year, I have been more diligent the second time around and have even pumped once in an open office at the Toledo Opera during a daylong excursion with students. I believe sharing experiences is a good first step towards widening the conversation, although for change to occur, I recognize that I need to voice my concerns on my campus and advocate for more women to become part of the administration, as Connelly and Ghodsee suggest.

Although I do not feel that I have hit the “maternal wall” that Joan Williams describes (qtd. in O’Brien Hallstein and O’Reilly 13), I agree wholeheartedly with O’Reilly that the model academic is still expected to be unencumbered by family life (10). I received praise for the “good timing” of my second pregnancy, as my due date was just after graduation in May. Actually, it is true that I had tried to time it that way in order to avoid having a discussion with the provost about taking time off as a junior faculty member, since there was, and still is, no paid maternity leave policy in place. Financially, I did not have much of a choice, since my husband was still writing his dissertation and his part-time monthly salary adjuncting was only enough to cover the daycare tuition for one of our daughters. As a result, I sacrificed a summer of research and teaching. I have taught a summer class on campus or in France almost every summer except for the two during which I gave birth. In the end, research deadlines ran up against my pregnancy clock: I spent the last few weeks of my third trimester writing a book review seated on an exercise ball, and on my official due date, I was revising article proofs of a second project rather than giving birth (the baby emerged nine days later). At the time, I had never heard of the idea of asking for a year off the tenure clock; instead, I had already asked for and received a two-year credit towards tenure from my years as a visiting professor. Fortunately, I am at a small liberal arts college where the primary focus is on excellence in teaching, followed closely by professional development and service. This was also a deliberate choice on my part; the second tenure-track offer I received my last year on the job market came from

a Research I university. Teaching is my first passion, and I have seized the opportunity to teach and work with study abroad programs in France nine of the last eleven summers. Although I have a couple of publications in my field and I regularly present at national and international conferences, it is hard for me to imagine how I would have measured up to the publication expectations at a Research I institution while also being on the parent track. But determination can go a long way, and pursuing a different job would have led to a whole different set of decisions on my part.

Although the college where I teach needs to implement more family-friendly policies (as I imagine is the case with most small liberal arts colleges), I appreciate that family life is valued by students and faculty, in part as a reflection of its conservative, Christian mission. A few times each semester, there are even activities for faculty and their children: nature games in the arboretum; brunch with Santa in the dining hall; an Easter egg hunt at a sorority house; craft and film night for kids so parents can go on a date; and kids' night at the sports complex. Both of my daughters have participated in child research studies through the psychology department. My five year old absolutely loves being on campus and seeing students. We have had some special mother-daughter dates, such as attending free cultural events, including performances by an all-female a capella group from Zimbabwe and ballets put on by the student dance troupe. I make it a point to show her that campus is a place that her mother loves, and I even manage to give her little glimpses into what I do in class. For example, I recorded a short video in French asking her to point to various body parts. I then showed the video in my introductory French class to help the students review for their quiz. My students seem to light up when I share an anecdote about my family life, and I overhear them telling stories about other professors doing the same. I quietly acknowledge the presence of the voice in my head telling me it would be wiser to present the cleaner image of the professor unimpeded by family life. In reality, a surprising number of my male colleagues have large families with four or more kids. Yes, many of their wives stay at home, and although it does not impact their work days in the same way—I have not yet observed a male colleague sporting a pump bag or complaining of back pain or swollen ankles from pregnancy—I see that they are loving parents who make a concerted effort to be engaged in their children's lives. They, too, struggle with the work-family balance, which is why we need to be framing future discussions in a way that invites fathers into conversations on caregiving.

How does one strive towards balance among the messy chaos? And where does wellbeing fit into the picture? Anne-Marie Slaughter emphasizes in *Unfinished Business* that each person inevitably has a tipping point that causes their work-life balance to collapse. For me, this seems to be when I or another family member is sick for an extended period. The year following the birth of

my second child, I constantly struggled to stay healthy, and I could not seem to carve out the time to reintegrate the regular exercise routine I had established after my first child. I barely managed to squeeze in two months of physical therapy appointments for an injured arm and shoulder into my workday, already shortened by having the girls in two different daycares. I remember sitting through sessions of the TENS machine, which delivered small electrical impulses to my damaged muscles, while trying to read the novels I was teaching in class—all the while wishing that I could hook something up to my brain and jolt it back into focus. Ironically, the bicep tear and tendinosis were caused in part by the overuse of my arm while nursing and poor form while carrying a baby in a car seat between the house and the car.

The winter break did not bring me closer to that equilibrium I hoped to achieve. Between semesters, I worked on my application for tenure through pinkeye, a sinus infection, and a massive cold. That spring semester leading up to and during spring break, I fell prey to influenza, then to a sinus infection, and finally to a stomach flu. Is this simply the price one pays for mingling in three different germ pools—two daycares and a college campus—or is this more telling of an underlying fatigue and burnout from the psychological stress of being reminded each day that you cannot do it all, professing or parenting, the way you had hoped? I recognize that perfection is unattainable; I try to make realistic goals. I have become far more efficient than I was before kids, but I still struggle to let go of projects and limit my involvement, even when I know it is what I need to do to stay healthy. Fortunately, my arm has now healed, and I am back to jogging and yoga. In other words, some of the time I had been spending nursing, I now spend exercising. I still ask myself: What could I have done differently during the year following the birth of my second child? Would having had maternity leave or a reduced course load in the fall freed up the time for the self-care that I needed? Perhaps. But I did not feel that I was in a position to be able to ask for this, given that this was the year I was applying for tenure. Even if a campus-wide policy was in place, would I have felt encouraged using it? This is where the cultural shift in mentality regarding working and parenting needs to occur. Professors are rewarded for caring about their students, but what about caring for their families and themselves? How can we imagine these care models working together?

I know that I am happiest when I see the overlap between work and family—two spheres of my life that can feel at odds with each other. One way that I have been able to reconcile them is by speaking French to my daughters and observing their dual-language acquisition. This has been a fun way for me to bring my passion for language into our everyday family life. Although my husband and I are not native speakers, we have both committed to raising our daughters bilingual, each of us speaking solely in French to them at home. I



learn something new from my daughters every day in this context. I remember my joy when, at age two, my oldest daughter started making word connections between the French she was learning at home and the English she was learning in daycare. She would say a word in French and then in English, gleefully exclaiming “*même chose*” (same thing). Having had her in France with me during three summers when teaching and working with summer study abroad programs, and giving her the chance to interact with the students during social activities, has been memorable for all involved. In this way, not only do the students witness how a second language can be a dynamic part of family life, they also get to see a wider picture of their professor’s identity, which allows them to grasp more fully how knowledge and experience inform each other. Last summer, my family of four spent two months in France while I researched, directed a study abroad program, and enjoyed family-life adventures. We created many special memories, such as when we celebrated my oldest daughter’s fourth birthday with two of my students at a gelato shop in record-breaking heat. The ice cream was melting almost as fast as we could eat it. And as we sat there sweating with colourful birthday hats topping our heads and singing “*Joyeux anniversaire*” (Happy Birthday), I could feel my heart swelling—not due to the heat but to my recognition of another small victory in blending work and family.

### **Vignette: Leaving Campus**

I live only a ten-minute walk from campus; however, the year after the birth of my second daughter, I often asked my husband to pick me up at the end of the workday. My laptop, purse, pump bag, lunch sack, and coffee thermos were just too much to carry when I had to keep everything on one side of my body to allow the partial tear in my bicep muscle to heal. Although I felt in desperate need of exercise, when the little blue car—the same car I drove pregnant to the snowy interview years ago—would pull into the parking lot with my husband and two daughters in tow, a big smile would spread over my face. Then, the back window would roll down, and my eager three-year-old daughter would start screaming “*Maman! Maman! Maman!*” at the top of her lungs. Usually, these shouts drew the curious eyes of a student or colleague, and I would think of how odd it is to hear young children’s voices on a college campus. But these are my two worlds, and some days they blend together more harmoniously than others. When I would climb into the car, and my daughter would ask in her mixture of French and English, “*Maman, you travailler sur le campus? You enseigner your étudiants?*” (Mommy, you work on campus? You teach your students?), I would begin to tearfully laugh with gratitude for my daughter’s affirmation: I am both Madame and Maman.

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## Parenting Policies and Culture in Academia and Beyond: Making It While Mothering (and Fathering) in the Academy, and What COVID-19 Has to Do with It

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*For those of us involved in MIRCI, it is no surprise that being a mother in academia is often seen as a liability. In fact, Anna Young found that “no other industry has a higher ‘leak’ rate for mothers” than academia, and she surmises this is partly because “the upper echelons of the academy are still overwhelmingly dominated by men”—a cultural institution that historically has been “a place by and for men” (x). Recently, the COVID-19 pandemic has exacerbated these inequities in our workplaces. As a matter of maternal health and reproductive freedom, academic mothers must be considered in policies in academia. This article will examine necessary policy and culture shifts that can help mothers in the academy while also discussing personal and local decisions that can be made by those with institutional power that can immediately improve the conditions of mothers in the academy. Of course, we should continue to push for larger systemic changes—such as fair parental leave policies and quality as well as affordable universal child care that need to happen at a societal level—but until those developments are a given, we should work on the following steps, which will be expanded below: 1) Individual choices to not bifurcate our lives into parenting and scholarship; 2) reappointment, tenure, and promotion (RTP) decisions recognizing the importance of interdisciplinary and autoethnographical scholarship, along with enforcing policies and transparency around tolling or stopping the tenure clock and fair research productivity expectations; 3) tolling policies to account for the time needed for the parenting of young children, with options for being part-time on the tenure track or remote teaching possibilities; 4) local decisions to provide intentional community and friendship to parents as*

*well as dedicated space for breastfeeding mothers and children on campus; and 5) sensible scheduling. Our ultimate goal must be larger systemic changes towards parental leave and childcare that will grant the types of policies that will help all parents. In the meantime, we need to use everything we have to help our colleagues who are raising the next generation.*

For those of us involved in MIRCI, it is no surprise that being a mother in academia is often seen as a liability. Anna Young reports that “There is a consistent talent leak in the professorial pipeline,” because academic mothers are leaving even as the number women in the academy has more than doubled from 1990 to 2010 (ix). According to Young, 61 per cent of male professors are tenured, whereas only 43 per cent of women professors are. Furthermore, women account for only one-fifth of faculty positions but comprise 40 per cent of all “voluntary” departures, in which academic women leave prior to a negative tenure decision; a full 75 per cent of full professors are men (Young ix). Outcomes for mothers are even bleaker than they are for women; mothers who opt to stay in the academy are far more likely to be second tier—that is, they occupy adjunct and contingent faculty positions (Young x). Even more disturbing is the information that fathers fare far better than mothers in academia; far from a “baby penalty,” fathers receive an actual career boost (Young x). There is an evident mother penalty in academia, and the COVID-19 pandemic has exacerbated it. Maternal health is impacted by workplace and social policies that too often harm mothers and caregivers. Academia should be a champion of equitable worker practices, but all too often, the scarcity of jobs and unforgiving nature of the tenure clock and its timing do not actually allow mothers to find fulfilling and remunerative careers, despite their training and qualifications.

Until the COVID-19 pandemic, facts like those listed above were rarely highlighted; the age-old reputation of the academy being a masculine place still has teeth. Young’s finding of the “maternal leak” points to the fact that “the upper echelons of the academy are still overwhelmingly dominated by men,” and academia itself is a cultural institution that has historically been “a place ... for men” (Young x). It is unfortunate that it has taken a global pandemic and changing working conditions for academics everywhere for *The Chronicle* and *Inside Higher Ed* to start taking seriously the plight of academic mothers. I left my campus on March 10, 2020, knowing I would not be back for a while, but I never dreamed the pandemic would upend life as completely as it has for academe at large. We have the potential in this moment of a near universal health crisis to take stock and consider how to be better. Specifically, we need to consider what we should be doing for academic mothers and academic parents more broadly. Due to the current impact of COVID-19 on academic mothers, this article examines some ways in which the pandemic has

exacerbated and underlined the need for reform in academia. This article outlines the necessary policy and culture shifts that can help mothers in the academy; it discusses the personal and local decisions that can improve the conditions of mothers in the academy while waiting for larger systemic changes.

Most of the information regarding academic mothers' responses to the COVID-19 crisis in this article has been drawn from my survey about academic parents during the pandemic. Over the course of two weeks in early May 2020, 221 respondents, 216 of whom are mothers, responded to the survey. The desire to talk about the inequities for mothers in academia, particularly under the new crisis, was a welcome outlet for the many I was able to reach through various Facebook academic mom groups. The survey, which has Institutional Review Board (IRB) exempt status<sup>1</sup>, makes no claims of being a representative sample of academic parents. Of the respondents, 201 are currently partnered, with only seven being in a nonheterosexual relationship. Seventy-nine of the respondents are promoted and tenured faculty, and seventy-eight respondents are tenure-track faculty (not yet tenured). Twenty-eight respondents are in fulltime contingent or fixed-term (nontenure-track) positions, seven are part-time faculty, twenty are graduate students, and eight listed themselves as administrators. (Some did not answer this question.) The respondents come from every type of institution, but the largest majority (110) are from a large public institution. A total of 144 respondents, or 67 per cent of the sample, have a household income of over \$100,000 annually, and thirty-nine make between \$75,000 and \$99,999. We are clearly talking about a group of respondents with some privilege, yet their concerns and fears about their professional and personal lives under COVID-19 are palpable in their responses.

Despite the clear hurdles existing for women in academia (even prior to the pandemic), mothers are still making it. As Sara M. Childers writes, "There are far too many of us to anymore view it as impossible" (124). Young notes that motherhood can have benefits for scholars. The added responsibility of mothering, and therefore, the pressure to manage time well, is a necessity for mothers. There is evidence to show that mother-academics are actually better at time management and finding strategies that allow them to be even more productive after motherhood than before (Young viii). Mother-academics, such as Childers, Elizabeth Rose Gruner, Tara McDonald Johnson, and Venitha Pillay, just to name a few, note the importance of rejecting the bifurcation of the two roles—mother and scholar, body and brain. Instead, they advocate for the productivity that occurs when mothering is "inscribed" into their scholarship (Pillay 1). I myself can attest to the increased productivity of mothering on my research and writing; not only did I have to find ways to be more organized and fruitful, but I also found that I had more to say. There

was more at stake when I inscribed my mothering self onto my academic self. Still, as mothers we often deal with not only policies that fail us and our chance for success but also individual attitudes and a culture that fails to make room for the duality of our lives as mother-scholars. Since fully embodying both parts of that false binary is key to our success, we need to find ways to make being a mother and scholar simultaneously more doable, healthy, and productive.

Too often, the work of changing our culture (be that our department or university culture or the culture at large) seems far too insurmountable to take on, so we focus instead on the changes we can control individually. Childers suggests this leads to us “covering” our mothering selves inside our profession to make ourselves and others more comfortable (111). In addition to covering our mothering, we may also feel that we need to be superwomen—unimpeachable in our attendance to all of our duties and responsibilities, unflappable in a crisis (at home or at work), and productive to the point of exceeding all expectations so that we can have a “slam dunk” in our professional pursuit of promotions. Women (and other marginalized faculty) “believe that they must be twice as good to go half as far” (Castañeda and Hames-Garcia 272).

This need to “cover” our mothering has reached new heights for many under the pandemic. A swift and prodigious backlash erupted when Kristie Kiser posted her article, “Instructors, Please Wash Your Hair,” on *Inside Higher Ed* arguing that “the last thing that students need to see is their professional, highly educated professor falling apart at the seams” (par. 1). The comments rightfully point out that the burden of professional appearance falls disproportionately on women, particularly BBIPOC (Black, Brown Indigenous, People of Color) women, and Kiser’s article points specifically to the assumed horror of piles of dirty laundry in the background of a Zoom meeting and implies that a less than tidy home (which of course is far more likely to exist when multiple children also live in the home and require care) can lead to accusations by students and others of unprofessionalism. Zoom backgrounds can, of course, mask the reality of a mother’s home, but how can academic mothers be expected to function at full capacity when they are expected to participate in any number of “pointless” online meetings without childcare and any other type of domestic help during the pandemic (Willey). Respondents to my COVID-19 survey asked that institutions provide “flexibility with the nonstop web meetings” or recognize that due to the lack of childcare, not everyone will be able to easily meet via computer during normal business hours. Sorting through academic mothers’ responses to the pandemic, it becomes clear that most mothers, especially mothers of younger children, need childcare and domestic help to continue their work as mother-scholars.

Even with many challenges—more so in this historical moment—productive mothers in academia are not an anomaly. Many of us have exceeded by a long shot our colleagues’ productivity because we know better than most that each day is unpredictable in how it unfolds, so we must make every moment count. And we do. Mothers are among the least likely, in my experience, to hold onto largely false myths of needing four hours of uninterrupted time to really get any writing done, as I have heard some of my nonmother counterparts explain. Mothers know how to schedule and utilize time when they can, even in fifteen minute bursts, to get their research and writing done. We have learned how to manage our work lives in the same way we manage our home lives—with flexibility and grit and some good humour thrown in. Of course, the ability to reach this level of productivity is predicated on the notion that mother-scholars have some space and time of their own to work. Of the 221 respondents (not all of whom were research active prior to the pandemic), fifty-eight lost ten or more hours a week of research time, whereas fifty-three lost five hours of research time per week. The reasons for these losses are myriad and include more time spent on online/remote teaching and preparation, stress and lack of concentration due to pandemic worries, and the literal loss of lab access; however, the most clear reason for the loss of time for many had to do with loss of childcare coupled with homeschooling children and an increase in domestic labour. The most common estimate of the additional time spent on domestic labour, including cooking and cleaning, of the respondents was an additional five to six hours per week for sixty-seven respondents, eight to thirty hours for fifty-one respondents, and even more hours for thirty respondents. One of the latter respondents did not even know how many extra hours she spent on domestic labour: “God only knows. I spend my days in a nightmare of fruitlessly attempting to do my job, but I end up full-time taking care of the home and family” (Willey). A total of 154 respondents, or 70 per cent of the total sample, said they spend seven or more hours a week on new childcare duties they did not have before COVID-19, with the range capping out at over sixty hours a week. Although many mothers (especially prior to the pandemic) have succeeded in academe, the current conditions show that without real institutional and societal help, mothers may be facing insurmountable challenges working in the academy.

We make individual choices and changes to our work lives to accommodate our families. Although life will most likely never exist as we knew it before the pandemic, someday we will return our children to daycare and school, and we will teach and interact in person again. At that point, we can utilize individual choices that will help mothers succeed. We can learn that the binary of mother-scholar is false and that we are always both. We are not “heads on a stick” (Gruner 128), nor are we only embodied mothers, who are stereotyped to be “nature, feminine, bodily, irrational and wild” and the anathema to



scholars, who are seen to be “masculine, logical, and rational” (Childers 115). We are fully mothers and scholars, and many of us weave our maternity into our scholarship and our scholarly minds into our mothering. Some of us write while holding children. (My copy of *Mama PhD*, which I opened for the citation above from Gruner, is full of my son Isaac’s scribbles, who must have been about two the last time I used that book.) We might think while rocking babies and nursing. Or we might see a problem one of our children is having through the lens of our studies, or we might actually write our children into our scholarship. I have done all of the above. There is no question in my mind that being a mother has made me not only more productive with my time but also a better scholar, thinker, and writer. Furthermore, I believe I am a better mother due to my ability to apply my critical lenses to my mothering.

But these individual choices are not enough. I must note that even as a scholar-mother of older children, fifteen and twelve at the time of writing, who has many privileges in my job security and who enjoys a safe and comfortable home, I have had a terrible time concentrating enough to read and write under these pandemic conditions. Writing the revisions for this chapter, for instance, took about twice as many hours than is typical for me. I trust that one day, I will learn how to produce under COVID-19, and I also trust that at some point, we will open our lives again to others in a way that will feed our minds and hearts—professionally and personally. Right now, the spectre of the global pandemic, along with the global Black Lives Matter movement, is showing some of my previous calculations about parental policies in academe to be overly simplistic. Yet we must take what we have learned from this moment and then find a way to move forward.

I have had the great fortune to be involved with this group, MIRCI, and its sister, Demeter Press, as a member, presenter, writer, editor, and reviewer for almost twenty years. When I was building my case for my promotion to full professor, I looked for scholars doing similar work to list as external reviewers, some of whom are members of this organization. At some point in the promotion process, Andrea O’Reilly told me that it is our job, as senior scholars, to shepherd in the next generation of mother-scholars. Mother-scholars know that we did not get where we are alone. We also know that just because it might have been hard for us to make it, we should still strive to make it easier for the next generation. One of the projects of my feminism, of my mothering inside the academy, has been to create and run a faculty mentoring program on my local campus. In that capacity, I can do individual work (importantly, this work is supported by the administration, who gives me load to offset my teaching work) to help individuals, and that has value. But I can and do also try to effect cultural and policy changes that will make individual help less crucial. Our ultimate goal should be to create an academic culture that makes discussions about the “mommy track” as well as discussions

about the inequities mothers face in the system unnecessary, a thing of the past. I believe we are in a moment where we can truly see the weaknesses inherent in our system, so we can clearly look toward a future that will be more equitable for mother-scholars and other marginalized members of the academy.

Making the mommy track, with its “voluntary” separations and less academic success, disappear might actually mean first recognizing that parents of any gender should have parity in parental leave policies. We know that for women, biologically fertile ages coincide closely with the tenure clock (Loveday and Brander par. 2), which makes achieving both parenthood and success in the academy especially difficult for mothers. Mothers, of course, must almost always bear the children, so they cannot “cover” their parent status in the same way that fathers and nonbiological parents can. Still, if we know that generous parental leave helps mothers recover from birth, bond with their children, and get healthy (read: not sleep deprived, not in pain, and not suffering from postpartum depression), then we know it will help them succeed. If parental leaves cover not only job security but also guarantee pay, then economic stressors are less of a factor on families, enabling everyone’s wellbeing. As Emma Kate Loveday and Susanne Brander write:

A number of studies demonstrate the numerous benefits associated with paid leave for both men and women. Sufficient leave paves the way for a smoother transition back to work as well as better outcomes for parents and their babies. Paid leave reduces infant mortality by up to 10 percent, and women are less likely to experience depression even later in life. Children receive higher rates of immunization and increased breastfeeding duration. Paternity leave is becoming more common, *and men who take paid leave continue to share in child-rearing responsibilities years later, changing the long term dynamics of their families as well as shaping their children’s chances of succeeding in school.* (my emphasis, par. 13)

Generous maternal leave should be a given in our push for better policies that enable both maternal health and academic mothers’ professional success, but we must work towards parity in parental leave for fathers and other caregivers as well. With generous parental leave, fathers, as well as other nonbiological parents, can take their parenting duties seriously without fear of reprisal or economic uncertainty. This move, if taken seriously by all parents, will actually shift the larger gender dynamics at play in many families that delegate childcare and domestic duties primarily to women. If both mothers and fathers regularly take leave, if it becomes the norm because it is financially and professionally feasible, eventually it will not seem like an anomaly, as if it is something only (struggling) mothers do. When it is advisable, and when

there are two parents, parental leave can be staggered, leading to even better childcare coverage for the first part of the baby's life and giving peace of mind to the entire family. Creating a norm that allows for generous parental leave for all parents legitimizes every parent's role in their child's crucial (and often comparatively difficult) early life.

We might have a few knee jerk (and somewhat justified) responses to the idea of expanding parental leave to all parents of any gender. First of all, we might assume that mother-scholars who are partnered are more likely to be in equitable partnerships. Academic mothers are by definition highly educated achievers. Considering the time they put into training and the vagaries of the academic job search, we might be forgiven for assuming that if they are partnered, they would only agree to a partnership that places an equal emphasis on both partner's careers and on the requisite sharing of household and childcare duties. But even feminist partnerships can be thrown onto shaky ground with the birth of a child. Only the biological mother's body had to carry the infant for nine months, and only the biological mother's body can literally continue to feed the baby, if the parents are committed to breastfeeding. Plans to somehow equalize childcare duties can take a back seat to survival in those early months, particularly when the infant might be bonding more with the biological mother than the other parent. Additionally, if the partner continues to work without leave, she or he might not understand how gruelling time at home alone with a baby or toddler can be, and briefly taking over during an evening or on the weekend never fully relays the challenges of the primary parent. My own early parenting is a clear case of testing the bounds of equitable and feminist parenting practices. My partner and I are on the same page now, but in the early years, especially prior to the birth of our second baby and despite our joint commitment to feminism, all was not equitable or well. One of my first personal essays was written in response to this period in our lives ("Anger in the House").

But this is far from my personal story alone, and if anything has laid bare the problems of inequity in partnerships, especially parenting ones, it is the COVID-19 pandemic. A recent article from *The Guardian* shows that "Working mothers have been able to do only one hour of uninterrupted paid work for every three hours done by men during lockdown" (Topping par. 1). Of the 201 respondents to my survey who are partnered, 115 of them believe their partners are only doing somewhere between one and four more hours of domestic labour per week, and 33 of them report no extra labour by their partner. Showing more involvement with childcare, eighty-one partners are reported to be doing somewhere between seven and fifty more hours per week of child care since COVID-19, with only twenty-seven partners showing no change, and fifty-eight performing between one and four hours more. Compared with the 70 per cent of respondents who report spending more

than seven extra hours per week on childcare duties since COVID-19, approximately 36 per cent of partners are perceived as really picking up extra parenting duties during this crisis.

Understandably, then, tensions often run high in households that outsourced domestic and childcare duties or where slight gender disparities were ignored are now all too obvious as well as all too damaging to the careers of academic mothers. In response to the open-ended statement “Please share your biggest concerns about the impact of COVID-19 on your home and family life,” twenty-seven respondents explicitly mentioned the unfair division of labour inside their homes. One respondent astutely noted her concern about a new pattern developing in which “we will develop new norms for division of labor that will be hard to undo in the future” (Willey). Another participant wrote the following: “Gender inequities in childcare and domestic work have become more apparent and more unequal. My concern is that because I took on this burden at this time, it sets a precedent for these inequities to continue” (Willey). Labour issues also cropped up throughout the text-based answers to other questions as well; for instance, when asked if they were caring for adults in their home, one respondent quipped, “Does an inept husband count?” (Willey).

Providing parental leave policies that equally impact all parents can seem troubling to biological mothers who often assume most of the care for a newborn. A long-standing concern that is unfortunately being proven more clearly during COVID-19 is that academic mothers are not only falling behind, but some men are actually getting research boosts during this crisis, which supports the idea that men taking a leave can actually harm mothers. If men, as the anecdotal evidence suggests, actually use their leave to create more research, then it hurts academic mothers who, by comparison, actually need to use their leave to recover and be a primary caregiver.

A quick Google search found four articles on the effects of COVID-19 on research productivity by men and women. The realities of the coronavirus shelter in place orders have meant that domestic and childcare labour have increased for many and that professional labour—particularly in the realm of teaching remotely but also in the form of increased meetings and email—has decreased the amount of hours mother-scholars have for research. As mentioned previously, 111 respondents indicate they have lost five or more hours of research per week. Reasons for the loss of productivity vary greatly; some lack space at home for uninterrupted work and have limited library or archive access, whereas others have had to stop their research for the foreseeable future completely due to lab closures. Of course, many of these issues will be cited by men as well as women, but we know that women are being disproportionately affected. Megan Frederickson writes the following:

Even if women split childcare duties evenly with a supportive partner (like mine), we are still competing with many men who do way less at home. One study of scientists found that men were four times as likely as women to have spouses who work only part-time or not at all. And that was before more women than men lost their jobs because of COVID-19. (par. 9)

Job precarity for mother-academics is exacerbated under coronavirus, and the precarity is further problematized by decreased productivity in relation to men. In another study that demonstrates that women are producing fewer single-authored scholarship journal submissions than men under COVID-19, Colleen Flaherty notes some of the reasons:

It's not that men don't help with all this, or that they're not also individually overwhelmed by work and family life. But women already juggled more domestic and affective, or emotional, labor with their actual work prior to the pandemic. Female academics, as a group, also struggled more with work-work balance, as well: numerous studies show they take on more service work than men and are less protective of their research time, to their detriment. The coronavirus has simply exacerbated these inequities by stripping away what supports women had in place to walk this tightrope, including childcare. (par. 10-12)

It is not surprising, then, that academic mothers are producing less research than most academic men right now, but it will be detrimental to their career trajectories—everything from successful tenure and promotion cases, merit pay increases, and promotion to full professor status are on the line. The effects of the coronavirus on family life are not equal. How can they be when the conditions before coronavirus were not equal?

Yet I will continue to argue for parental leave for all. It is unfortunately true that men will not utilize leave in the same way as women. However, as I have explored elsewhere, one of the best and only ways to break down the reproduction of gender-based family roles is through modelling gender role changes to children through parenting them toward intentional equity (“Raising Men”; “Mothers and Sons”). Not only will making parental leave possible for everyone equalize problems around discrimination by gender within the family and at work—lending authority to every parent, biological or not—it will also allow fathers to bond more closely with their children, understand the labour of parenting, and create more equitable partnerships in the home. This will not happen in every case, nor will it happen quickly, but it is the standard we should be striving to attain, even if some men will take advantage of the situation.

After parental leave is over, childcare is probably the next most important concern of all new parents. We all have and know stories of poor childcare

options, especially the absurdly expensive ones. Although I have heard many purport that universities should provide childcare for their faculty, staff, and students, and have even seen evidence of fruitful partnerships between universities and their academic programming to provide childcare, I am not sure it should be each individual campus's or university's responsibility to provide an actual childcare facility, even though when that works, it is an excellent option. Subsidies for childcare could be a more fruitful avenue to consider. Still, when it comes to childcare (and parental leave), I believe the culture at large should change to make these universal benefits. Keep in mind that the lack of childcare help is one of the primary drivers in women's lack of research productivity under COVID-19; therefore, we absolutely know that quality and affordable childcare is a must for academic mothers. Although the academy needs to change, so do many other industries. The academy is (not surprisingly to many of us) almost archaic in its lack of parental policies (Loveday and Bander par. 7), and this is only emboldened by lax laws in the United States. Canada does quite well, but the United States continues to fall far short, despite the recommendations by the United Nations:

Approximately 50 percent of OECD nations offer at least 14 weeks parental leave, as advocated by UN International Labor Standards since 1952. In contrast, the United States is one of only four countries (also Liberia, Papua New Guinea, Eswatini) lacking mandated leave for new mothers. Our Canadian neighbors qualify for 35 weeks of paid leave, with an optional extension. In Europe, parental leave is a minimum of 14 weeks to a year or more, funded by employer/employee contributions similar to those supporting U.S. unemployment benefits. (Loveday and Brander par. 3)

Some universities do offer paid leave of some type, but these leaves are far from standardized and often fall embarrassingly short where I work in the United States. Cultural momentum for systemic change, not just in academia, is needed for this problem. If we remove the economic and professional uncertainty created by the lack of parental leave, as well as the expense and uncertainty of quality professional childcare (which includes certifications and better pay for childcare workers as well as subsidizing or making universal these services), we will have solved a large part of the parenting crisis for parents of young children not just in the academy but in the society at large. If we do this for all parents, we will begin to remove the liability of mothering in favour of a more equitable and culturally endorsed ideal of all parents taking responsibility for their children, fortified by help from quality daycares. The COVID-19 crisis has shown us that we must address our lack of leave and universal child care systemically and, beyond academia, the need for strong public health policies and universal healthcare.

Until we have universal childcare and universal, and generous, parental leave, universities should feel pressure by senior faculty and administrators (who might be mothers and parents) advocating for their colleagues who are still in need. The recruitment and retention of faculty would no doubt improve with better parental policies; they could cut down on the expensive costs of job searches and turnover that occur when (mostly) mothers decide to leave academia in favor of a better work-life balance. Additionally, universities can create and standardize policies that make lives easier for parents of young children. One prominent tool is the ability to “toll”—or to put a stop or stay on the tenure clock for a year or more—for family and health issues. Universities that provide this option understand, at least at the policy level, that some flexibility is needed for parents who are also on the tenure track. Policy is necessary, but culture must also shift to make mothers feel that tolling without reprisal is possible. I must mention a disturbing trend I have noted in my own university system, and there is some research to support it: men are more likely to be significantly helped in research productivity by tolling for the addition of children, whereas women are hurt. Consider the following situation in the discipline of economics:

The policies led to a 19 percentage-point rise in the probability that a male economist would earn tenure at his first job. In contrast, women’s chances of gaining tenure fell by 22 percentage points. Before the arrival of tenure extension, a little less than 30 percent of both women and men at these institutions gained tenure at their first jobs. The decline for women is therefore very large. It suggests that the new policies made it extraordinarily rare for female economists to clear the tenure hurdle. (Wolfers par. 8)

And this problem has, again, showed up in COVID-19 tolling policies. Many faculty members are still hesitant to use tolling policies for fear that more will be expected of them when they do submit their next file. At my own institution, I have recently been told of additional hurdles being created to achieve tolling status under COVID-19 rather than fewer. As was noted by several survey respondents, “adjusted performance expectations” could be much more helpful than tolling, since this is time no one will ever get back, and stopping the tenure track will simply delay pay raises and job security.

The answer to these problems is not to remove tolling, but to change the reappointment, tenure, and promotion (RTP) culture, which is no small feat. RTP reviewers must be instructed about the importance of the policies, how they work, and what reviewing without prejudice means in light of such policies. Institutions and departments should consider reviewing their expectations for fairness, especially considering current challenges. Culture is hard to change, so strong leaders, especially senior faculty who have been



through the ringer and often without the benefit of tolling, must lead the way. As more women and mothers break through the “Associate Professor Glass Ceiling,” a phrase coined by Mari Castañeda and Michael Hames-Garcia, the culture will continue to shift as newly minted women and mothers will begin making personnel decisions. In the meantime, union representation and strong advocates can be called upon to help demonstrate this unfair disadvantage.

There are other policy changes that universities are uniquely situated to offer, such as truly flexible scheduling options for faculty who are dealing with childcare issues. I do understand that faculty who are not parents, or who are not actively parenting, should not be asked to always keep schedules that do not fit their lives in favor of priority scheduling for parents, but I have found at my institution that when faculty sit down together to address scheduling needs, we all try to accommodate one another. As Jim Larimore notes in his work on mentoring, “people, especially very bright and accomplished people, are more comfortable speaking about each other than they are with each other” (228). Scheduling from a distance allows tensions to build, whereas being in the room together seems to create more willingness to cooperate. It is not a perfect process, and my department is small (seven people), which helps enable our cooperation. If such a meeting is not possible, then chairs and others in charge of making the schedule should consider scheduling requests based on the needs parents of young children. It is also possible (though not always easy), to use Doodle or other scheduling software to try to take into account a small group’s actual availability when it comes to committee meetings and the like. As much as possible, we should try to be considerate of one another’s lived lives away from the academy and try to make meetings work for everyone, even using Zoom or other teleconferencing technology to facilitate them. In fact, if one silver lining has come out of COVID-19 for academia, it is that we have now seen the possibilities concerning how we meet—remote meetings are doable and often quite productive. Other important flexibilities the academy can offer have to do with creating dedicated space and time for breastfeeding mothers, showing understanding when it comes to missed or curtailed meetings and offering a sympathetic ear when needed. All of us in academia have now been forced to understand that sometimes our jobs really can be done from home; perhaps more remote teaching possibilities for academic mothers and parents could be extended even after the risk of the coronavirus is no longer with us. Individual efforts towards sensible scheduling can go a long way, but they should not be where our efforts end.

Feminists should heed the call for more collective action in our personal and professional spaces, as well as in larger society. Senior scholars and administrators have work to do, including advocating for new policies and

fostering a culture that does not discriminate against mothers, especially mothers of young children. I have seen progress locally, but we are not there yet, and much work is left to be done. I spent five of my six years on the tenure track pregnant or lactating. A tolling policy did not exist with my first pregnancy, but it did with my second. That is progress. However, I still work with faculty members who are reluctant to utilize our tolling policy for legitimate reasons, such as seeing it backfire in departmental RTP, where balloters are expecting to see more work for the extra time; we have work to do. As for parental leave, I was able to take six weeks of paid leave for the birth of my first child (paid because although I had not built up enough sick leave, I was in the sick leave pool, another important tool). With my second, I took eight weeks because his was a C-section birth. I needed a doctor's note for the operation and the payment of the additional two weeks. My family was able to plan the births to best utilize summer break, and we did not suffer financially, so this is a start. My husband (a professor at the same university) was only able to take off a couple of days with each child, and he used his sick leave each time. This was the norm, and he did not challenge it. We need to go further.

Even if my husband and I could have each taken the recommended fourteen weeks of paid leave, and even if I had been able to toll with my first child, new parenthood would have still been a family-based and individual struggle for each of us. Beyond policies and culture, we need to recognize that networks, communities, extended family, and friends are necessary to get us through the stresses of parenting, particularly the shock of the early years. (My children are now in middle school and high school—the stresses are still there, but their quality, and my life, is different.) As my children have grown, I have needed to rely on the support of friends and family to help me through the difficulties they present. As a mentoring coordinator, I am constantly thinking about ways to provide the types of support faculty (junior and mid-career, tenure stream and contingent) need on my campus. The model provided by Ellen Daniell about her problem-solving group of women academics in *Every Other Thursday* seems promising, though not everyone can find a group that will voluntarily meet for peer mentoring every two weeks. More informal types of connections can work as well. Thinking about the eagerness with which young parents in the academy reached out to my 2017 MLA panel about parental policies in academe, I am reminded that no matter how far we (hopefully) will continue to move forwards in what we can provide academic parents, new faculty, new parents, and academics not aware of MIRCI and its excellent work still need to find places to have these conversations. Facebook groups like Tenure-Track Moms, websites such as *akidemiclife.com*, and more intentional cohorts of women working in relational mentoring practice to provide safe spaces for discussion and support (Hammer et al.) can all provide needed help until society catches up with parents' needs.

While we are waiting for and working towards fair parental leave policies and quality as well as affordable universal childcare, we should work on the following steps: 1) Individual choices to not bifurcate our lives into parenting and scholarship; 2) RTP decisions recognizing the importance of interdisciplinary and autoethnographical scholarship, along with enforcing policies and transparency around tolling, and fair/reasonable research productivity expectations; 3) tolling policies to account for the time needed for the parenting of young children, with options for being part-time on the tenure track or remote teaching possibilities; 4) local decisions to provide intentional community and friendship to parents as well as dedicated space for breastfeeding mothers and children on campus; and 5) sensible scheduling. Our ultimate goal must be larger systemic changes to parental leave and childcare that will grant the types of policies that will help all parents. In the meantime, we need to use everything we have to help the health and wellbeing of academic mothers who are raising the next generation.

### Endnote

1. All survey information, unless otherwise noted, regarding academic mothers and COVID-19 is pulled from data gathered in a survey called “COVID-19 and Parental Policies in Academe,” created and distributed by the author, which received 221 responses. This survey has IRB 20-227 exempt status. It was shared via social media and e-mail for approximately two weeks ending May 15, 2020.

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## Notes on Contributors

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**Zoe Freney** is an artist, a writer, and an educator based in the Adelaide Hills, South Australia. Zoe is currently a candidate in the PhD program at the Australian National University, where her project explores depictions of mothers and mothering from a matricentric feminist standpoint. She has written for online art publications, including *Art Guide*, *Fine Print*, and *Artlink*.

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**Anne Maree Payne** is a sessional academic at the University of Technology Sydney. Her research interests lie in the area of gender and human rights. Her book *Stolen Motherhood*, based on her PhD research into the experiences of the mothers of the Stolen Generations in Australia, is forthcoming in 2020.

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