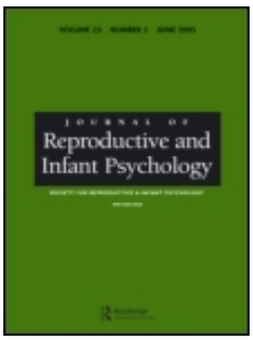

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Supermum, superwife, supereverything: performing femininity in the transition to motherhood

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Supermum, superwife, supereverything: performing femininity in the transition to motherhood

For Precilla. For all that she gave to us, for her friendship. For the women everywhere whose lives she touched with support and encouragement. For the inspiration that will endure.

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Abstract *The aim of this qualitative study was to comprehend how mothers understood and accounted for their experiences in relation to the ideology of motherhood which has been socially constructed as a critical aspect of femininity. Semi-structured interviews were conducted with 24 primiparous and multiparous women, and transcripts analysed using open and axial coding with triangulation. Using a material-discursive approach to interpret the data, two higher order themes are presented: 'the realization of new motherhood' and 'coping with new motherhood'. These themes demonstrate how unprepared for motherhood the women were and how their expectations were based on various myths of motherhood. This led to feelings of inadequacy as they struggled with the myth versus reality discrepancy. However, they could not be seen to be inadequate and therefore employed greater efforts to portray themselves as supermum, superwife, supereverything and hide the opposite. These findings are interpreted within the context of the social construction of femininity and how it is performed within motherhood. Implications for antenatal and postpartum care are discussed.*

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Introduction

This paper reports a study that aimed to explore women's subjective experiences of first time motherhood from a feminist perspective and thereby contribute to a reconceptualisation of motherhood within a broader socio-political context. Our theoretical framework was the (Western and white) social construction of femininity and how it is performed (Butler, 1990), taken up (Ussher, 1997a), or practised (Stoppard, 2000) within motherhood. In brief, we sought to appreciate how mothers understood and accounted for their experiences in relation to the ideology of motherhood which has been socially constructed as a critical aspect of femininity (Stoppard, 2000).

Recent years have seen the growth of a body of woman-centred psychological research on women's experiences of motherhood. This research, usually qualitative and from a feminist perspective, has given priority to the voices of women themselves and their subjective experiences. In so doing, the findings have presented a very different picture of motherhood (e.g. Brown *et al.*, 1994; Nicolson, 1998) than the cultural representations that depict positive images only. These images come from an ideology of women as natural mothers, immediately able to care for their babies, and ultimately fulfilled in this role of selfless carer and nurturer (Woollett & Marshall, 2000). The reality of motherhood is very different to the myth (Phoenix *et al.*, 1991), but even with more realistic depictions of motherhood in popular literature and prenatal classes, this ideology remains dominant (Mauthner, 2002). It sets the standard for what is a 'good' mother (and therefore a good woman) and what is a 'bad' one. It is, therefore, the standard for women to measure themselves against, and against which others measure women (Ussher, 1989). This makes it difficult for dissatisfaction and negative feelings about motherhood to be expressed without the guilt or fear of being considered a 'bad' mother (Parker, 1995).

Indeed, a number of researchers have documented that women's expectations of motherhood are influenced by the ideology and, when faced with the reality, have to accept that they cannot meet this ideal which leads to conflict (e.g. Brown *et al.*, 1994; Mauthner, 1999; Phoenix *et al.*, 1991; Ussher, 1989; Weaver & Ussher, 1997). This conflict has been associated with depression following childbirth, although the relationship is not straightforward as not all women who experience this conflict will become depressed (Mauthner, 1999). Nonetheless, it could hardly be surprising if some degree of unhappiness, characterized by negative affect/dysphoria, resulted as the woman adjusted to motherhood. In addition to the myth versus reality discrepancy, she may also have to deal with feelings about her changed status as a woman and the loss of her former self (Nicolson, 1998; Oakley, 1980), and changes to her relationship with her partner, where appropriate (Mauthner, 1998; Woollett & Parr, 1997). Moreover, whilst some or all of this may be occurring, there is the overwhelming tiredness that inevitably follows childbirth, sometimes there is pain from childbirth procedures, and stress resulting from having to learn the practical skills of caring for an infant.

Depression following childbirth continues to be extensively researched by both biomedical and social scientists, with the former focusing on individual factors such as hormones and previous psychiatric morbidity as precipitators. The social science research, on the other hand, has focused attention on the context and experience of childbirth and motherhood. This research has highlighted external stressors (such as lack of social support) and internal stressors (such as changes to identity) that may influence the development of depression. These findings have led to the notion that

depression is a realistic response to motherhood (Nicolson, 2000). However, Mauthner (1999) is opposed to this position because it implies that women are simply passive victims of social conditioning. She suggests that in attempting to resolve the myth versus reality conflict, women actively struggle to resist the ideology of motherhood and this shows women to be agentic and not passive. Stoppard (2000) similarly argues that women are agentic and, to make sense of their experiences, draw on culturally available discourses of which femininity features very strongly. For example, marriage and motherhood are central to femininity and are, therefore, a resource for women in constructing feminine identities as well as offering positive social and material rewards (Stoppard, 2000). Women's agency, therefore, is in choosing to have a baby as a way of producing a feminine identity as opposed to the notion that women have babies as a result of some natural (i.e. biological) force inherent within them. Similarly, in the arena of female sexuality, Ussher (1997a) argues that women actively negotiate the available discourses of femininity choosing which to take up and perform depending on the situation and context in order to reconcile any conflicts.

To further explore how this process might occur in the context of new motherhood, the present study employed Judith Butler's (1990) theorizing on gender. Butler posits that gender is performative and that we perform our gender by engaging in behaviours that are thereby appropriate and consistent. We learn these through social conditioning and access them through available cultural discourses. However, in engaging in them, we perpetuate and reinforce such cultural norms so that they remain unchallenged. Thus, performing gender is what Butler (1990) calls 'reiterative' and, as such, not entirely a choice because there are societal retributions for not performing one's gender 'correctly' (e.g. Bordo, 1993; Butler, 1990; Krane *et al.*, 2004). For example, marriage and motherhood might be chosen by women but what are the costs of choosing an alternative? The woman who chooses to remain single and who chooses to remain child-free is considered to be abnormal (Choi & Bird, 2003; Leatherby, 2002). This is also the case for the woman who chooses to parent with a woman instead of a man, with assumed negative consequences for the child or children (Tasker & Golombok, 1997). Moreover, although motherhood is no longer the sole resource available to women in constructing a feminine identity, nurturing others remains central within discourses of femininity (Stoppard, 2000).

The present study

How then do women perform femininity in the context of motherhood as a socially constructed critical aspect of femininity? This was the question for the present study in relation to first time motherhood. In their study of loss in motherhood, Lewis & Nicolson (1998) propose that, due to the complexities of the changes experienced in motherhood, there is value in investigating this some time after the birth because the women can be reflexive. What follows, therefore, is the experiences of first time motherhood as described to us by the women some years later. Two higher order themes (supported by sub-themes and data categories; Table 1) will be presented: the realization of new motherhood and coping with new motherhood. To interpret the data we took a material-discursive approach which has been put forward in recent years to further understand a variety of aspects of health and illness (for examples see Yardley, 1997), including depression (Stoppard, 2000) and reproduction (Ussher, 1997b). This approach gives equal importance to the material reality of women's lives (e.g. tiredness, demands of baby) and the culturally available discourses (e.g. motherhood as

Table 1. *Higher order themes and underlying sub-themes and categories.*

Higher order theme: Realization of new motherhood	
Sub theme	*Categories*
Expectations of motherhood	Expectations
	Feelings after birth of baby
Reality of motherhood	Demands of baby
	Adjustment to motherhood
Postpartum support	Partner support
Higher order theme: Coping with new motherhood	
Sub theme	*Categories*
Postpartum support	Family/friends support
	Others opinions
Postnatal distress	Attributions
	Coping
	Adjustment
	Denial

ultimately fulfilling) used to construct their experiences. How women respond to these experiences can be viewed as the result of a complex interaction between the material and the discursive.

Method

Participants

Twenty-four mothers were recruited from an original cohort of 99 women who had taken part in a previous study investigating whether women develop postnatal depression (PND) following postnatal blues (Henshaw, 2000). They had been recruited between 1991 and 1994 during late pregnancy with their first child while attending an antenatal clinic in the West Midlands, UK, and at the time, consented to a follow up study after the birth of subsequent children. After the birth of their first child, 14 of the women developed the 'blues' and four (two of whom had blues) later developed PND (see Results for further details). However, at the time of interview, none of the women were in a period of major or minor depression.

The age range of the 24 women was from 27 to 45 years (mean age 35.92 years, SD 4.43), they were all Caucasian and came from a variety of occupations, social classes, and educational levels. At the time of this study, 22 were married or cohabiting, one was single and one was divorced. Nine of the women did not have any more children, 11 had one other and four had two others.

Design and procedure

This was a qualitative study that utilised in-depth one to one interviews which were tape recorded and subsequently transcribed for analysis. To recruit participants, a letter was sent to each of the original 99 women. The letter notified them of the current

study, enclosed an information sheet that explained the study, and advised that contact would be made by telephone to ask if they wished to participate. Of the original 99, a total of 29 were willing/able to participate. Of these, data were collected from a total of 24, as three cancelled their appointments, there was no reply at the home of one woman when the interviewers turned up at the agreed time, and one did not show up for her appointment at the interviewers office.

All of the interviews that did take place were in the women's homes except for one which took place at the woman's place of work. One female interviewer conducted the interviews and she was accompanied by a female associate whose role was to assist the interviewer with the tape-recorder and to keep amused any children present. Written informed consent was obtained from each participant prior to the start of the interview which was then conducted using a semi-structured qualitative interview guide that contained facilitating questions/prompts to elicit information on four topics: the birth of the first child, the birth of any subsequent children, and the experience of motherhood. The interviewer began by asking the woman to tell her about the birth of her first child and from then on, the guide was used to address further questions and offer prompts in order to ensure that all topics were discussed. The guide was not designed to be followed in a sequential manner. The interviews, which were tape recorded, lasted 30–60 minutes.

Following the qualitative interview, the interviewer administered the Schedule for Schizophrenia and Affective Disorders (SADS-L; Endicott & Spitzer, 1978), a semi-structured diagnostic interview, to ascertain any periods of major or minor depression. Upon completion, participants were debriefed and thanked for their assistance.

Data analysis

Data were analysed through open and axial coding (Strauss & Corbin, 1990). The first three authors individually read and carefully coded each transcript so that all possible themes and discourses in the data were identified. The three researchers then met to discuss these individually derived open codings, comparing and contrasting interpretations until agreement was reached. Once this had been done for all transcripts, all codings were reviewed individually followed by in group until agreement was reached.

After the open coding stage, axial coding took place where the open coding categories were grouped into related categories with connections between and among them being explored. Interpretation of the data and the emergence of higher order themes and subthemes occurred at this point as the meanings of the codings and categories were explored and discussed. As before, discussions continued amongst the three researchers until agreement was reached concerning the themes.

Reflexivity

The authors have a range of different backgrounds and experiences that assisted in the interpretation of the data. Of the three main authors who analysed the data, all of us are feminists and academics. Two of us are academic health psychologists and one an academic psychiatrist who is also a practising clinician. The latter, plus one of the health psychologists, have been researching issues of women's reproductive health for a number of years. One of us has a child; of the two that have not, one has chosen to remain childfree. This variety of experiences afforded us advantages in our understandings and negotiations of the interview data.

Results

The women were a diverse group in terms of their pregnancy and childbirth experiences. For example, not all of the pregnancies were planned or subsequently wanted. Pregnancy experiences spanned the full range from 'wonderful' to 'uncomfortable but fine' to 'I felt sick more or less the whole way through' to 'horrendous'. Childbirth experiences were similarly varied but with far more detailed descriptions of the event. Following the birth of their first child, 14 of the women were rated as having experienced severe blues using the Blues Questionnaire (Kennerley & Gath, 1989). There were also four women (two of whom had blues) who had been diagnosed as having PND according to Research Diagnostic Criteria (RDC) after SADS-L interview. At the time of interview, all but two of the women claimed to be satisfied with their lives. The SADS-L revealed none of them to be in a period of major or minor depression at the time of interview.

The realization of new motherhood

For the vast majority of the women, motherhood had either not been what they expected or they had not known what to expect. As previous studies have found, any expectations or preconceived ideas they might have had were strongly influenced by the ideology of motherhood. Upon becoming mothers they realised that this ideology is very different to the reality. Becoming a mother for the first time brought home to the women some truths that they had not previously realised. For example:

> it's not as happy, you know like when you see on the telly all these happy families. It's not like that what I expected. (73–190) [1]

This very popular image of 'happy families' has been specifically mentioned by women as unrealistic in previous studies (e.g. Lewis & Nicolson, 1998; Weaver & Ussher, 1997) with participants in the Lewis & Nicolson (1998) study reporting feelings of anger at having been cheated and conned by this myth. This view also emerged from our study as illustrated by the following where the woman felt resentful towards her baby because it cried a lot:

> When I [pause] when she was first born [pause] the crying actually made me feel desperately ill. Desperately desperately ill. If she cried, I just felt like I wanted to [pause] give up, you know? Really, I mean honestly, I've thought some terrible things [pause] towards myself, not towards her. At times I've thought: 'if I could just unscrew her head and shut that noise up, I'd be alright.' … I felt dreadful and, er, probably very resentful at times because she was so, so low. I had no sleep y'know. Sleep deprivation really got me. (6–422)

Another element of the ideology of motherhood, that women will immediately be able to take care of their babies, was also found to be a myth. The sub-theme *expectations of motherhood* showed how the women overwhelmingly reported being unprepared for motherhood when their first child was born. For one woman it was a 'tremendous shock'. She explains:

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[1] All quotes are numbered: (participant number – transcript line number).

> Y'know, the ignorance of the first child is terrifying. Y'know, I just felt scared all the time sort of, in a panic situation all the time. (6–236)

This sentiment was echoed by many of the women:

> …before I had Andrew I had no experience whatsoever with children, no experience whatsoever with babies … then all of a sudden I had this little baby you know to look after and at three weeks he was screaming the place down and I didn't know what it was. (191–261)

> I'd never changed a nappy. I'd never, I'd never bottle fed a baby, I'd never looked after a baby … I didn't know what to do … I was in despair … (51–255)

Not knowing what to do contrasts sharply with the ideology of motherhood that holds mothering to come naturally to women. Childcare skills have to be learnt and, for most of those in this study who had a subsequent child or children, it was easier the second time round, even though the amount of work was greater, because the mothers had learnt what to do. This however, contrasts with a previous study where the women reported that the shock regarding childcare was the same (Nicolson, 1998).

However, it was not just the practical skills of childcare that the women were unprepared for:

> *Researcher: would you say that motherhood is as you expected it to be?* [Respondent sighs] I don't know that people really know what to expect from motherhood. Em, even though you've seen your own mother I don't think you really know what it's going to be like until you've actually got a child yourself … You don't realise how all-consuming it is. [Laughs] *Researcher: what were you expecting, can you remember?* I think you expect to have this child that em will feed and then be put down and have a few hours sleep so you can get on and do lots of things and you can be sort of Supermum, Superwife and Supereverything and it's not like that at all cos they don't go to sleep to order or do anything much to order so … [laughs]. (11–222)

The all-consuming nature of motherhood also emerged in the sub-theme *reality of motherhood* where the women described how their lives had been completely changed:

> I think it's [motherhood], yeah, I think it's hard work. Definitely changes your life, changes everything. You can't go out, you can't go round the corner to fetch a loaf of bread when you want one. You have to take them [children] everywhere. You have to take their many things everywhere with you, y'know? It definitely changes your life. (51–406)

> I don't think people realise how the baby takes over almost everything, your whole life changes completely, everything revolves around the baby … you have no time to yourself and you need to realise that, em, and that you can feel, experience feelings of real joy but also feelings of loneliness, depression as well. (11–184)

Similar findings emerged in Weaver & Ussher's (1997) study where a theme, which they named, 'self sacrifice' reflected the 'selfless Madonna' (p. 58) image of motherhood. As with the women in this study, the effort involved in being a selfless Madonna was considerable and could be distressing. Acknowledging and reconciling this can be problematic and in some cases remain so years later:

> At times I thought perhaps it's better if I go and let somebody else have them [laughter] but nobody else could you see so I was always stuck there. I felt trapped, desperately trapped … and here I was struggling. That was how I felt … and I always felt guilty. I still feel guilty now she's older when I think about it … (6–477)

In addition to the realization that the reality of motherhood meant that their lives were changed completely, was also the realization that this change was far greater for them than for their partner. This has been reported in a number of previous studies (Hays, 1996; Mauthner, 1998; Nicolson, 1998) and may explain why men report more positive feelings postpartum and why women are less satisfied with their relationship (Woollett & Parr, 1997). In our study, the sub-theme *postpartum support* , data category *partner support*, showed that for four of the women there was some feeling of resentment that, compared to how much their day to day life had changed due to the baby, their partner's was not all that different:

> I still felt resentful. I felt that once he'd gone out through that door then he didn't have to think about it until he came back through the door … When he went off in the morning his life hadn't changed. It was the same as the day after we had her. It was the same as the day before we had her. But everything for me had just gone completely, you know, up in the air. Everything was different. (62–205).

In the case of one woman, her partner could not understand why she found it so difficult to adjust to new motherhood nor could he understand why his life had to change. The woman came to realise that this was because his day to day life had not changed:

> I couldn't understand what his problem was but then I thought well, it's not just me that's got this new baby, it's both of us and he's got to adjust too, you know? And I think it's because they go out to work all day you know and they're just having a normal life, aren't they? Whereas, your life changes so much but theirs doesn't really till they come home at night … but at the time he was like my life's not going to change, I'm still going to go out sort of thing. (191–320).

For one of the four women in the study who was diagnosed with postnatal depression some months after her baby was born, she felt that because her partner was able to get away from it all, it enabled him to avoid dealing with her depression and getting help for her:

> I don't think he could cope with it [her depression] to be honest. I think, I don't think he knew what to do. I mean, he should have carted me off to the doctor's but he was going to work and sort of forgetting. He blotted it out. It was alright for him, he just went to work everyday … (124–458)

In Nicolson's (1998) study, the feeling of having been 'let down' by their partners was a very prevalent theme and, for two of the women, this was a major factor in their depression. Numerous other studies have also highlighted marital difficulties as predictive risk factors for PND (for review see Pope *et al.*, 2000), although Mauthner's (1995) study emphasised the greater, or at least equal, importance of support from other relationships which also emerged in our study and which we discuss under the next higher order theme below.

Coping with new motherhood

For the women in our study, support was considered to be crucial to the process of coping with new motherhood and this was very much acknowledged in the sub-theme *postpartum support*. Of particular value to new mothers was the support of female family members or friends who were also mothers, as in Mauthner's (1995) and Cronin's (2003) research. As one woman put it: 'I don't think you can beat another mum's advice' (51–320). However, it also emerged that help and advice from others could be simultaneously unwanted even though very helpful. For example:

> I suppose, I mean, that was a great help when the friend came in but, um, and I felt that she was taking over, even though, that I had to let her do these things. (121–52).

Another woman who was living with her mother at the time and whose sister lived just around the corner felt that: 'they were very supportive, perhaps a little bit too much really' (41–185). She went on to explain that 'they really took over' and that made her jealous:

> Yeah, I felt like they were taking my baby away from me yeah I did. I felt quite jealous. He had colic and because he cried from between 6 and 10, and of course my mum's: 'Oh give him here. You don't know what to do with him. Give him to me and I'll sort him out for you', and I remember having a few tears over that because she'd taken him away from me … (41–199).

Thus, advice from others in particular could be simultaneously wanted because the new mother does not know what to do and unwanted due to feelings of inadequacy:

> I mean, it's nice to have someone give you hints and tips but um, when they're handing it down on tablets of stone you feel like if you can't do it that way there's something vastly wrong with you and you're a very poor parent. (23–182)

Another woman felt that others behaved as though she was inadequate for asking for advice:

> … there was still this sense of 'fancy you not knowing that' if you had to ask about anything, you know? You felt like you should know it all, it was some sort of inbuilt programme for mothers that should come in your brain the minute you've anything, any doubt or anything and um. The visitors, sort of, they did make you feel as though you were lacking something if you needed to ask and that you hadn't done your homework properly. (23–303)

Here we can see the ideology of motherhood as natural being reflected in the women's feelings of inadequacy when motherhood does not come naturally. This has also been

reported by Mauthner (1999) where women felt that they had failed as mothers when they had to ask for help. Cronin (2003) reports that, for some of the mothers in her study, 'letting go' of the baby when they were offered help and support was 'extremely difficult' (p. 265). Cronin (2003) does not offer an explanation for this but in our study, the sub-theme *postnatal distress* illustrated that feelings of inadequacy were common. A typical response to the question 'were you depressed after the baby's birth' or 'did you experience postnatal depression' was: 'I don't know if it was depression but …' and the women would then go on to describe feelings of inadequacy or inability to cope with new motherhood which resulted in considerable distress. What is very striking in the accounts from our study is the women's expectations of themselves that they should be able to cope together with fears of being seen by others as unable to cope, which relates to the simultaneously wanting and not wanting advice from others described above:

> … it's self denial and I think that's when you really can lead into quite a severe depression because it's this difference between the façade you're putting up and how you're really feeling inside. And if it's a feeling of that you can't cope very easily and you don't want people to know how you're really feeling, you don't want people to know you can't cope because everyone does cope and nobody ever shows the side of not coping, or very few people, and so you don't want to be one of those people who isn't coping or who aren't coping well. (48–205).

Coping was not just a matter of taking care of the baby, it was also managing to do many other tasks such as the housework and caring for other people—in other words, being supermum, superwife, supereverything:

> I think you put yourself under pressure and feel that you ought to be doing these things, you ought to cope better. I know all sorts of other things, hormones and that have changed and what have you, but um, I'm sure it was feelings within me that made me feel that I should cope better and that I should still be up and down doing all sorts of things and taking care of other people as well. (121–144)

Thus, whilst attempting to cope with and adjust to new motherhood is difficult, admission of this to themselves and others incurred deep feelings of inadequacy in the women in our study. Not wanting to be seen as bad mothers meant mixed feelings about asking for and accepting help and support as well as not wanting to admit to negative feelings such as depression. These findings are consistent with those of Mauthner (1999) where all 18 of her self-diagnosed depressed women were reluctant to ask for help and support on the basis that mothers should not need this and should not be depressed. They also illustrate the prominence of those discourses of femininity that hold up to women the ideology of motherhood and an absence of alternatives for women to draw on to make sense of their experiences in the light of the discrepancy between the myth and the reality and/or to resist the hegemony.

Discussion

For the women in our study, reflecting back some years later, their accounts of the postpartum were predominantly negative. Their expectations, based on various myths of motherhood, were not met and they felt both unprepared for and overwhelmed by

new motherhood. They experienced considerable loss as their lives became consumed by the tasks of mothering. This, therefore, was the material reality of new motherhood for them. Supporting a considerable body of previous research, our findings show that it is still the case that '[i]t is hard to avoid the fact that there is something really depressing about motherhood' (Oakley, 1986, p. 61). The lack of positive experiences in their accounts is striking although previous studies have reported these (e.g. Cronin, 2003; Green & Kafetsios, 1997; Weaver & Ussher, 1997). Our focus in the interviews was not, however, on the negative. We used facilitating questions/prompts that we deemed to be neutral (e.g. 'How did you feel after your baby was born?' and 'Is motherhood as you expected?') thereby enabling the woman to tell us what was salient to her.

The women's expectations were very strongly influenced by the myth of motherhood and it would seem that there is a lack of alternative motherhood discourses for women to draw on in constructing their experiences. It is hardly surprising therefore, that conflict occurred as a result of the discrepancy between the myth and the reality. In addition to that, our findings show that feelings of inadequacy are likely as a result of this conflict. Not only did the women feel that they should be able to cope with the caring of a new baby, but also with domestic tasks and the caring of others. This reflects the cultural representations of femininity today that are of a 'superwoman' able to cope with so many competing demands (Ussher *et al.*, 2000). Thus, women are reluctant to be seen to have failed as perhaps this would threaten their sense of self and their identity as a woman. As this is informed by discourses of femininity (Stoppard, 2000), femininity is performed (Butler, 1990) by not revealing their true feelings and taking up the discourses of the perfect woman who can cope and who does not need help. The gender performance then becomes a masquerade or a façade that depicts the supermum, superwife, supereverything, and hides the opposite. It hides what Walkerdine and colleagues (2001) describe in the context of femininity and girls/young women 'a defence against failure, a terrible defence against the impossibility that the supergirl identity represents' (p. 186). This has very serious consequences for the woman as her depression is hidden. In Mauthner's (2002) research, so good were some of the women's performances that their depression went unnoticed by health professionals (e.g. midwives, GPs), family, and friends for months.

What we did not find in our data was any evidence of resistance to the ideology of motherhood and therefore agency in the women as described by Mauthner (1999) and Stoppard (2000). It seemed that, so strong was the fear of being seen to have failed, the only option was to work harder at the performance and, as Butler (1990) has contended, this then perpetuates and reinforces the ideology. Challenging the ideology may also not be a viable option given the material reality of new motherhood. Unlike sexuality, for example, where women can begin to experience or experiment with these when they are still girls and (hopefully) develop a sense of agency over time, there are rarely opportunities to experience mothering vicariously and, once the baby arrives, the woman cannot change her mind about being a mother and becomes consumed by the task. Agency may develop later when the woman has adjusted—this seemed likely in those women in our sample who had found it easier the second time round. In addition to knowing what to expect, for one woman it was also not 'play[ing] by the book' and learning to 'cut corners' (194–93). This is consistent with Mauthner (1999) who suggests that in attempting to resolve the conflict, women who reduce their standards and modify their expectations of themselves are those who are less likely to become

depressed. One limitation of our study is that in focusing on new motherhood only we were unable to explore this. How mothers resolve the conflict over time with and without the birth of subsequent children is an area for future research. Furthermore, the experience of conducting a thematic analysis in this study suggests that narrative analyses of autobiographical accounts (see Kirkman, 2000) may be particularly suitable for this future research. This method may be more illuminating as it would allow for different narratives (the story constructed by the participant and the discourses used in this construction) in relation to the different stages of motherhood.

According to Stoppard (2000), one of the central ideas of material-discursive approaches is that performing femininity can, in some circumstances, 'exhaust a woman's body while undermining her morale and sense of well-being' (p. 92). We propose that new motherhood is one of these circumstances, and that antenatal and postpartum care needs to be reconsidered within this framework. One obvious forum for this is the antenatal/preparation for parenthood class. However, the experience of the second author, who is a clinician working within a multidisciplinary team, is that midwives encounter resistance to discussions about the material realities of motherhood and that the primary concern of the women is dealing with labour and delivery. The findings of Renkert and Nutbeam's (2001) study with health care providers, pregnant women, and new mothers indicate that this may be understandable. As childbirth is well known to involve pain, it is anxiety provoking and, given the time constraints of antenatal classes, the focus then tends to be restricted to this. This was recognized by all three groups in Renkert and Nutbeam's (2001) study. As a result, the task falls initially to the midwife involved in immediate postpartum care and, following this, to the health visitor after the woman has returned home. This has implications for training and resourcing given that women have considered many aspects of postpartum care as inadequate (Baker *et al.*, 2002). One aspect, for example, was that the focus of the care provided by the health visitor was almost solely for the baby, with little or no attention to the mother herself. Indeed, Baker *et al.*, (2002) report that often health visitors did not ask how the woman was feeling or coping. One of the women in this study was depressed but felt unable to bring it up with her health visitor because the topic was never mentioned. She claimed that if her health visitor had asked her if she was depressed she would have sought help sooner. Training of health visitors, therefore, must emphasise care of the mother as much as care of the baby.

In many countries there are, of course, a number of programs designed to assist new mothers (and fathers) in different ways such as 'Surestart' and 'Homestart' in the UK. Surestart is a government initiative to improve outcomes for children via a variety of measures including increasing the availability of childcare and supporting parents in their role. Homestart is a charity that provides trained parent helpers to parents with at least one child under 5 years of age who are finding it hard to cope. Unfortunately, neither of these are UK-wide and only available in the most deprived areas. As written accounts of women's experiences of new motherhood testify (e.g. Frank, 2002; Mauthner, 2002; Wolf, 2001), it is not just low socio-economic mothers who find it difficult to cope and to resist the ideology of motherhood.

Ultimately, however, the ideology of motherhood (and femininity) must be challenged. The need to challenge patriarchal ideologies has, of course, been emphasised in numerous feminist writings for many years now. Notwithstanding the small number of self-selected participants, this study illustrates through its theoretical approach that this need is not yet obsolete. In constructing a feminine identity,

traditional ideologies of femininity still feature and, in the case of motherhood, remain central.

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