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Navigating The Transition Into Motherhood: Women's Experiences Of Control, Emotions, And Social Ideals

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DEDICATION

For my family:

My grandparents, Twila, Boyd, Carol and Gene

My parents, Janelle and Mike

My husband, Shawn

And our children, Lily Cate and Hunter Michael

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TABLE OF CONTENTS

DEDICATION.....	ii
ACKNOWLEDGEMENTS.....	iii
LIST OF TABLES.....	vii
CHAPTER 1 "Introduction"	1
Chapter 2 "Review of the Literature"	5
<i>The Motherhood Mandate</i>	5
<i>The Beauty Mandate</i>	20
<i>Gaps in the Literature</i>	31
CHAPTER 3 "Relevant Sociological Theories".....	33
<i>Medicalization of Gendered Reproductive Processes</i>	33
<i>Foucault's "Docile Bodies" Thesis</i>	36
<i>Doing Gender</i>	39
CHAPTER 4 "Methodology"	44
<i>Methodological Approach</i>	45
<i>Recruitment Procedures</i>	48
<i>The Sample</i>	53
<i>Data Collection</i>	57
<i>Analysis Procedures</i>	60
<i>Summary</i>	64

CHAPTER 5 " Control and Lack of Control: Pregnancy, Labor and Early Motherhood"	64
<i>Labor and Delivery in the Hospital</i>	66
<i>Early Motherhood</i>	92
<i>Conclusion</i>	106
CHAPTER 6 "Contrasting Maternal Emotions: Guilt and Pride"	108
<i>Before Baby Comes</i>	109
<i>After Baby Comes</i>	116
<i>Conclusion</i>	137
CHAPTER 7 "Ideal Mothers: Appearance and Mother Work":	138
<i>What do Ideal Mothers Look Like?</i>	139
<i>The Real Mom</i>	145
<i>I Don't Want to Look Like a Mom</i>	150
<i>Mother-to-Mother Comparisons</i>	116
<i>Reactions to the Media</i>	158
<i>Conclusion</i>	163
CHAPTER 8 "Conclusion"	164
<i>Control</i>	165
<i>Guilt and Pride</i>	167
<i>Autoethnography</i>	168

<i>Limitations, Contributions, Avenues for Future Research and Policy Change</i>	172
APPENDIX A: Flyers.....	175
APPENDIX B: Checklist for Screening Potential Participants	177
APPENDIX C: Research Information Sheet	179
APPENDIX D: Interview Guide.....	181
APPENDIX E: Questionnaire.....	185
APPENDIX F: Women's Resources	191
REFERENCES	192
ABSTRACT.....	219
AUTOBIOGRAPHICAL STATEMENT.....	221

LIST OF TABLES

Table 1: Demographics of Women in the Sample.....	55
Table 2: Birthing Experience.....	56
Table 3: Infant Feeding.....	57
Table 4: Interviews.....	59

CHAPTER 1 INTRODUCTION

Women are held to a variety of ideals, including but not limited to the motherhood mandate and the beauty mandate. Feminist literature proposes that current motherhood ideology says that all women are mothers (Russo 1976) and that motherhood, such as caregiving, consume all a woman's time (Hays 1996). Western beauty ideals suggest very specific body prescriptions, such as "taut, small-breasted, narrow-hipped" figures, "slimness bordering emancipation," (Bartky 2003:28), unblemished, light skin, youth, and smooth hair (Kwan and Trautner 2009), as well as an athletic body (Bell et al. 2016). These prescriptions cause body image concerns which disproportionately affect females over males (Tatangelo and Ricciardelli 2013). All women are ultimately held to the dual standards of beauty and caregiver, whether mothers or not. Few women fully meet these standards of both mothering and beauty, especially simultaneously. For instance, in terms of beauty, only one in 40,000 women meet the requirement of a model's size and shape (Women's Action Coalition 1993). Postpartum women (women who have had a baby within the past twelve months) have difficulty meeting these strict standards of beauty ideals alongside ideals of intensive mothering.

The postpartum period is a very particular life stage and a time of massive change in women's lives, both in body and in responsibilities. A postpartum woman's body has gone through pregnancy and the birthing process and, thus, their body has been altered. Postpartum women are also negotiating a new role in their lives, that of a mother. These women have moved from having a body of their own, to a body shared with another, back to a body of their own but simultaneously caring for another. They also face changing relationships with others, including intimate partners, coworkers, older children, and peers. Thus, the postpartum time represents a major time of change in women's lives.

Research on postpartum lifestyles emerges from the biological disciplines, including obstetrics, as well as disciplines such as nursing and psychology. Less attention has been paid from a sociological or sociocultural perspective. Compared to the general dearth of sociological research, postpartum women's voices are, for the most part, quiet within current literature. Past feminist scholars even suggested that women's concerns are trivialized and considered unworthy topics for sociological investigation (Dellinger and Williams 1997). Possible reasons for this exclusion are that the established categories of research in sociology have traditionally reflected the interests and experiences of men and have excluded issues that are relevant to women's everyday lived experiences, until late (DeVault 1991). Furthermore, among feminists, a general ambivalence toward emphasizing gender differences may provide another explanation for the small amount of research on postpartum experience (or other women-only experiences such as menopause) (Dellinger and Williams 1997). Bordo (2003) argues that many feminist academics fear that a discussion of how women differ from men will jeopardize the likelihood that women will be viewed as equal to men. Few sociologists have looked at the multiple and intersecting contradictions that new mothers face, such as being in control yet lacking control, experiencing guilt and pride simultaneously, and how to navigate appearance work and mothering work at the same time.

Despite probable arguments against studying subjects and aspects only related to women's lives, women occupy over half of the world (Conley 2016; World Fact Book 2016) and all women -- almost regardless of whether they are mothers or not -- are continually faced with the dual ideals of mothering and beauty. The average mother experiences her first birth at age 25.6 (World Fact Book 2016). In 2014, 3.9 million women between the ages of fifteen and fifty were counted as having given birth within the last twelve months, which is the official definition of the postpartum

period (U.S. Census Bureau 2014). Of these women who experienced childbirth, 2,699,951 women experienced vaginal deliveries and 1,284,551 women experienced cesarean deliveries (this was 32.2 percent of all births) (Center for Disease Control and Prevention 2015). As is evident, then, many women experience the postpartum stage each year.

The purpose of this study was to gain a better understanding of the actual lived experiences of women who birthed and mothered a child within the last twelve months. In defining this purpose, I sought to give postpartum women their own voices so that they could help define the postpartum experience on their own terms. In Chapter Two, I discuss the existing literature on the motherhood mandate, the beauty mandate, and postpartum bodies, to frame the background for my study. In Chapter Three I cover relevant theoretical approaches, including Foucault's "Docile Bodies," Medicalization, and "Doing Gender," all of which serve to ground this sociological study individually and as a whole. These theoretical approaches help frame my findings and conclusions in later chapters. In Chapter Four, I review my qualitative methodological approaches, and highlight information about data collection and analysis. This chapter specifically explains how this research study involved in-depth interviews and a questionnaire of forty-two women who were less than twelve months postpartum. In Chapter Four I also initiate a discussion of my own autoethnography and my reflexive position as a new mother myself, which formed a partial basis of and rationale for this dissertation. As I discuss in Chapter Four, the following research questions formed the basis for this research project, to fill gaps in the literature on postpartum experience:

- a. How do women deal with the dichotomy of having a lack of control throughout the journey into motherhood versus having and/or taking control throughout the journey into motherhood?

- b. How do women transition into the motherhood experience and cope with the contrasting emotions of guilt and pride?
- c. How do women transitioning into motherhood cope with being held to two ideals: that of an ideal appearance and that of an ideal mother?

Three chapters of findings (Chapters Five, Six and Seven) follow, and in these chapters I present participants' thoughts and experiences as they learn to navigate their new role as mothers. Each chapter is organized to highlight major themes within the data and answer the research questions that frame this study. In Chapter Five I concentrate on presenting data that show how women dealt with being controlled or attempting to take control during pregnancy, labor and delivery, and the postpartum period. Chapter Six is organized so that I can attend to data on the primary emotions that women report as part of their transition into motherhood. Because women were most likely to talk about guilt and pride, Chapter Six primarily highlights women's conversations about these two emotions. Chapter Seven focuses on the dualing ideals that new mothers face, and how women end up intertwining their discussions of how mothers look and act as they talk. Thus, women are dealing with both appearance work and mothering work at the same time, and the dialog between the women and myself illustrates this. Finally, I use Chapter Eight to summarize major findings, make tentative conclusions about women's journey into new motherhood, and suggest avenues for future research. In this effort, I hope to add to the existing literature on postpartum women's experiences, and increase the attention to how much women are negotiating on their journeys to and through early motherhood, with possible policy recommendations.

CHAPTER 2 REVIEW OF THE LITERATURE

This literature review will investigate research on women's entry into motherhood. First, I will discuss the roots of various forms of gender inequality, including the ideals and requirements that women are expected to mother and the ideals and requirements that women are expected to be attractive. I will also discuss how these requirements or prescriptions impact how women feel about themselves, their experiences, and their images of their physical bodies and appearances. These discussions will aid in understanding my research purpose of understanding how women learn to navigate their lives as they become mothers. Investigating how women begin motherhood and how this story is partially about navigating unfamiliar waters and responsibilities, feeling a lack of control, facing multiple social ideals, and acknowledging a range of positive and negative emotions. Finally, I will address the gaps in the existing sociological literature.

The Motherhood Mandate

A variety of social and cultural forces propel women into motherhood. Mothering is a gendered form of caregiving that typically involves both the relational and logistical work of child rearing. It is a “constructed set of activities and relationships involved in nurturing and caring for people” (Arendell 2000:1192). Mothering and motherhood includes the maintenance of dynamic social interactions and relationships, located within a societal context organized by gender and in accordance with the prevailing gender belief system (Arendell 2000). It is controlled by the systems of patriarchy and the economic relations within which it is embedded, but when we define motherhood as something more than a caring relationship between women and her children, it is a social institution (Rich 1976). Mothering involves caring for a family but it does not just occur in the isolated context of the family; mothering brings women in contact with many other social institutions and social norms (Andersen 2009).

The Expectation to Mother

Arendell (2000) claims that it is women who do the work of caregiving. Motherhood is entwined with notions of femininity and women's gender identity is reinforced by mothering (Arendell 2000; Chodorow 1978). Chodorow (1978) explores this issue by asking how the psychological structures of gender emerge through the current organization of parenting. She notes that women's mothering role is one of the few seemingly universal elements of the gender division of labor. Instead of relying on explanations that see motherhood as a "natural" fact, however, Chodorow (1978) asks why the psychological characteristics of motherhood are reproduced so that women, not men, want to be mothers and develop the capacity of nurturing others. "Women, as mothers, produce daughters with mothering capacities and the desire to mother. These capacities and needs are built into and grow out of the mother-daughter relationship itself. By contrast, women as mothers' produce sons whose nurturing capacities and needs have been curtailed and repressed" (Chodorow 1978:7). This process is the result of both the gender division of labor and the psychological processes it inspires.

While, Chodorow (1978) claims that women become mothers through a continual reproduction of the role, since women are often the primary care givers of their children, Russo (1976) claims that there is a "motherhood mandate" in Western culture. The "motherhood mandate" claims that that all women should be mothers and that the "good mother" is measured by "the number of her children and the quantity of time she spends with them" (Russo 1976:148), as well as the quality of the time that is spent with them. This mandate declares that mothering is exclusively and wholly child centered, emotionally involving, and time consuming (Hays 1996). Pogrebin (1983) refers to this phenomenon as "compulsory motherhood." Similarly, the "motherhood mandate," "compulsory motherhood" is the idea that a woman's primary purpose is

to be a mother and that all women should mother and gain intense satisfaction from it. Women are expected to find total fulfillment in having children and taking care of them. In both perspectives, an ideal mother is portrayed as devoted to the care of others, self-sacrificing, and puts others needs above hers. A woman's well-being is so tied up with mothering that her identity is sometimes assumed to be "tenuous and trivial without it" (Coltrane 1998:90).

According to Russo (1976:144), "advances in the technologies of birth control have theoretically eliminated the biological inevitability of motherhood. Women can plan both if and when they wish to have children". Even if the perfect contraceptive were developed and used, social and cultural forces would still enforce and perpetuate the "motherhood mandate" (Russo 1976:145). Through socialization, women and men develop expectations about what women can or cannot do, and expectations for mothering are built into the operating principles of society's institutions. For this reason, the idea that a woman might be something other than a mother first and foremost seems unthinkable (Russo 1976:145). "According to conventional wisdom, something is wrong with women who do not want to have babies, and something is wrong with mothers who are not always and forever willing to put the needs of their children ahead of their own" (Coltrane 1998:95). Nevertheless, the "motherhood mandate" is not equally forced onto all women. White middle class women are expected to bear children, while, for the most part, "women who are poor, immigrant women, and women of color have been discouraged from becoming mothers" (Coltrane 1998:94). While, poor, non-white women are discouraged from mothering, educated, middle class white women have been bombarded with "pregnancy propaganda labeled 'maternity chic'" emphasizing both beauty and motherhood (Pogrebin 1983).

In recent years, the "motherhood mandate" has slightly weakened. This is seen in the reduction of the ideal, desired, and actual family sizes in the Western world. Having as many

children as one can afford is now part of the “motherhood mandate.” The total fertility rate, or number of births per woman in the U.S., in 2006 was 2.1 (U.S. Census Bureau 2006), while in 1973, up to four children was the prescribed norm (U.S. Census Bureau 1973). In 2015, the average women bear 1.87 children (The World Fact Book 2016). The average of 1.87 children is expected to continue through 2016 (The World Fact Book 2016). Despite the notion that women are no longer expected to have as many children as possible, having no children is still viewed as a deficient condition. When a woman passes the age of 26 she is often asked, “When are you going to have children?” Persons who entirely disregard the “motherhood mandate” and expect to live a child free life are relatively rare, although numbers have grown. According to the U.S. Census Bureau’s Current Population Survey, in 2014, 47.6 percent of women between the ages of fifteen and forty-four who have never had children is up from 46.5 percent in 2012. This is the highest percentage of childless women since the bureau starting tracking this data in 1976. The data considers all women in childbearing age, which is 15 to 50 years old, with the average first time mother around age 26. We need to understand that the birth rate may be low since teenage births are at an all-time low, thus making the average lower than if we were to look at women ages eighteen and up (World Fact Book 2016).

Ideal Mothers

Women’s roles as mothers are idealized in our society as all-loving, kind, gentle, and selfless (Rich 1976; Hays 1996). Consequently, our culture has conveyed strong messages about what motherhood means and has promoted an idealized model of motherhood. “Ideal” mothers are middle-class, white, heterosexual, stay-at-home, and completely fulfilled by their role within the family. Additionally, the woman is expected to be married to the father of her children and live together (Thorne 1993). This dominant motherhood ideology in the U.S. has varied little since

the 1950s (Hays 1996; Arendell 2000). Hays (1996) claims that women must adhere to three main components of “intensive mothering” if they are to be viewed as “good” mothers. First, childcare is the primary responsibility of the mother. Second, childcare should be child centered. Third, and finally, children “exist outside of market valuation, and are sacred, innocent and pure, their price immeasurable” (Hays 1996:54). Intensive mothering presupposes a psychological bond between the mother and young child (Hays 1996; Lorber 1995; Macdonald 1998) and that the mother, and only the biological mother, is “best suited to comprehend her child’s needs and can interpret and respond to those needs intuitively” (Macdonald 1998:30). That is, instinctively the mother knows how to care for her child; no one needs to teach a mother how to care for her child.

The media, such as film, magazines, and books, as well as other cultural representations, reinforce these conventional notions of the “motherhood mandate” and “intensive mothering” (Kapan 1992). Johnston and Swanson’s (2003) content analysis of the five most popular women’s and parenting magazines found that these generally endorse the indicators of the traditional motherhood ideology (e.g. middle class, white, stay-at-home, and the woman is completely fulfilled with her role as a mother). In comparison, employed mothers are portrayed as being tired and feeling guilty for neglecting their children and failing to meet their children’s basic needs (Johnston and Swanson 2003). The ideal mother is expected to center her life on mothering her children giving them her full attention in all areas of life, including her time, space, energy, and affection (Hays 1996). The belief is that a stay-at-home mother is giving her total identity by not dividing her time or focus between her employment and children. Only by doing this, a woman becomes the “ideal” mother (Johnston and Swanson 2003). The construction of a mother as the constant caregiver can cause mothers who are by choice or necessity away from their children to

feel a sense of loss, sadness, or guilt when they must be separated from their children (Hock, McBride, and Gnezda 1989).

Rogers and White (1998) claim that the identity of being a mother is more powerful than the identities associated with either marital status or occupation. Mothering may hold even greater salience for women of color because of racial and ethnic communities' extended families and loyalties (Dill 1994). Women with children report experiencing greater meaning in their lives than women without children (Ross and Van Willigen 1996). Some women who work, part or full time, still refer to themselves as "full time mothers" and they see their primary identity as a mother. Thus, placing the family in the same regard as stay-at-home mothers do (Johnston and Swanson 2004). Despite this, women may only report this because they know they are supposed to feel this way, based on gender socialization. They are following a set of gendered expectations.

The maternal responsibility for the home is often referred to as the "cult of domesticity," where women of upper class families are expected to stay-at-home and care for the house and children, thus idealizing the "separate spheres" (Coltrane 1998:87-89). A woman is considered fortunate if she does not have to work and gets to be home with her children. Because motherhood has traditionally mandated that women stay-at-home with their children to be "good" mothers (Hays 1996), women have experienced role conflict as they attempt to balance the relative rewards and costs of children and paid work. Many working women experience the "second shift" where women perform a full day at the office and then come home to perform a second shift in the home caring for the home and family. Employed women, as well as stay-at-home women, do most of the housework and caring duties (Hochschild 2003). Some mothers feel they need to compensate for their employment and time away from their children. To do this they engage in "extreme parenting" (Sears et al. 2003). This may involve emphasis on quality time with the family or even

co-sleeping (Sears et al. 2003). Some women attempt to be the sole caregiver of their children and be employed. The image of this woman is a “supermom.” Despite this pervasive image, many women express experience of spillover and stress from trying to “have it all” (Moen and Wethington1992). Gender inequality is reinforced in these scenarios through women trying to attain multiple, and often conflicting roles (here, work and motherhood).

Transition to Early Motherhood

The postpartum period is a time of major life transition for women. Throughout this stretch a woman is recovering from childbirth, as well as negotiating her changing roles (Landy 2008). As she encounters new experiences throughout her life, she learns the role expectations associated with her new statuses. Although gender identities are established relatively early in our lives, changes in our status in society, such as becoming a mother, bring and reinforce gendered expectations about appropriate beliefs, behaviors, identities, and roles (Miller 2007). Depending on the definition, the postpartum period can last from six weeks after birth to one year following the birth of the child.

The definition or description of term “postpartum” can be deliberated. However, despite any dispute over the term “postpartum,” it remains a time of major life transition (Landy 2008). The association between the postpartum period and mood disturbances has been noted since the time of Hippocrates (Miller 2002). Postpartum depression usually begins within 1-12 months after delivery of the child (Robertson et al. 2008). The time, “the postpartum” is a socially constructed term. Medically, it is zero to twelve months’ post birth (Landy 2008). The word itself simply means “post child birth.” It comes from the Latin word *post partum*, meaning after childbirth. In recent times the word “postpartum” has become partnered or associated with postpartum depression and automatically takes on a negative connotation when the word is used since the

medicalization of postpartum depression (Miller 2002). Not all cultures or groups view the time after the birth of a child in the same manner.

Some women describe the transition to motherhood as the happiest times of their lives, while others find the period difficult and challenging (Landy 2008). Thus, the transition to motherhood is a period of social, psychological, behavioral and biological change. Almost all aspects of a woman's life are altered by the birth of a child, but concerns about weight gain and getting back to one's pre-pregnancy shape are among some of the most expressed by postpartum women (Upton and Han 2003).

Research on the transition into motherhood has emerged from the fields of nursing and psychology, for the most part. The clear majority studies look at first time mothers. For example, Darvill et al. (2010) completed a study in the United Kingdom on the transition into motherhood for first time mothers. Thirteen postpartum women participated in the semi-structured interview. A key finding was that the women felt they had lost control over their lives in the early stages of pregnancy, as well as after birth. Early changes of their self-image and the change in focus from themselves to the fetus started within the first trimester. Pregnancy was unfamiliar, as was early motherhood. There was a need for a mentor to help guide the women through these changes to "normalize" their experiences and feelings. These women recognized that having a child transformed themselves, as well as their relationships with family.

In the United Kingdom, as well, Miller (2007) studied seventeen, white, first time mothers and their transition into early mothering. Miller found that the women had unrealistic assumptions about mothering. She specifically looked at how women "do mothering." Her sample, while they were pregnant, had unrealistic assumptions that motherhood would come naturally to them. But, as the women went on into uncharted territory they found mothering was not natural to them. The

women's birth experiences let them down by what they had thought "official discourses had promised" (Miller 2007:347). Additionally, they found out that nature was not to be trusted in the early weeks of mothering. A few weeks postpartum, women found the skills of nurturing must be learned (Bobel 2002; Miller 2007). When Miller (2007) interviewed her subjects at nine months postpartum "the women gradually became more practiced at recognizing and meeting their child's needs.....This development is linked to a growing confidence in their own mothering skills..... was a slow and lonely process" (350). Thus, the journey into motherhood is a "steep, lonely—and bumpy—learning curve for which, in retrospect, they felt ill prepared (Miller 2007:351). Women were afraid to try things their "own way" as they found this "risky" and wanted to be told what they should do.

A study in Australia, by Harwood et al. (2007) found pregnant women often have optimistic expectations about parenthood but the actual transition also presents several challenges. Their sample consisted of 71 first time mothers who completed quantitative questionnaires, both during pregnancy and then again four months postpartum. The researchers found the women's experiences were negative in relation to expectations, like Miller et. al (2007). There was also found to be greater depression and poor relationship adjustment among Harwood's sample (Harwood et al. 2007).

Using a different method, Barclay et al. (1997) conducted nine focus groups, with a total of 55 women who were first time mothers, in Sydney, Australia. Their analysis produced six categories. This included: "realizing," "unready," "drained," "aloneness," "loss," and "working out." Their core category was "becoming a mother." This integrated all the other themes and the process of change experienced by the participants. Barclay et al. (1997) found there are factors mediating the distress that women experience when becoming a mother. They suggest developing

strategies for midwives, nurses, and other helping women negotiate the challenge of becoming a mother as Darville et al. (2010) did.

Deave et al. (2008) sought to address the transition into parenthood, not only motherhood, by asking first time mothers and their partners about how they could be better supported during the antenatal period, particularly in relation to the transition to parenthood and parenting skills. Taking place in England, purposive sampling of 20 women and their partners were interviewed on and off through pregnancy to 3-4 months postpartum. Deave and partners (2008) found that knowledge about the transition to parenthood was poor. Parents had been unaware of, and surprised at, the changes in the relationship with their partners. They would have liked more information on elements of parenting and baby care, relationship changes and partners' perspectives prior to becoming parents.

Mercer (2005) identified four stages of the process of becoming a mother, from nursing research reports, that would be helpful for mothers to be. The first process Mercer (2005) identifies as commitment, attachment, and preparation for an infant during pregnancy. The second is acquaintance with and increasing attachment to the infant, learning how to care for the infant, and physical restoration during the early weeks following birth. Third, moving toward a new normal the first 4 months. Fourth, and finally, achievement of a maternal identity around 4 months (Mercer 2005). Mercer claims these stages may overlap, and maternal, infant, family, and environmental variables influence their length as well, but this is a general outline of what women experience as they become mothers.

This is a time within which women have accomplished the motherhood mandate; therefore, the postpartum time could potentially be a very positive time. Yet, women are also confronted with expectations about *how* they should mother (when they are not taught how) and are exposed

to intensive mothering ideals. Further they begin navigating cultural expectations about “getting their bodies back,” and both sets of expectations may lead to a variety of emotions in the postpartum. On top of these expectations, women also must master new responsibilities, such as properly feeding their babies and must make the “right” choices in doing so.

Breastfeeding

Breastfeeding is currently considered the “correct” choice for mothers, while in the 80s and early 90s formula was pushed onto mothers and considered the better choice for their infants. The Center for Disease Control and Prevention’s *Breastfeeding Report Card* is published every two years. Thus, the most recent data on women in the U.S. is from 2014. The current report claims that seventy-nine percent of new mothers are breastfeeding their babies. Breastfeeding rates in the U.S. are on the rise. This is up seventy-one percent from 2003. Although breastfeeding is on the rise, breastfeeding does not continue for the duration it is recommended by pediatricians. Experts advise breastfeeding exclusively for the first sixth months and continuation of partial breastfeeding up until the age of two. Of infants in the last report card, 49 percent women are still breastfeeding at six months and 27 percent were breastfeeding at twelve months (Center for Disease Control and Prevention 2014).

Studies have suggested that women who choose not to breastfeed consider it “distasteful” and fear an adverse effect on their bodies, particularly their breasts. Foster et al. (1996) found no relation between BMI and intention to breastfeed. However, a woman’s *attitude* toward her body, even after controlling for social class, predicted intention to breast versus bottle feed. Bottle feeders had greater body shape related concerns and less body image satisfaction, while women intending to breastfeed were more satisfied with their shape. Similar to Foster’s (1996) findings were demonstrated by Barnes (1997) epidemiological study of 12,000 women. Women who had

no concerns over their body image were 1.25 times more likely to intend to breastfeed in the first week than women with marked body image concerns. Weight concerns also predicted breastfeeding at four months, with greater concern over weight resulting in greater likelihood to bottle feed.

Women may have a change in how they identify with their breasts. For example, prior to pregnancy women associate their breasts with sexuality or for themselves. Bailey (2001) found that many women, postpartum, are unable to describe themselves in sexual terms. For example, they saw their breasts as being for the child and were now fulfilling “their true purpose for the first time” (118). Although, women who choose to breastfeed do experience larger breasts, they feel that their enlarged breasts do not contribute to a bodily shape that is widely seen as sexualized in our culture. Women felt that through breastfeeding they were finding the true purpose of their breasts and saw nothing sexual or attractive to others about it. These women could celebrate their bodies in a way that rejects the dominant, popular media accounts of feminine sexuality (Bailey 2001). Many conclude that after pregnancy a woman’s body is now her own, however, when women chose to breastfeed a woman’s body may not become her own until breastfeeding ceases (Upton and Han 2003).

Contemporary medical accounts of breastfeeding serve as a positive affirmation of femininity, which goes beyond the emphasis on fertility to the ability to respond to the needs of a child. Bailey (2001) found that women value the ability to supply their babies with milk. In interviews, she was repeatedly told of the “wonder that the woman’s body produces exactly the right amount and the ideal sort of milk for their child” (116). Although women could list many complaints about their bodies and appearance after giving birth, many observed their bodies with awe, now that they had managed to produce a child (Bailey 2001). So, despite not feeling

attractive, for many, bodies are offering a positive reflection of the feminine self. Riley (1988) suggests that we are not constantly aware of our gender, but that it comes forefront in our attention when it becomes the source of either positive or negative reactions from others. Pregnancy and motherhood are times when this occurs. Pregnancy is often thought of the visual manifestation of sexual activity and feminine fertility.

There is an assortment of difficulties that women encounter through breastfeeding. Although it depicts good mothering, women often feel uncomfortable breastfeeding in public and feel they are required to cover themselves up when breastfeeding while not in private (Stearns 1999). In Western culture women's breasts are sexualized, whereas in nursing the breast becomes nurturing (Stearns 1999). Breastfeeding is considered the morally correct choice for mothers. Those who fail in breastfeeding or do not choose breastfeeding are subjected to negative judgement by others. Qualitative studies have shown that women who do not breastfeed report feelings of guilt, inadequacy, and isolation (Williams et al. 2012; Baker et al. 2005; Hegney et al. 2008). Mothers who choose formula feeding or find the experience of breastfeeding taxing and challenging can be excluded and marginalized (Marshall et al. 2007). When describing a maternal ideal, individual breastfeeding was frequently constructed as a reflection of a natural maternal bond that cannot be replicated by formula feeding. Mothers should also be in control of their own feelings and should manage any guilt they feel because of their feeding choice (Williams et al. 2012)

Emotions

The shift into motherhood contains a range of emotions for women. There are gender rules and feeling rules that are based on one's gender, culture, social class, relationships, and settings. For example, upper class women may be more reserved in expressing their delight than lower-

class women. Feelings are expressed more freely in places where one is with people of close relationship and in a setting, that is comfortable (Elkman 1980; Hoschild 2008). There are contrasting views on how many emotions humans feel and show. Ekman (1973) claims that globally humans all feel six of the same emotions and show six of the same emotions. Beyond this, each culture may differ. The six emotions Elkman (1973) claims everyone experiences include: anger, disgust, fear, happiness, sadness, and surprise. Conversely, Kemper (1987) claims there are only four primary emotions. This list includes: fear, anger, depression and satisfaction.

Kemper (1987) believes that “satisfaction” is a primary emotion linked to biology. Other emotions that are shown or felt, such as the socially constructed feelings of guilt and pride, are linked to the four primary emotions. For example, guilt and shame are less evidently primary emotions in this respect. Whole cultures may be oriented toward one or the other of these. Emotions like guilt, pride, shame, love, and hate, among others, do not emerge in the earliest stages of development. These emotions are socialized. Kemper (1987) argues that guilt is a socialized response to the arousal of the physiological condition of fear and anger. Meanwhile, pride is a socialized response to satisfaction. Thus, both guilt and fear are socially constructed and are emotions women encounter as new mothers.

It is proposed that guilt results from a sense of a use of excess power against another (Kemper 1978). This power can take on many different forms. Guilt, when one does a forbidden act (harming or threatening a child) is punished based on experience; at the same time, verbal indications are given linking the act to punishment and the label (“You should feel guilty for acting that way”) to the feeling that already exists in the context of punishment, namely fear (Kemper 1978). Pride, socially constructed because it is not shown in the early years, emerges from satisfaction. Pride manifests through competence and achievement. The better the performance

the greater in general is the status obtained. Pride, a feeling of satisfaction, focuses on the self as worth. Emde (1980) argues that satisfaction is a primary emotion humans feel, not simply a socially construct such as guilt. Therefore, satisfaction with something, such as mothering decently, can create pride in a woman.

Emotions resembling guilt have become commonly associated with motherhood in the U.S. and other western countries. Guilt is apparent in both working and stay-at-home mothers (Sutherland 2010; Liss et al. 2013). Mothers feel they must be devoted fully and wholly to their children. Mothers feel complete responsibility for how their children mature and develop (Wall 2010; Sutherland 2010). High standards and a sense of responsibility means that to be a good mother may lead women to feel depleted, guilty, and inadequate at times (Seagram and Daniluk 2002). Mothers may report feeling guilty because of their inability to live up to their own, or society's, expectations for high maternal investment in children. The "motherhood myth" might be one of the primary sources of maternal guilt (Rotkirch 2009). Western society has set such high standards for being a perfect, intensive mother, and this has been internalized by women (Arendell 2000; Hays 1996). When women feel they are unable to live up to these standards they show signs of or express guilt. Liss et al. (2013) explain that "self-discrepancy theory proposes that guilt and shame result from perceived discrepancies between one's actual and ideal selves" (1112). A fear of being evaluated and judged negatively by others may enhance guilt from failing to live up to the internalized standards of motherhood (Liss et al. 2013).

Research has shown that both internal and external resources, such as friends, family, and social networks, may contribute to the growth of a new mother. While lack of these resources may lead to guilt or a sense of loss (Tedeschi and Calhoun 2004). Cronin's (2015) research found that having children cause some friendships to disappear, while other friendships improve, and new

friends are made. Women who have a strong network of “mum friends” or “domestic friends” used their friends as a resource enhancing their positive emotions (Cronin 2015).

As reviewed earlier, a societal ideal for new mothers is that they nurse their newborns. Breastfeeding is the “morally correct choice” and it “has implications for actual decisions and practices as well as subjective judgements and feelings, particularly those of guilt and inadequacy” (Williams et al. 2012:339). Bottle feeding versus breastfeeding constructs a good mother/bad mother dichotomy. Qualitative, in-depth research has reported that women who do not breastfeed report experiencing feelings of guilt, inadequacy, and isolation (Baker et al. 2005; Hegney et al. 2008), as well as frustration, failure, and marginalization (Lee and Furedi 2005). This can be attributed to the construction of breastfeeding as “morally correct.” It excludes and marginalizes women who choose formula feeding, women who face problems breastfeeding, as well as women who experience breastfeeding as taxing and challenging (Williams et al. 2012).

If mothers feel unable to adequately protect their children from risk or harm, it can lead to feelings of guilt (Baumeister 1994). Guilt is an undesirable outcome in that it is an aversive emotional experience (Perskey et al. 2015). Often, individuals are motivated to take steps to reduce these negative emotions (Tangney et al. 2007). For example, Perskey et al. (2015) found that if a mother transfers her genetic risk of obesity over to her child, the guilt mothers feel is especially strong. In attempt to help their child and reduce likelihood of obesity in their child mothers attempt to demonstrate healthy eating patterns for their child. Actively working to reduce the risk of obesity helped to lessen the mother’s guilt (Perskey et al. 2015).

The Beauty Mandate

Women are defined via their appearance (Kwan and Trautner 2009). The current feminine beauty ideal is thin, fair skin and eyes, youth, unblemished skin, and smooth hair (Kwan and

Trautner 2009). Gruber (2007) and Bell et al. (2016) argue that an “athletic ideal” for women is becoming increasingly desirable. The feminine beauty ideal is viewed largely as an oppressive, patriarchal set of expectations that objectifies, devalues, and subordinates’ women (Bartky 1990; Bordo 2003; Freedman 1986; Wolf 1991). The ideal is a prescription for behavior that women engage in, called body work. Body work is the “management and modification of one’s own looks and physical wellness” that is prescribed by beauty norms (Gimlin 2007:355). More specifically, beauty work is work that “individuals perform on themselves to elicit certain benefits within a specific social hierarchy” (Kwan and Trautner 2009:50). Beauty work “occurs within a social system that distributes rewards and sanctions partially based on appearance” (Kwan and Trautner 2009:50). Women are held accountable for various appearance norms. Forms of beauty work include, among others, fashion/clothing selection, dieting, exercise, makeup, cosmetic surgery, hair removal, and hair styling (Gimlin 2007; Kwan and Trautner 2009).

Beauty Work

Women are held accountable for various appearance norms relating to hair, makeup, body hair, body size, body shape, fashion, and nails. The “basic assumption that underlies all of these norms is that women’s bodies must be altered in some way—that their natural state is unacceptable” (Kwan and Trautner 2009:55). Because of this, much body or beauty work is “normal.” For example, women are expected to remove body hair to be “normal” and to style their hair in a specific fashion (Toerein and Wilkinson 2003). Older women are expected to use anti-wrinkle creams, cosmetics, hair dyes, and cosmetic procedures to appear youthful and “normal” (Clarke and Griffin 2007). To be “normal” some women purchase procedures such as cosmetic surgery, which further defines beauty as a commodity (Gimlin 2000). Here, the body becomes a commodity which needs to be upgraded continuously (Gimlin 2000). The cosmetic surgery

industry has been rapidly expanding (Wolf 1991; American Society of Aesthetic Plastic Surgery 2015). Not all women can afford cosmetic surgery; however, the ideals that are presented and prescribed are shown to all women. Gimlin (2000:86) found that many of her participants had “fantasized” about cosmetic surgery, even if they never have it done. Women jeopardize their health in other ways than just cosmetic procedures for the attainment of beauty. For instance, women purposely use tanning beds and sunbathe to attain tan skin despite the risk of skin cancers (Clarke and Korotchenko 2009).

The social importance of the feminine beauty ideal lies in its ability to sustain and to reproduce gender inequality (Bartky 1990; Freedman 1986; Wolf 1991). The feminine beauty ideal is a normative means of social control whereby social control is accomplished through the internalization of values and norms that serve to restrict women’s lives (Bartky 1990; Fox 1977). In this way, women internalize norms and adopt behaviors that reflect and reinforce their relative powerlessness, making external forces less necessary. Media conveys similar messages about the importance of feminine beauty by demonstrating how beauty gets rewarded (Currie 1997). Media images also reinforce gender expectations and predicts body dissatisfaction in girls and women (Cafri et al. 2005; Grabe et al. 2008; Groesz et al. 2002;).

Body Image

Each of us live within a larger culture and the ideals that the culture portrays shape our own perceptions of ourselves, such as the ideal of what a woman and mother should look like. When we are shown specific images, and are expected to attain a certain ideal, we come to have a certain image of our own physical appearance (i.e. body image). Grogan (1999) claims that body image is a person’s perceptions, thoughts, and feelings about her own body or physical appearance. A person with a poor body image will perceive her body as being unattractive or even repulsive to

others, while a person with a good body image will see herself as attractive to others, or will at least accept her body in its current form. Perceived body image is not necessarily related to any objective measure or the average opinion of other people (Grogan 1999). For example, a person who has a poor body image may be rated as beautiful by others, while a person with a good body image may be rated as unattractive by others (Andersen 2009). Body satisfaction problems are concerns particularly for adolescent girls (Micali et al. 2014). During times of bodily change concerns over the body can heighten. For example, the transition of puberty has been identified as time of vulnerability to body dissatisfaction and eating disorders (Rogers et al. 2015)

The dominant culture promotes a narrow image of beauty for women. Women and girls who internalize this ideal, one that is generally impossible to achieve, often end up being disturbed about their bodies. Adolescent and adult women across the spectrum are consistently more dissatisfied with their bodies than adolescent and adult men, often resulting in poorer body image and increased focus on appearance in women (Tiggemann 2004). The pressure to look “normal” or “right” can be internalized causing extreme self-disapproval. It drives many to spend long hours exercising, looking in the mirror, and dieting. Even for those who would be considered attractive within their own communities, the dominant culture’s obsession with youth, whiteness, blondness, and thinness undermines the positive attitudes of many (Disch 2009). Many of us feel that we do not physically appear “normal” throughout our lives because what we are shown as “normal” is just an “ideal” that has been socially constructed and is continually reinforced by our own participation in it.

Women are Socialized to Value Beauty and Thinness

As depicted above, women’s assessments of body weight are a central part of body image in our culture where women experience considerable social pressure to be slim (Garner et al. 1980;

Hesse-Biber 2007). Slim bodies are regarded as beautiful and worthy, while overweight bodies are not only unhealthy but also offensive (Harrison and Cantor 1997). Being overweight is linked to laziness, lack of will power, and being out of control. Bordo (2003) claims that the outward appearance of the body is a symbol of personal order or disorder. Slenderness symbolizes being in control. Most people do not have slim, toned bodies naturally, so they must be constantly vigilant through diet and exercise to conform to the current ideal (Bordo 2003). People who do not conform to the ideal face prejudice and discrimination throughout the life course (Cash 1990).

Media images reinforce gender expectations in regards to female beauty. Internalization of societal standards of attractiveness as depicted by the media predicts body dissatisfaction among women (Cafri et al. 2005), which in turn contributes to dieting, exercise, and disordered eating behavior (Stice 2002). Exposure to the thin-ideal media leads to negative feelings about one's own body (Grabe et al. 2008; Groesz et al. 2002; Hesse-Biber 2007). In the previous eras media consisted of advertising, film and television. Today people are spending more time on media when we add in time on Facebook, Twitter, Myspace, Tumbler, or Instagram, where photos are often doctored. Research shows that these create even higher levels of body dissatisfaction, drive for thinness, internalization of the thin ideal, body surveillance, self-objectification, and dieting (Fox and Rooney 2015).

In addition to gender expectations, the media influence standards associated with race, class, sexuality, and age. The mass media promote narrow definitions of who people are and what they can be. Although aging is inevitable, women are warned to fight the signs of aging. Youth, not age, defines women's beauty. Light skin is promoted as more beautiful than dark skin, regardless of race, although being tan is more beautiful than being pale (Herring et al. 2003). Furthermore, an additional component has been "added" to the ideal beauty requirements of a

female, this being “athletic” in appearance. Bell et al. (2016) claim that rather than simply thinness, preference is increasing for an “athletic ideal” typified by a slightly muscular upper body, toned abdomen and firmer lower body. This ideal can be arguably even more unrealistic than the “thin ideal” for women, or mothers, to achieve. A muscular female physique is not achieved without significant weight training, dieting and cardiovascular exercise (Bell et al. 2016; Gruber 2007). When women transition into the phase of motherhood the time it takes to maintain an “athletic” body may be unattainable. Furthermore, a mother’s body may have extra skin that cannot be toned and appear ideal in an “athletic” way.

Body Image during the Postpartum

It is estimated that with each birth, women in the United States experience a permanent weight gain of 2.2 pounds (Institute of Medicine 1990; Harris 1999). On the higher end, Smith et al. (1994) found that women retain from 2 to 6.6 pounds and Williamson et al. (1994) found that women retained from 3.7 to 4.9 pounds. Harris (1999) claims 10-30 percent of new mother’s experience a permanent weight gains of ten pounds or more. However, women with higher socioeconomic status retain less weight than women with lower socioeconomic status (Shrewsbury et al. 2009). Greene (1988) reported that twelve percent of women carry gains of fifteen pounds or more to the start of their next pregnancies. Gains like these carry elevated risks of obesity, coronary heart disease, breast cancer, and other potential health risks (Walker and Freeland-Graves 1998). The medical community has constructed losing “baby weight” as something that is necessary and healthy. Many women construct this as necessary as well.

After birth, media images warn that “letting the body go” constitutes failed womanhood and motherhood (Dworkin and Wachs 2004:616). Regaining control of the “unruly pregnant form is normalized in pursuit of an openly stated central goal: to return to one’s former size” (Dworkin

and Wachs 2004:616). It is not surprising that body image dissatisfaction has been found to peak in the postpartum period (Strang and Sullivan 1985). After giving birth women have persistently expressed concerns about returning to their pre-pregnant weight (Fairburn and Welch 1990). Most women continue to look pregnant in the first few weeks following birth, and in the first few months most new mothers continue to weigh more than their pre-pregnancy weight. During pregnancy, this may have been regarded as a positive sign of the baby's health and development. However, it is generally not experienced as acceptable after giving birth, and quick weight loss is the expected goal (Heinberg and Guarda 2002).

The physical changes associated with the after-effects of pregnancy present concerns for women. Women feel that their bodies become less aesthetically pleasing after pregnancy, and that they had been relatively attractive in the "golden days" before pregnancy and childbirth (Grogan 1999). According to the literature, for many women, pregnancy did not result in any positive effects that women can identify. The main negative effect is stretched skin around the stomach and drooping breasts (Grogan 1999). Several researchers have demonstrated that postpartum body image concerns are far greater than at pre-conception and that they may continue to increase for six months postpartum. For example, Hiser (1987) found that 75 percent of recent mothers studied were concerned about their weight at two weeks postpartum. Baker et al. (1999) demonstrated that 70 percent of women were still trying to lose weight at four months postpartum. Jenkin and Tiggemann's (1997) participants were, on average, heavier four weeks after having their baby than they were prior to becoming pregnant, and were less satisfied with their post-natal weight and shape. They were also slightly heavier than they had anticipated, particularly in the case of the younger women (Jenkin and Tiggemann 1997). Women with more than one child feel more

positive about their postpartum bodies compared to women who have had their first child (Strang and Sullivan 1985).

The motherhood transition offers an opportunity to study weight concerns and weight management strategies during a period of weight fluctuation that is part of a life transition for many women. Devine, Bove, and Olson's (2000) aim was to develop an in-depth understanding of women's experiences of postpartum body image through semi-structured open-ended interviews. Pre-pregnancy orientations towards body weight emerged as the primary influence on women's postpartum attitudes toward weight, on patterns of physical activity and diet, and on postpartum weight outcomes among their participants. Walker (1998) used content analysis to categorize 227 new mothers' written descriptions of feelings about their weight. More than 40 percent were somewhat satisfied with their weight, another 40 percent were mildly dissatisfied, and eight percent experienced weight-related distress. Higher pre-pregnancy body mass index, larger gestational weight gain, higher current postpartum body mass index, less healthy lifestyle, and greater body image dissatisfaction were associated significantly with more dissatisfied feelings about weight (Walker 1998).

Part of postpartum body image dissatisfaction may be due to unrealistic expectations. Many new mothers expect to return to their pre-pregnancy weight and shape by six weeks postpartum. However, most weight loss occurs during the first postpartum year, with decelerating loss occurring as the year progresses (Jenkin and Tiggemann 1997). Many women experience permanent weight gain. Women typically retained weight after delivery, although there is considerable variability (Jenkin and Tiggemann 1997). Many women are dissatisfied with their weight and shape after having a baby. A possible reason for disappointment is that women, especially women having their first child, tend to expect that their bodies will return to their pre-

pregnancy weight and shape shortly after the birth of their child. Younger women are often the most unrealistic in forecasting their expected post-natal weight (Jenkin and Tiggemann 1997).

Women are expected to immediately conform back to the cultural ideal of “thinness” directly following birth. Dworkin and Wachs (2004) contend that as new mothers, women are responsible not only for their first shift of paid work, and the second shift at the home of caretaking for the family and the home, but also responsible for a third shift of body work and fitness practices. When women are faced with the first, second, and third shifts, the third shift is the first to go (Dworkin and Wachs 2004). Given the large amount of responsibility new mothers have, it is an unrealistic expectation that they return to their pre-pregnancy form quickly, but, nonetheless, is expected and valued in western culture.

Dworkin and Wachs (2004) claim that *Fit Pregnancy* articles define the postpartum body as “chaotic, disorderly, and stressful” (617). Similarly, Upton and Han (2003) contend that the female body is expected to be under control in contemporary society. Pregnancy signifies a state of being out of control, particularly for women involved in the paid labor force, and the struggle to reassert and literally regain identities after childbirth is paramount but given less attention. Upton and Han (2003) interviewed and observed women in a semi-urban area in the Midwest who were pregnant or recently gave birth. They found that for women who already are forced to negotiate boundaries when pregnant, there is an imperative to regain ownership of their body in the postpartum.

Upton and Han (2003) question just what “getting your body back” signifies. They conclude that it is not clear what is meant by this idealistic statement. They contend that for many this is “a path, a trajectory toward a certain kind of ideal type, an ideal role” (Upton and Han 2003:868). For most women, “breasts, hips, stomachs may be different after pregnancy and may

never be recaptured” (Upton and Han 2003:688). In the U.S., the message is clear -- women must get their bodies back. The medical community claims that this is the “healthy” thing to do. It is a woman’s responsibility is to get her body back. Entire industries have grown around the postpartum body. For example, there are workout videos, special programs at health clubs for new moms, web sites, and even chat groups (Upton and Han 2003). While pregnant bodies are public bodies, postpartum bodies are not. Postpartum bodies are something that the individual person must have in control.

The larger question is why does it matter if a woman gets her body back or not (Upton and Han 2003). Motherhood is essentially defined by loss, a loss of a previous identity and a loss of a previous body, both of which women struggle with in the postpartum period.

They struggle with the lived experience of what it means to attempt to recapture a lost identity, forge a new one, and be responsible for a new body and self. They express feelings of losing their ‘own’ bodies, their own ‘selves’, both as a result of pregnancy and in the period after giving birth. Studying why and how women get their bodies back does matter—it tells us about the real boundaries which remain between work and family domains for women, and it tells us how other social pressure on the individual body always exist for women in the United States (Upton & Han 2003:689).

The body is always subject to context, as it does not represent a fixed concept. However, discourse on “getting the body back” after pregnancy seem to suggest some sort of fixed ideology of what it means to be female in the United States, and that there is some form of fixed notion of what a woman is, even though it is ever changing.

Layne (2000) expressed that a loss of identity is a central and integral aspect of motherhood. While pregnant, a certain identity has been lost, or replaced (Upton and Han 2003). After delivery, a woman, in a sense, is transformed into a different kind of person. She is now a “mother” and a “tension exists between this new social self and the individual who is struggling to get a particular body and self-back” (Upton and Han 2003:672). There are two losses after

delivery as discussed above, the loss of the pregnant self and the loss of a previous body, which are often associated with a previous identity. Trying to reassert a certain kind of self and body after delivery is central in many women's lives (Upton and Han 2003). This can be difficult, however, since after delivery women are expected to care for themselves, their job, their newborn child, among other responsibilities (Upton and Han 2003). Fox and Neiterman's (2015) qualitative study on forty-eight postpartum Canadian women within twenty months of giving birth, found that they are most concerned about their body when they are in the public sphere. For example, "concerns about appearance persisted and became especially when the women returned to paid work" (Fox and Neiterman 2015:671).

Bailey (2001) attempts to understand how important the shift of a women's sense of self identity is throughout the pregnant and postpartum stages in relation to the woman's body. Her data suggest that we should not overstate the importance of the changes. She found that self-identity was distinct from bodily changes, both before and after the birth of children. Some women specifically distance their identities from their bodily changes because they feared that others would reduce them to only their bodies (Bailey 2001:125). However, Bailey (2001) studied only white, middle class, working, educated women. Therefore, little information can be taken from this on women of other social categories. We do not know if all women can separate or distance their identities from their bodies like her sample was able. Furthermore, whether the child was planned or not, whether it is the first child of the woman or not, and the age of the woman, may play an important part in how much bodily changes impact self-identity, as well as gender roles.

Bailey's (2001) sample wanted to conceal their pregnancies as much as possible at the workplace, whereas out of work they did not attempt to conceal their pregnancies. These women seemed to take a special interest in distancing themselves from their bodies, particularly in the

workplace. Their audience, the people they worked with, exerted a form of social control. Postpartum, the physical shape of pregnancy was no longer a concern for these women, but lactation was. Women found themselves happy and willing to breastfeed anywhere except their workplaces (Bailey 2001). The functions of their body were accepted by the woman depending on her audience, and these women may not have internalized any form of identity change in relation to their bodies during pregnancy because work aided in keeping their body and identity separate, and thus these findings on identity in relation to bodily changes cannot be applied to other groups of women.

A key theme in feminist writing on motherhood is women's sense of alienation from seemingly out of control bodies. Despite this, Bailey (2001) argues that motherhood provides women with the chance to appreciate their functional bodies and gain a new sense of their embodied selves. Fox and Neiterman's (2015) study support this. Valuing maternally functional bodies is predicted on bodies meeting the expectations of "good" mothering, of giving birth "normally" and enabling breastfeeding without any problems. However, the positive embodied sense of self that result may be fleeting. For the women in the study at hand, the prospect of the return to paid work reignited worries about appearance. "Celebrating functional maternal bodies involves the contradictions inherent in dedication to privatized mothering. Even when these women talk of prioritizing their own care through body work, many did so in the name of maternal responsibility" (Fox and Neiterman 2015:688).

Gaps in the Literature

Martin (2003: 56) has argued that "since childbirth socially and psychologically marks most women's transformation into mothers, it is striking that there is little sociological work on childbirth" (56). Feminist scholars who have studied medicalization of birth, conceptualized

issues of control and power during birth, and how women hand over control in hospital settings, this work does not often include women's discussions of whether they want control or feel like they have control during birth. (Martin's (2003) remains an exception to this statement.) We need to know much more about how women talk about control during pregnancy and birth, and begin to understand how issues of control extend through the transition to the postpartum year. Most work on control has been focused on control during pregnancy and birth, and does not include an exploration of women's sense of control during the postpartum stage.

Further, while some research exists on mother guilt, particularly focusing on women's guilt about returning to paid work, and although we know that mothers' guilt is frequently reported, we do not have enough of an understanding of how women talk about guilt as they make the transition to early motherhood, and how guilt might manifest differently in pregnancy, birth and the postpartum. Social science researchers would also do well to compare women's discussion of other emotions (such as pride or satisfaction) to their discussions of guilt, to get a better sense of when emotions become more negative. Finally, while feminist scholars have documented the existence of appearance and mothering ideals and there is plenty of research that shows how ideals prescribe behavior, there is less understanding of how ideals intertwine. That is, I hope to show that appearance ideals and mothering ideals are negotiated together in early motherhood, and women must balance the pressures to adhere to each and both norms at the same time. We also do not yet understand how issues of control and lack of control, guilt and pride, and the pursuit of dual (and even dueling) ideals may be related, and how postpartum women may be in a very contradictory space as they adjust to changing bodies and changing roles. In completing this dissertation, I hope to delve deeper into these issues.

CHAPTER 3 RELEVANT SOCIOLOGICAL THEORIES

Theories that will be applied to women's postpartum experiences in relation to their bodies and mothering include medicalization, Foucault's "docile body's thesis" and the social constructionist approach of "doing gender". These three theories fit the topic of new motherhood and overlap in various areas.

Medicalization of Gendered Reproductive Processes

Medicalization is the process by which previous non-medical problems are defined and treated as medical problems (Conrad 2007). Medicalization includes defining a "problem" in medical terms, adopting a medical framework, and treating this "problem" with medical interventions (Conrad 2007). The increasing trend of medicalization of processes such as pregnancy and childbirth are linked to the growing authority of the medical profession. Beginning with the extension of medicine's jurisdiction, medicalization is viewed as a process whereby "natural occurrences" in everyday life come "under medical domination, influence, and supervision" (Zola 1983:295). Riessman (1983) claims that medicalization has far-reaching consequences for women. Thus, medicalization has transformed several gendered reproductive experiences, such as pregnancy, childbirth and women's aging, into medical and technical problems.

Per Riessman (1983), a "plethora of female conditions" have been re-conceptualized as illnesses (Riessman 1983:9). In fact, research on medicalization has shown that women's issues have been disproportionately medicalized (Conrad 2007). "Medicalization has resulted in the construction of medical meanings of 'normal' functions of women -- experiences the typical woman goes through, such as menstruations, reproduction, childbirth, and menopause" (Riessman 2003:57). Previously, midwives aided in pregnancy and childbirth. Childbirth has moved from

the home to the hospital, transforming it from a “human experience to a medical-technical problem” (Riessman 2003:51). No longer are midwives in charge, but the patriarchal authority of the medical community. Particularly, doctor’s orders are followed by medical staff, such as in Freidson’s theory on professional dominance (1970).

Throughout pregnancy, women are constantly monitored at monthly check-ups through weigh-ins, blood work, and other tests where women are deemed “normal” or “abnormal.” Women are given prescriptions throughout pregnancy for “problems” such as nausea or constipation. At each state throughout pregnancy women are expected to gain certain amounts of weight, measure a certain number of inches across the stomach, among other technicalities that deem one as being “correct” throughout pregnancy or “incorrect.” Han (2003) argues that pregnant bodies are subject to heightened scrutiny and expected to eat for two, but not too much. Women must adhere to strict prescriptions about proper diet (Han 2003). During labor and delivery, women are admitted as patients to a hospital and hooked up to monitors (Riessman 1983). As a result, one consequence of medicalization is the expectation of women to be under medical supervision during pregnancy and to relinquish control over the pregnant and childbirth process.

During pregnancy, childbirth and the postpartum periods women feel they have minimal control over their bodies (Bordo 1993). Women claim to be shocked at the unpredictability of their bodies in labor (Miller 2007). Many new mothers are upset about their lack of control over the birthing process (Fox 2009). However, Brubaker (2007) and Fox (2009) point out that this may be a middle-class issue and not every woman’s priority. Some women who receive pain related medication or cesarean sections during labor experience anger at their bodies. They believe their bodies failed to give birth naturally (Miller 2007). Upton and Han’s (2003) study (discussed

in the literature review) also highlights middle-class women and their sense of their body being out of control.

The amount of weight to be gained during pregnancy has become medicalized by public health officials, with adherence to these rules being checked by doctors and other health professionals, who monitor how closely women conform to this range (Williams and Potter 1999). Women are the ones who are expected to be in control of their weight, even throughout pregnancy, and especially in the postpartum. Women are expected to gain certain amounts of weight at certain points in their pregnancy, and are expected to lose the weight soon after delivery of their child. They are solely to blame if they gain “too much” or “too little.” Doctor’s advice is a prescription for their behavior regarding weight gain and procedures are in place (e.g. weigh-ins) to monitor whether women are “behaving” correctly. Yet, women are always expected to still be “in control” of their bodies. Pregnant women feel the pressure to become the ‘perfect’ pregnant woman (Stern 1993). If a woman chooses to drink or eat the wrong foods she is constructed as negligent and is criticized for risking the health of her developing baby (Lupton 1996). Williams and Potter (1999) found that their participants felt an increased amount of pressure to follow ‘expert’ advice on dietary choices and felt constantly subject to public scrutiny. The “provision of expert advice around weight gain and nutritional intake may disempower pregnant women and inflict guilt if they cannot conform to the exacting standards” (Williams and Potter 1999:234).

During pregnancy, the objectification of women’s bodies is intensified as women become “incubators of babies” rather than bearers of their own bodies (Reissman 1983). Women are expected to eat more and differently during the period of their pregnancy, reflecting the change in their status of their bodies and roles (Lupton 1996). The responsibility for the baby’s nourishment originates in pregnancy. Now a woman is expected to nourish her body “appropriately” to ensure

optimal health and development of the baby. So, women should not eat more for themselves but rather for the baby. This carries into breastfeeding as well, where women are expected to eat only nutritional foods that will be carried through their milk to their infants. The postpartum period itself has not been fully discussed in research on medicalization. It could be argued, that the postpartum period has not been medicalized to the same extent as pregnancy and childbirth have. Women are expected to see doctors constantly throughout pregnancy and during the birth of the child, but are then left on their own to get through the postpartum period (apart from one postpartum visit at approximately six weeks after birth). The focus after the birth of the child becomes the child, not the mother. During the postpartum period women are expected to take their infants in for a series of check-ups with physicians and to become the “perfect” mother, to put themselves aside for their child. Whereas throughout pregnancy the focus was the mother and fetus, after childbirth, the focus becomes the child and the woman’s ability to mother the child. Thus, medicalization focuses on the child more than the woman herself who has recently given birth. This study investigated how women deal with the idea that they must become perfect mothers directly after giving birth, even though they may be given little to no direction after the birth of the child from the medical profession, who previously oversaw much of what was going on with their bodies and life.

Foucault’s “Docile Bodies” Thesis

Feminists have used Foucault’s (1979) “docile bodies” thesis to understand the obsessive practices of beauty and body work such as weight control, hair maintenance, fashion, and cosmetic surgery (Barky 1990; Bordo 2003). Foucault (1979) ascertained that docility is achieved through the actions of discipline. Discipline is different from force, because it is a way of controlling the operations of and to the body. His basic idea of discipline is that one will be rewarded for

achievement, and be punished for a lack of achievement or non-conformity (Foucault 1979). In this study, Foucault's work can be applied to the postpartum period in terms of both body image and mothering on how women are expected to conform to certain standards of both beauty and mothering through the actions of self-monitoring and self-discipline.

Foucault (1979) believed that constant supervision and forced discipline break the will of people, in his case prisoners and in this case women, and make them into "docile bodies." A docile body" is easy to control. For example,

One may have hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus, discipline produces subjected and practiced bodies, or "docile bodies" (Foucault 1979: 138).

Foucault (1979) maintained that the body is a central location for the expression and reproduction of power relationships. Through self-surveillance and everyday disciplinary practices, individuals internalize and reproduce hierarchies of social status and power, transforming their own bodies into "carriers" or representations of prevailing relations of domination or subordination.

"The disciplinary power that inscribes femininity in the female body is everywhere and it is nowhere; the disciplinarian is everyone and yet no one in particular" (Bartky 2003:36). Women self-check and regulate among one another to keep women in line. For example, competition between women is a prominent feature of internalized sexism, "reflecting women's collusions with beauty expectations that are both limiting and unrealistically demanding" (Zones 1997:254). Women "become each other's critics, keeping each other anxious and in line, thereby maintaining the status quo" (Zones 1997:254).

New mothers may look to magazines and books to understand what is going on with their bodies, infant care, and mothering during the postpartum. Thus, institutions have a strong hold on what a postpartum woman feels about her body, what types of body and beauty work she performs,

how she cares for her infant and mothers. What the media presents as a proper postpartum body and mothering, may not be realistic for most women and decrease women's self-esteem, thus keeping these women "in check." Women may have been free of this oppressiveness throughout pregnancy, but during the postpartum, they will likely feel this institutional power again, and conform to the notion of "getting the body back." For example, in Dworkin and Wachs (2004) content analysis of *Shape Fit Pregnancy Magazine* the authors reveal how contemporary mothers are defined as newly responsible for a second shift of household labor and childcare, as well as a new third shift of bodily labor and fitness practices.

Feminist writing about motherhood has highlighted the discursive policing of women's bodies. Women's concerns about appearance persist in the transitions to motherhood. In relation to beauty, there is first the social pressure to lose the weight gained (Fox and Neiterman 2015). Family, friends and acquaintances come see the new baby, as well as the new mother and be given tips on "how to lose that baby weight" without even asking for this. Additionally, a Foucauldian approach of the postpartum may look at what information women are getting from institutions in terms of care for their bodies, infant care, and mothering in the postpartum period. For example, women likely receive some information from medical institutions that is similar across the entire medical field, but they may not be receiving enough information, hence the lack of the medicalization of the postpartum period. More information may come from family, friends, and the media. Women are expected to adhere to mothering norms throughout the postpartum stage such as not talking about the "bad" aspects of being a new mother, how their body may hurt, and how sleep deprived they may be. Women are expected to fall in line, love mothering, love your baby, forget your postpartum body and concentrate on the baby only.

Foucauldian understandings of discourse focus on the complex, and at times conflicting, nature of power relations (Wall 2001). Foucault (1979) identified a set of strategies by which discourse constructs a certain view of reality in the presence of alternative views. Notions and images of mothers becomes interpretable not as neutral depictions of reality, but rather social constructions that are shaped by relations of power that naturalize these images and ideas across a range of settings. Within Foucault's framework of knowledge and power Williams et al. (2012) analyzed the ways in which childcare texts construct issues of infant feeding. Williams et al. (2012) focused on the ways in which discursive strategies normalize and moralize mothers who breastfeed by undermining identities and subjectivities that fall outside of this norm and the implications that this has in relation to guilt. Similarly, other aspects of motherhood are normalized and moralized, such as attachment parenting, which undermines those who fall outside of this and lead to possible guilt. Essentially, new mothers are controlled by their desire to not feel guilt.

Doing Gender

Riesman (1998) contends that gender operates not only on the macro level, but at the micro and individual levels of society, and that the micro-level enactment of gender bears a heavy responsibility in the persistence of gender inequality. Here, gender is a stratification system based on categorizations that are created and reinforced everyday (West and Zimmerman 1987; Lorber 2009). Almost all organizations are built on gendered principles and almost all people "do gender" because if we do not, we are deemed abnormal. By "doing gender" we continually re-create the expectations that men and women do, and ought to, think and behave differently (West and Zimmerman 1987). Thus, males and female are expected to occupy different roles within society. However, simply accepting gender as a legitimate basis for any role allocation validates inequality

(West and Zimmerman 1987; Lorber 2009). Women “do gender” and by “doing gender” they are expected to take specific roles. One of these is mothering. So, women “do mothering” in a sense (Miller 2007) which is different than the ways “males do fathering.” Both are social constructions that are continually recreated in everyday life.

Gender theorists do not assume the dichotomous gender categories of “male” or “female” or the roles attached are “natural,” nor that the gender boundaries are or should be stable (Acker 1992; Lorber 2009; Riesman 1998). Despite this, many of us are born male or female, except for a small few who are born ambiguously sexed, a classification based on biology, and we learn to be masculine or feminine. Most of the differences between the sexes are socially created, not “natural.” The meaning of gender grows out of our society’s values, beliefs, and preferred ways of organizing collective life. Our culture constructs and sustains meanings of gender by investing biological sex with social significance (Fausto-Sterling 1992). Butler (1990) argues that sex itself is socially constructed. We assume sex from the assumed gender. Masculinity and femininity have different meanings. For example, to be masculine is to be strong, ambitious, successful, rational, and emotionally controlled, while to be feminine is to be physically attractive, deferential, unaggressive, emotional, nurturing, and concerned with people and relationships (Andersen 2009). Additionally, in relation to this study, to be feminine is to mother (Miller 2007)

Gender is learned. Although gender is rooted in the structure of society, and is even referred to as a structure (Riesman 1998) or institution (Lorber 1994) itself, gender is passed on through social learning and is enacted through gender roles. Gender roles are patterns of behavior in which females and males engage, based on our societies expectations associated with gender (Andersen 2009). Gender roles are learned from infancy on through agents such as our families, the education system, our peers, and the media. From infancy on we are encouraged to conform

to the gender that society prescribes for us. Boys are praised for strength and independence, while girls are praised for looking pretty, nurturing and being nice to others. Parents describe their infants differently depending on their gender, including rating their male children as more intelligent than female children (Furnham and Gasson 1998). Furthermore, girls are dressed in frilly, light colored, confining clothing that easily shows stains if girls engage in “boyish” activities, while boys are dressed in rugged clothing that allows freedom of movement and getting dirty. Girls are taught to care for dolls and boys are taught to run free outside.

Through socialization processes such as these, we gain our gender identity. One’s gender identity is one’s definition of self, based on that person’s understanding of what it means to be feminine or masculine (Andersen 2009). The dramaturgical tradition of symbolic interactionism has contributed to our understanding of the connection between gender and identity (Goffman 1959), and more recently Butler (1990) has worked with the idea that gender is performative. Butler (1990) argues that the examination of phenomena such cross-dressing and drag suggests that the individuals involved are drawing on “scripts” of masculinity or femininity to succeed in doing gender. This makes it possible that all femininity is a performance of some such scripts. One of Butler’s (1990) central arguments is that identity is an effect of such performance, rather than its cause like we like to think. For example, women perform beauty or body work, whether it is putting on makeup, hair styling, and/or dieting, it is a way of doing gender. The body is a text for expressing and reproducing gender hierarchies (Kwan and Trautner 2009). Men are expected to perform some forms of beauty or body work, but not near to the extent that women are. Men perform body work in terms of dominating space as a form of body work, whereas women do it in terms of appearance. How women mother or feel about mothering also becomes a text about

gender. Men and women are expected to perform different roles in terms of child rearing. Men are not held to the standards that women are.

Characteristics and behaviors that males learn and internalize are deemed more worthy than are the characteristics and behaviors that females learn, resulting in gender inequality. There are a variety of gender expectations or ideals that contribute to the perpetuation of gender inequality in U.S. culture. Two of these ideals include the expectation of women to mother and to conform to traditional forms of feminine beauty. During the pregnant and postpartum periods of women's lives these two ideals are confronted simultaneously. Among the tensions faced by women during pregnancy is that at "exactly the moment when a woman's body is accomplishing a highly valued route to femininity, she is least likely to be viewed as aesthetically ideal" (Dworkin and Wachs 2004). During the postpartum period, when a woman is learning to become a mother, she is expected to "get her body back" and to conform to traditional norms of femininity and beauty, thus being expected to perform body and beauty work while being expected to "intensively mother." This dissertation investigates how women think and do mother work, within the theoretical perspective of "doing gender," during postpartum stage, when women are faced with opposing ideals and expectations.

Although gender identities are established relatively early in our lives, changes in our status in society, such as becoming a mother, bring and reinforce gendered expectations about appropriate beliefs, behaviors, identities, and roles (Miller 2007). Mothering is an aspect of "doing gender," The "good" mother is not only "physically at home with her children, but also she is spending physical and psychological quality time with them to ensure their proper development" (Dillaway and Pare 2008:441). Intensive mothering is a constant responsibility (Macdonald 1998) and a "good" mother is always present and forgoes all income earning activities inside or out of

the home (Johnson and Swanson 2004). “Good” mothers are supposed to “subsume their own personality to family,” and have “no other real interests, but only substitute or contingent ones, depending on the other family member’s desires” (Berry 1993:25).

The social constructionist perspective views people as defining, creating, and recreating gender, and thus mothering, through their ongoing interaction with others. According to this perspective, gender is a system of meanings that people enact. Moreover, even when “doing gender” people may not internalize what they are doing (West and Zimmerman 1987; Lorber 2010). More than seeing gender as a matter of unchangeable differences, social constructionists see people as having human agency, actively creating their lives, even within the context of social structures that supersede them. The fact that the social meanings of gender are taught to us does not mean we are passive recipients of cultural meanings. We evaluate cultural meanings, and we can influence them (West and Zimmerman 1987).

Summary

The purpose of this dissertation is to understand women’s transition into early motherhood and how women learn to navigate their emotions, issues of control, and ideals about motherhood and beauty in their new roles. Thus, the three perspectives chosen, Medicalization, Foucault’s “docile bodies” thesis, and “Doing Gender,” apply to new motherhood. Medicalization and Foucault’s “docile bodies” thesis can both aid in explaining women’s thoughts and experiences as well as constraints in the postpartum stage. The social constructionist approach of “doing gender,” or in this case doing mothering, is applicable as well, as a general framework under which women think and act. I will work to apply these theories to my findings in Chapter Eight. In Chapters Five, Six and Seven I also hint at the application of these theories when relevant.

CHAPTER 4 METHODOLOGY

The existing research on postpartum women's personal narratives on control, emotions and ideals, has been both qualitative and quantitative. Quantitative research on postpartum women has emerged from the fields of psychology, nursing, and obstetrics and gynecology. Within feminist literature, where my study is situated, most the studies have been qualitative in nature. For this study, a phenomenological perspective was used and an autoethnographic account supplements this methodological approach. The benefit of using this approach is that it aids in gaining information on the lived attitudes and experiences of individuals who are all experience a similar life moment, leading the researcher to be able to look at the group.

A phenomenological approach was necessary because little recent exploratory, empirical, and sociological research has been conducted on the roads a woman navigates while learning to be a "mother" in U.S. society; specifically, how women transition to the norms of being a mother in current times. Because of its phenomenological basis, this dissertation furthers our understandings of women's feelings of control and lack of control, guilt and pride, and their experiences of appearance and mothering ideals. Most of these findings arose organically from my interviews with new mothers. The original research questions differed from the research questions I pose for this final dissertation. This is because as I completed the study I realized what the women wanted to say went beyond my questions, and that in turn made me realize what I needed to express in my autoethnographic sections. The transition into motherhood has not been studied in full in sociological literature and, overall, we know very little about the lived experience of the postpartum period in the U.S.

My dissertation fills important gaps within the literature on new mothers' experiences. As mentioned in Chapter One, the following research questions became a frame for this study:

- 1.) How do women learn to navigate the “new world” of motherhood they are entering?
 - a. How do women deal with the dichotomy of having a lack of control throughout the journey into motherhood versus having and/or taking control throughout the journey into motherhood?
 - b. How do women transition into motherhood experience and cope with the contrasting emotions of guilt and pride?
 - c. How do women transitioning into motherhood cope with being held to two ideals: that of an ideal appearance and that of an ideal mother?

Methodological Approach

Phenomenology emphasizes the lived experiences of people as conscious beings (Moustakas 1994). Utilizing this phenomenological approach, I interviewed forty-two individuals (Creswell 1998). My study focused on the “essence” or the essential, invariant structure of the human experience of postpartum women during the first year after giving birth (Moustakas 1994; Creswell 1998). Phenomenology as a qualitative research tradition attempts to understand the lived experience through an insider's point of view, as standpoint feminist theory contends most appropriate, as thus was relevant to use in conjunction with autoethnography (Lorber 2010; Creswell 1998). Moreover, this approach can focus on individual experiences, not just the group experience, as a vehicle for eventual understanding of the larger group (Creswell 1998; Lorber 2010). Since this study is qualitative in nature, in-person, semi-structured interviews were chosen.

Women's journey into early motherhood is a personal subject. Accordingly, one-on-one qualitative interviews were chosen as the method of data collection for this sensitive topic. A

strength of this method “lies in the depth of understanding it permits” (Babbie 2001: 298). There is interaction between and interviewer and interviewee in which the “interviewer has a general plan of inquiry but not a specific set of questions that must be asked with particular words and in a particular order” (Babbie 2001:291). It was vital for me, the interviewer, to be familiar with the basic set of questions so that the interview could go along smoothly and naturally. This helped me to gain rapport and allowed me to probe for women to answer more difficult, sensitive questions.

The key issues this dissertation originally planned to investigate were women’s attitudes and experiences of: (1) a changing body, (2) acceptance or non-acceptance of a changed body, (3) body and beauty work, and (4) the multiple, and often contradicting, ideals that women face. The interview guide (see Appendix D) was created to highlight these issues and allowed for exploration of these issues during the interview. The data I received took me off guard. The interviewees answered my questions and supplemented their answers with other related stories. The interview guide allowed women to express way more than I originally thought, however, and this dissertation is a product of that fact. Unprovoked topics such as being controlled versus controlling, and feeling guilt versus pride emerged organically. It became clear in early data analysis that I had to veer away from topics of body image and self-esteem and more towards the conflicted emotions that women were having in early motherhood.

The questionnaire (see Appendix E) was also designed to allow for the collection of demographic data, and questions regarding pre-pregnancy weight, pregnancy weight and current weight. Although I do have this data, I use very little of this closed ended data in this dissertation because of how rich my interview data are. In this dissertation, I am choosing to focus on the topics that were most important to the participants during in-depth interviews, and I am saving

other data for articles that I write in the future. I choose to prioritize women's own voices in the dissertation, and add my own voice, using an autoethnographic approach.

Autoethnography

The research method of autoethnography was chosen for this dissertation for a variety of reasons. This study was exploratory, but I did and still do have a vested interest in the topic and had experienced the phenomenon being studied. My "personal experience becomes important primarily in how it illuminates the culture under study" (Ellis and Bochner 1999:740). Autoethnographies "range along a continuum from starting research from one's own experience to ethnographies where the researcher's experience is actually studied along with other participants" (Ellis and Bochner 1999:740). Feminists have advocated for starting research from one's own experience or standpoint (Smith 1979). In this way "researchers incorporate their personal experiences and standpoints in their research by starting with a story about themselves, explaining their personal connection to the project, or by using personal knowledge to help them in the research project" (Ellis and Bochner 1999:741).

As is the nature of autoethnographic research, I interwove parts of my experience as a pregnant, birthing, and postpartum woman throughout this dissertation, and I bracket my experiences very carefully using italics and asterisks (to assure that readers are very clear about where my autoethnographic accounts stop and start). If I were to hide my experience I would be dismissing an entire perspective that can add to the validity of the project at hand, and that forms a partial basis for my interest in doing this project. Ignoring, or "pretending" to ignore, my own personal part in the study would be to falsify objectivity and take a possible strength away from the study.

There are a variety of ways to use autoethnography. I learned about my own experiences through the writing process and through the research process itself. The autobiographical aspects of my study become a vehicle for me to maintain reflexivity and acknowledge bias, as well to link the personal to the cultural, thus, enhancing and validating my study. To ensure that I not only separated myself from my participants but also compare my own and others' attitudes and experiences, I kept a journal throughout the interview processes; in this journal, I kept track of my emotions and reactions to interviews and I also noted early connections between my experiences and my interview data. Consequently, alongside analyzing the qualitative, in-person, semi-structured interviews of the participants, I also studied my own experience of the journey into new motherhood.

Recruitment Procedures

I applied for and secured IRB approval before any recruitment and data collection took place. Participants were restricted to those women who volunteered for the study and all participants consented to the research before completing the interview and questionnaire. Women were assured that their answers to questions on the interview guide and questionnaire would remain confidential and that they could refuse to answer any question. Before beginning each interview, the subject was given an information sheet (see Appendix C) to read per the IRB protocol and a copy of the information sheet was given to each woman to keep. I read over this information sheet with each participant at the start of the interview, to make sure that the potential participant understood what the study was about and what rights they had as a participant. Only after individuals acknowledged understanding of the information sheet and consent was given, the interview began. All participants were given a pseudonym during the analysis and write-up of

data, and near the end of completing this dissertation the women's real names were deleted entirely.

Women were recruited using the methods of convenience and snowball sampling. The sample was recruited using the following criteria: (1) interested in qualifying for the study, (2) over the age of 18, (3) less than one year postpartum, and (4) willingness to be interviewed. The sample was chosen to ensure that the participants had experienced the phenomenon of interest using the above criteria (Creswell 2003).

Recruitment was facilitated initially through referrals by friends and acquaintances. Flyers were posted in areas frequented by women with young children, such as day care centers, parks, libraries, gyms, and stores that sell baby products, as well as various places around the university campus (see Appendix A). Upon the initial contact with me, possible participants were asked a set of screening questions (see Appendix B). These questions addressed the sample criteria and allowed me to decide if the subject qualified for the study at hand. If an interested subject did qualify for an interview, an interview was scheduled. Approximately forty-nine women contacted me to set up interviews. Five of these women were unable to commit to an interview because of time constraints. Forty-four women were interviewed. Of these, forty-two interviews could be transcribed and used for analysis. Two interviews were considered unusable due to these interviews taking place outdoors where the wind made transcription impossible.

Data Collection

After consent was given by the participant, the interview was conducted using the interview guide instrument (see Appendix D). Interviews took place at a time and in a location, convenient for the participants such as a coffee shop, participant's workplace or participant's home. The subjects were interviewed one time and in one sitting. After the interview a questionnaire was

completed by each responded to gather demographic, reproductive history, and other statistical measurements of the women's body image and sense of motherhood (see Appendix E). After the interview women were asked to recommend the names and contact information of other women who might qualify for participation in this study and might be willing to volunteer. Women were given a few flyers to distribute. The use of snowball sampling gave me groups of women who knew one another and spoke of one another during the interviews.

Compensation

In addition to the women being able to share their experiences, the women were compensated ten dollars for taking part in the interview, with an additional five dollars for completing the questionnaire, for a total of fifteen dollars in cash compensation. Some women were attracted to the interview for the money, while others did not want to accept the money after the interview. Despite this, I made sure that each woman left the interview with an envelope containing fifteen dollars in cash with a thank you note for participating in the interview. They received a list of postpartum resources in this envelope as well.

Interview Guide

The semi-structured, in-depth interview guide (see Appendix D) was developed to allow postpartum women to discuss their experiences as new mothers' one-on-one. This allowed for flexibility during interviews and the ability to ask probing questions based on the responses of the women. Interviews were conversational in nature. I found, as Oakley (1980) found, postpartum women enjoyed talking about their experiences that the women felt had typically bored other people. Additionally, Oakley (1980) found that women enjoyed telling personal stories and would talk for long amounts of time. Women described the interviews as useful because they needed "desperately" to talk to someone about their experiences (Oakley 1980). Because of this, a list of

support resources and informational sources was given to the women at the completion of the interview (Appendix F). When interviewees asked me questions, I would answer honestly and carefully to not to lead the interviewee into a different direction than they would have went naturally if I had not answered the question. I chose to answer the questions to gain rapport with the women. Example topics that respondents would ask about included how many children I had, if I planned on having more children, and my personal experiences as a new mother. I would move on with additional questions to the respondents as soon as I could sufficiently answer the questions posed to me.

The interview was designed to have a semi-structured approach to explore the social meanings and experiences of women's postpartum experiences in a conversational style, as well as to allow for a general set of questions to be asked to everyone (Esterberg 2002). Thus, I included specific categories of questions on the interview schedule (see Appendix D) based on my reviews of the literature on the transition into motherhood. Each specific category of questioning was asked to each woman. However, probing questions and follow-up questions varied from woman to woman based on previous questions answered. For example, to begin the interview, women were first asked to generally describe their postpartum experience. After women described their experience I asked specific questions, although still general enough to elicit a variety of responses, about what each woman spoke of or brought new topics to the conversation, such as specific social changes they experienced and how these made them feel. Other lines of questioning involved the women's attitudes and experiences with body image in terms of weight, appearance, and shape in relation to body and beauty work, as well as mothering in conjunction with this. I also asked women about the "ideals" women may face, as well as what they aspire to look and act like as postpartum women and new mothers. Finally, I asked about their choice of breast or bottle feeding.

I paid careful attention as the women responded to the first questions to facilitate in the development of a positive relationship to lead into more personal lines of questioning. This ability to change the ordering of questions allowed for women to be at ease and comfortable answering questions in the direction they led me. With children nearby in most interviews, and women speaking their minds, I sometimes passed over questions but then could add them back in at the end. Thus, the interview guide was used as a flexible tool. Questioning used a “tell me” approach to bring forth stories from the women. Therefore, women’s responses were not dictated in any way and women’s “lived experiences” of their social transition into motherhood and their reproductive bodies would begin to arise. The interviews were audio-taped with participants’ permission. Throughout the interview process and after the interviews were complete I transcribed the interviews word for word. The actual tapes and women’s names have now been deleted.

Questionnaire

The questionnaire instrument (see Appendix E) was developed to obtain demographic information as well as information on reproductive health topics that are either difficult to discuss face-to-face, such as actual weight, or topics that might take up too much interview time, such as medical information. Although the interview touched on most of the questions relevant to the study, the questionnaire is “nested” within this study specifically to gain related information that may have not come up during the interview (Creswell 2003). The information obtained in the questionnaire was standardized and collected via primarily forced response questions, so that women could complete the questionnaire quickly. Women were provided a self-addressed, stamped envelope so that they could send the questionnaire back to me at their convenience. However, all the women chose to complete the questionnaire directly following the interview.

Journaling

As the interviews were taking place between the interviewees and myself, I wrote notes on the interview guide. This included feelings that came up, as well as the demeanor and presence of the interviewee. Directly after each interview took place, I took the opportunity to “speak my mind” into the recorder. As I noted in an earlier section, I recorded my reactions to the interview, my own feelings and experiences of the postpartum period, and the commonalities and differences between my own experiences and thoughts of the most recent interviewee, to maximize my chances to use autoethnography. At home, after listening to my voice recordings following the interviews, I took notes in my journal. This journal was a Word document that I continually added to throughout the interview process with dates and interview numbers linking the interview to my journaling and notes.

The Sample

The population for this study consisted of women up to twelve months postpartum. Thus, women were recruited from zero to twelve months postpartum. There was an attempt to get equal numbers of women from each stage postpartum, but this was unattainable. The average months postpartum was six months. Twelve women were interviewed within the first three months postpartum (28.5 percent), nine women were interviewed between four and six months postpartum (21.5 percent), twelve women were interviewed between seven and nine months postpartum (28.5 percent), and nine women were interviewed between ten and twelve months postpartum (21.5 percent). Interviews took place between April and August 2010.

All women were recruited in Michigan and efforts were made to recruit from urban, suburban and rural settings. There were no restrictions for participants regarding race and ethnicity, income, sexuality, age, or marital status, and it was hoped that a wide range of women

would be interviewed. Flyers were put around the Detroit Metropolitan area, suburbs of Detroit, small Northern Michigan cities, and small rural towns. Unfortunately, due to women's snowball networks and the limits to my own connections and recruitment strategies, my sample is less diverse than I desired. Three women can be classified as living in an urban area or Detroit (7 percent), fifteen can be classified as living in the suburbs of Detroit (36 percent), eighteen can be classified as living in a small city (43 percent), and six can be classified as living in rural areas (14 percent). Of these four women classified themselves as African American or black (10 percent), one as American Indian (2 percent), and thirty-seven as White (88 percent).

The average age of the participants was 29.5 years old. The youngest woman interviewed was 19 and the oldest were six 36-year-old women. Of the entire sample, thirty-five of the women were married, five were in cohabitating relationships, and two were single. Eleven of the women received Women Infants and Children (WIC) (26 percent of the sample) while the other thirty-one did not (74 percent of the sample). Income of the women and their families varied. Income was marked on the questionnaire and not discussed during the interview unless the women themselves brought it up. In terms of income, three women claimed an income of \$100,000 and above (7 percent), ten women claimed an income of \$75,000-\$99,999 (24 percent), seven women claimed an income of \$50,000-\$74,999 (17 percent), sixteen women claimed an income of \$30,000-\$49,999 (38 percent), four women claimed an income of \$20,000-\$29,999 (10 percent), one woman claimed an income of \$15,000-\$19,000 (2 percent), and one woman claimed an income of \$0-\$14,000 (2 percent). Table 1 presents a summary of the results.

Table 1: Demographics of Women in the Sample

Name	Age	Marital Status	Race/Ethnicity	Months Postpartum	Income	WIC
Ashley	19	Cohabiting	White	6	30,000-49,999	yes
Lindy	21	Married	White	3	20,000-29,999	yes
Melissa	25	Single	White	12	20,000-29,999	yes
Kimberly	24	Married	White	1	15,000-19,999	yes
Silvia	37	Married	White	4	30,000-49,000	no
Louise	28	Married	White	11	30,000-49,000	yes
Lisa	27	Cohabiting	White	1	50,000-74,999	yes
Cassandra	30	Married	White	7	50,000-74,999	no
Jennifer	27	Married	White	4	30,000-49,999	no
Megan	25	Married	White	6	30,000-49,999	no
Sophia	30	Married	White	8	75,000-99,999	no
Michelle	32	Married	White	4	100,000 and above	no
Pamela	27	Married	White	8	75,000-99,999	no
Jeanette	29	Married	White	12	30,000-49,999	no
Denise	32	Married	Black/Caribbean	8	50,000-74,999	no
Judy	36	Married	Black	9	100,000 and above	no
Diane	26	Married	White	6	75,000-99,999	no
Leslie	28	Married	White	11	30,000-49,999	no
Asia	36	Married	Black	7	75,000-99,999	no
Summer	34	Married	White	1	75,000-99,999	no
Prudence	36	Married	White	2	30,000-49,999	no
Julie	32	Married	American Indian	12	75,000-99,999	no
Tiffany	28	Married	White	10	75,000-99,999	no
Noel	36	Married	White	1.5	75,000-99,999	no
Audrina	21	Single	White	7	0-14,999	yes
Kayla	26	Cohabiting	White	10	50,000-74,999	yes
Christie	28	Married	White	11	50,000-74,999	no
Colleen	36	Married	White	2.5	50,000-74,999	no
Avril	23	Cohabiting	White	8	30,000-49,000	yes
Jane	26	Married	White	3	30,000-49,000	no
Jade	26	Cohabiting	White	8	30,000-49,000	yes
Heidi	24	Married	White	8	30,000-49,000	no
Lillian	43	Married	White	7	20,000-29,999	no
Margaret	27	Married	White	0.5	75,000-99,999	no
Kelly	27	Married	White	6	30,000-49,000	yes
Sandy	28	Married	White	6	50,000-74,999	no
Ravan	36	Married	Black	4	75,000-99,999	no
Rachel	24	Married	White	3	30,000-49,000	no
Ruth	35	Married	White	8	50,000-74,999	no
Jamie	35	Married	White	12	30,000-49,000	no
Kathryn	31	Married	White	3	30,000-49,000	no
Amanda	35	Married	White	3	100,000 and above	no

Reproductive health information was also obtained via the questionnaire. For instance, women were asked what type of birth they experienced and whether this type of birth was planned. A total of twenty-five women had their birth go as planned (60 percent of the sample). The remaining seventeen women reported that their birth did not go as planned (40 percent of the sample). Thirty women had a vaginal birth (71 percent of the sample) and twelve women had a cesarean (29 percent of the sample). Table 2 presents a summary of these results.

Table 2: Birthing Experience

Childbirth:	Number of Women:	Percent of Sample:
Vaginal	30	71%
Epidural	12	29%
Natural	10	24%
C-section Planned	9	21%
C-section Unplanned	3	7%
Tear	7	17%
Episiotomy	7	17%
Induction	3	7%

Birth Experience Went as:		
Planned	25	60%
Unplanned	17	40%

Near the end of the interview women were asked what method they chose to feed their babies: by bottle or breast. Thirty-eight women (90 percent) attempted to breastfeed. Of these, seven women (17 percent) quit earlier than they had planned. Twenty-three women (55 percent) of the women planned to breastfeed for twelve months. Half of my sample (21 women) were still nursing their infants at the time of the interview, while four women (10 percent) chose bottle feeding from the start for their babies. These women had difficulties with earlier children and nursing, and did not want to endure the same experience. Thus, they chose to not attempt breastfeeding at all with their current newborn. Three of the women (7 percent) attempted

breastfeeding but found it difficult. Instead of stopping entirely, they chose to pump their own breastmilk and give it to their children via bottle. Table 3 summarizes these results.

Table 3: Infant Feeding

Option:	Number of Women:	Percent of Sample:
Breastfed	38	90%
Bottle-fed	4	10%
Still Nursing	21	50%
Stopped Earlier than Planned	7	17%
Only Pumped	3	7%
Planned to Nurse for 12 Months	23	55%

Data Collection

My shortest interview lasted thirty-two minutes and the longest lasted two hours and thirty-two minutes. Interviews took place in a variety of settings. Most interviews took place in the respondents' homes with their children present. Twenty-eight women (67 percent) welcomed me into their homes to be interviewed. Five women (12 percent) asked me to visit them at work during their break period, and nine women (21 percent) asked to meet at a diner, cafe or coffee house. During fifteen interviews (36 percent) no children were present, meaning that during the remaining twenty-seven interviews (64 percent) the women's babies, women's other children, or my daughter, age two at the time, were present. My daughter was present at nine interviews (21 percent). In twenty interviews (48 percent) the women's own children were within the situation and during nine (21 percent) both my daughter and their children were within the situation. Children likely caused the interviews to last longer as the children needed to be tended to. However, with children present women were more likely to be forthcoming with their experiences and spoke to me in depth for longer amounts of time. The children seemed to work as reminders of how the women felt. For example, when in a woman's home with her children, children would

scream, knock things over, and ask for things. When I asked questions such as, “How has your life changed since becoming a mother?” the woman would have a lot to say as she was experiencing the situation now. When at a diner or workplace when asked this same question, women took longer to think and had less to elaborate on their stories. Additionally, when the women saw my daughter present as I entered their homes, they seemed to relax knowing that I would be minding my child as they minded theirs. This made me one of them and created an instant bond that I did not feel in the interviews where my child was not present. Table 4 summarizes this information. Babies who were in another room sleeping were not counted as a child present.

Table 4. Interviews

Name	Location	Interviewee Children Present	My 2-year-old Present	Length of Interview
Lindy	home	1	yes	1hr 32min
Melissa	home	2	yes	54min
Kimberly	home	1	yes	1hr 14min
Silvia	coffee	1	no	1hr 2min
Louise	home	1	no	1hr 15min
Lisa	coffee	0	no	1hr 37min
Cassandra	her work	0	no	1hr 30min
Jennifer	home	2	yes	1hr 32min
Megan	home	1	yes	1hr 45min
Sophia	restaurant	0	no	1hr 25min
Michelle	home	2	no	1hr 20min
Pamela	café	0	no	1hr 40min
Jeanette	home	0	no	56min
Denise	her work	0	no	1hr 35min
Judy	her work	1	no	1hr 25min
Diane	home	2	no	2hr 32min
Leslie	home	0	yes	56 min
Asia	café	0	no	1hr 22min
Summer	home	1	no	1hr 16min
Prudence	home	1	no	1hr 8min
Julie	her work	0	no	1 hour
Tiffany	home	0	yes	54 min
Noel	home	2	yes	1hr 21min
Audrina	café	0	no	1hr 46min
Kayla	restaurant	0	no	1hr 22min
Christie	phone	0	no	1hr 16min
Colleen	home	1	no	47min
Avril	home	2	no	56min
Jane	her work	0	no	55min
Jade	home	1	no	1hr 30min
Heidi	home	1	no	47min
Lillian	home	5	no	1hr 12min
Margaret	home	2	yes	1hr 30min
Kelly	restaurant	0	no	1hr
Sandy	phone	0	no	52min
Ravan	coffee	0	no	40min
Rachel	home	2	no	46min
Ruth	home	5	no	1hr
Jamie	home	2	no	2hr 20min
Kathryn	home	1	no	2hr 5min
Amanda	home	2	no	45min

Analysis Procedures

Interviews were transcribed personally throughout the data collection process so that I was continually able to analyze and make possible amendments to probing questions during data collection to facilitate a more complete understanding of experiences. Transcriptions were placed in Microsoft Word documents. During early data analysis, I listened to and read all transcriptions in their entirety and then extracted significant statements and conversations from each interview (Creswell 2003). Subsequently, I looked for patterns within the women's answers to questions, concentrating on similarities and differences across women's discussions of various topics (Dillaway 2005). I put these statements in separate Microsoft Word documents, and then folders based on themes. The statements and conversations were formulated into various meanings. These meanings were clustered into themes that relate to the journey into motherhood experienced by the interviewees (Creswell 2003).

Initially, I aimed to create a general description of women's attitudes and experiences of the postpartum period, focusing on body image and how it may be influenced by the competing cultural ideals women face of beauty and mothering. Interviews provided more data than expected. Themes emerged outside my original goals of the study and were placed in a variety of different categories. Therefore, for this dissertation, three of the most prominent themes were chosen to highlight. These themes chosen include: (1) issues of control, (2) guilt and pride, and (3) notions of and comparisons to ideal mothers. Other themes were placed in Word Files to be used in future publications. Transcriptions were read through twice as I looked more comprehensively for information that related to the specific clusters of data that emerged in my first reading. Finally, the "search" command in Word was used to find related words within each transcription, to see if any statements were missed that could be clustered into one of the main areas of concentration.

Within each of these Word files statements were arranged into subthemes, and statements were selected that best supported the theme and subthemes of the clustered data.

Data Analysis

Most my interview guide represented open-ended questions intended to gather information about women's adherence to appearance ideals and mothering ideals. Initially the pure amount of data on these topics was so overwhelming that I had difficulty sorting through it. Over time and after multiple attempts at analysis, however, analytic codes about control and guilt stood out and became the subject of my analyses.

Control. Control was easier to code for than the other two themes, as women talked about it in more straightforward terms, and conversations about control were found in response to most of my major interview questions. Women discussed it in many ways. Quotes discussed in Chapter Five exemplify instances within which women outwardly expressed their feelings or experiences about some form of control (or lack thereof). I found it easiest to organize my data on control by specific life stage (i.e. pregnancy, birth, postpartum, and early motherhood). Within these groups, I analyzed subthemes to give a full understanding of how the women dealt with being controlled, taking control, and feeling out of control.

Guilt and Pride. Unprompted, women spoke to me of guilt. I noticed this early on while I was conducting the interviews. I went through the transcriptions specifically searching for quotes that dealt with guilt and I found an overwhelming number of women who spoke of guilt. I also checked for the contrast, pride, after seeing how prominent guilt was in the new mother's lives. Guilt conversations were also easier to find than pride conversations, but I found data on both easily once I came up with a strategy for how to code for women's emotions as they talked. In contrast to guilt, pride conversations were more difficult to search out. This led me to hypothesize

that mothers are quick to express guilt publicly (perhaps to acknowledge their lack of ability to match mothering ideals) but they may express feeling proud of themselves in more indirect ways. I also realize that I may be defining pride too narrowly. Pride traditionally is defined as being particularly proud of a quality or skill. However, perhaps women's expressions of satisfaction alone represent contentment and happiness, and perhaps that could be the opposite of data on guilt. The word "happy" is described as feeling or showing contentment or pleasure (Kemper 1978). "Satisfied" is described as content or pleased (Kemper 1978). Initially, I felt that my data on "satisfaction" needed to be coded as an "in-between" for guilt and pride. However, after my first reading to code for satisfaction it became apparent that "satisfied" women could simply be content that nothing went wrong with their births or that their baby slept well. Thus, the extremes of guilt and pride were chosen for analysis for the purposes of this dissertation. I may analyze my data on satisfaction further in preparing for future publications.

Appearance. I ended up analyzing data on appearance and mothering ideals last because I initially found it difficult to sort through. Once I realized that women were intertwining talk about the multiple ideals they faced, then it was easier to sort through and categorize data on this final topic. I specifically found that women's discussions of appearance norms and appearance work also included discussions of good mothering and motherwork, and that women balanced these dualing (or dual) ideals as they chose their everyday behaviors or made comparisons to other women. I also found that women talked both about ideal mothers and "real" mothers, and conversed quite a bit on their comparisons to other mothers. Thus, these became my frames for organizing my data on appearance.

Limitations and Assumptions

Limitations and assumptions to the study and my sample do exist. This includes, but is not limited to, researcher bias and methodological design. First, researcher bias and presumptions about participants' experiences may limit my study. To limit the assumptions and limitations of my study, I used an autoethnographic approach to let my attitudes and experiences be known. I continually wrote in a journal throughout the research process to learn about and analyze myself, the phenomena, and my participants. In making my own biases more explicit and finding a place for them within the research, I hoped to lessen the unconscious biases that might have slipped into the data collection and data analysis process. However, it is still in question whether I was reflexive enough in this process. Second, my methodological design may limit the study. For instance, the qualitative methodology may provide some validity to the data analysis but the data may lack in reliability, and is not generalizable to the larger population of postpartum women (as this is not the purpose of qualitative research). To counter this fact, the questionnaire was designed, but I did not have the space in this dissertation to analyze the quantitative data in full. Regardless, it is hoped that my in-depth exploration of women's journey into new motherhood will still enhance our overall understanding of postpartum women's attitudes and experiences. A third limitation of this study is that, despite some efforts to improve sample diversity, the final sample is not as diverse as originally planned. The respondents are diverse in social class, area of living, age, and place in life, but not in race and ethnicity.

A researcher comes to a study with a set of already established assumptions about the phenomenon under study. Here, I attempted to "bracket" my assumptions as much as possible (Creswell 2003). I assumed that during the postpartum period women would have very distinct, unique bodily experiences and attitudes, especially regarding specific parts of their physical

appearance. I assumed the attitudes and experiences of women vary considerably depending on how old their baby is and how many months they have spent in the postpartum stage. For instance, I assumed that women who had just recently given birth would give very little thought about their own bodies and appearances, and may be more focused on healing from birth and caring for their newborns. Consequently, I also assumed those nearing nine to twelve months postpartum are starting to navigate their “old” roles as well as their “new” roles, and may be more concerned than the former group with trying to “get back” a specific appearance and lifestyle. I initially believed that most postpartum women would have a difficult time engaging in forms of beauty and body work because they are in the process of learning to manage a new role in their life -- that of being a mother. Further, I thought that experiences of women may be positive or negative based on prior conceptions of what a woman or mother is, within the context of beauty norms and ideologies surrounding biological motherhood. Instead, however, I found that postpartum women tend to be more similar than not in their attitudes and experiences, and did not find as many differences by amount of time postpartum. I explore my findings more fully in Chapters Five, Six and Seven.

Summary

I am pleased with the findings of my study and surprised by the amount of data I could gather from forty-two women. Through this study I attempted to understand the lived experiences of postpartum women up to twelve months, with a focus on exploring women’s transition to early motherhood and a postpartum period, with a focus on women’s navigation of their emotions, issues of control, and ideals about motherhood and bodies. It took a phenomenological and autoethnographic approach to see how women do the work of mothering while navigating their new life stage. The study went beyond my own expectations in terms of both data gathered and the experiences that mothers were willing to share with me.

CHAPTER 5 CONTROL & LACK OF CONTROL: PREGNANCY, LABOR, AND EARLY MOTHERHOOD

When a woman becomes pregnant she begins the journey towards motherhood. This journey consists of navigating through pregnancy, birth, the postpartum period, and early motherhood. During this time, women slowly begin to lose control over aspects of their lives. For this study, I define control as how much restraint, influence, dominance or direction one has over a situation (Robinson 2007). For example, when women feel in control they feel they have a situation directed as they have planned it. On the other hand, when women feel out of control they feel that someone else is dominating the situation when they think they should be able to direct the situation. A non-pregnant, childless woman may feel she has some control over the basic aspects of her life. However, per my interviewees, women feel a loss of control as they enter the pathway to new motherhood, and they may never fully gain back that sense of control over their lives. While women technically have control over their postpartum lives and do not experience surveillance in the same way as they do in pregnancy and birth, they still feel somewhat out of control.

This chapter outlines the gradual loss of control one has during pregnancy and birth. This loss of control picks up speed the closer one comes to labor and giving birth. Per my interviews, as well as basic literature on medicalization, birth becomes the peak of women's loss of control over reproductive processes (assuming a woman is in the hospital during labor and delivery like the women in my sample), and the days spent in the hospital with their newborn immediately after birth are also heavily monitored. Leaving the hospital and in the weeks, afterward, women feel a significant lack of monitoring, however, as the medical community loses interest in their reproductive experiences. Some women in the sample report a sense of aimlessness because they no longer have someone controlling their bodies or actions. After being dependent on others, the woman suddenly is faced with caring for a newborn without any (or at least little) supervision. A

woman has theoretically returned to a state within which she can control her own life and body, but often lacks the confidence, knowledge, or resources to feel like she has gained this control back. Women are therefore left feeling out of control in the postpartum time, but for different reasons than they might have had during pregnancy and birth.

Pregnancy

Throughout the pregnant experience women in my sample report slowly losing control over their bodies, and decision-making processes, and even their identities. Pregnant women such as thirty-six-year-old Judy, who recently had her first child, gradually find that they “are their pregnancy.” No longer is a woman’s body for her own existence; it now exists for her growing fetus. Everything the pregnant woman does should in theory be in benefit to the fetus. Other individuals, such as family, friends, medical staff, and acquaintances now feel the need to tell pregnant women what “they” should be doing for their unborn child. People are constantly asking women about their pregnancy. Thirty-two-year-old Denise, who also recently had her first child, was bothered that all “conversations were centered on the baby and her future, not on me and what I was doing.” The loss of control in pregnancy is a slow, discrete descent, according to the women I interviewed. The loss begins with a woman’s first prenatal doctor’s appointment and, as the pregnancy becomes more noticeable, others find it their duty to tell women what to do in addition to the medical community. For instance, this is displayed by strangers asking to touch a pregnant woman’s growing stomach, or a person in a coffee shop expressing to a pregnant woman that she should not be consuming caffeine. Sandy, age twenty-eight with three children, explained, “I was very obviously pregnant and everyone always had something to say about it. What I should eat, what I shouldn’t drink.”

Within the medical community, women are constantly monitored at monthly checkups through weigh-ins, bloodwork, and other tests where women are deemed normal or abnormal. Women, such as twenty-one-year-old Lindy and twenty-eight-year-old Christie, both postpartum with one child, were given prescriptions throughout pregnancy for problems such as nausea or constipation. At each state throughout pregnancy women are expected to gain certain amounts of weight, measure a certain number of inches, among other technicalities that deem woman as being correct throughout pregnancy or incorrect. This is reinforced by outside surveillance to keep the pregnant women in check to keep the fetus safe, thus reinforcing what the medical community expects of a pregnant woman.

With my first child, I continually “measured” too small and only received comments from my doctor. With my second child, I continually “measured” too large. In both instances, what I was doing was “incorrect.” Being deemed “too large” with my second child, I received comments starting at a mere six months at the park or in the grocery store. As it was a hot summer, I wore sleeveless, sometimes low cut, above the knee dresses, in attempt to stay cool. Mothers were most apt to scrutinize me. I received comments such as “wow you are about to pop, “you are so big it looks like your legs are going to give in, “and when people thought I was not listening, “she should not be wearing that.” Compared to my pregnant friends my stomach was significantly larger. I hoped that my son would quit growing at a such exceeding rate so that I would be “normal “and not feel as though people were “snickering” at me as I “waddled” by.

When talking about being controlled during pregnancy, women talked about their realizations about how a pregnant woman’s body is now for her baby, and about the restrictions that they faced when having difficulties in their pregnancy. In the next sections, I first discuss women’s conversations about how a pregnant woman’s body is now for her baby. Then I explore pregnant women’s experiences of control/lack of control during bedrest and the diagnosis of gestational diabetes.

Body is now for Baby

During pregnancy, the objectification of women's bodies is intensified as women become "incubators of babies" rather than bearers of their own bodies (Reissman 1983). Women discussed taking control of themselves and their unborn children during their pregnancies by giving up caffeine, alcohol or cigarettes. While this may be adherence to medical guidelines and not control for women, these were not always the ways in which women themselves characterized their actions. For example, twenty-eight-year-old Louise, postpartum with one child, said, "I tried to eat as healthy as possible! I didn't drink pop, coffee. You don't know what these are doing to your child!" Prior to pregnancy, Louise claimed that she did not eat healthy and "lived on fast food." She is a lower-class woman who considers herself to be obese. Other women in my sample also attempted to eat a more nutritious diet for the "child they had inside them" [Pamela] than they had before their pregnancy. According to my interviewees, women are expected to eat differently during the period of their pregnancy, reflecting the change in their status of their bodies and roles (see also Lupton 1996). Possibly women felt they were taking control in these situations; however, women also talked about pamphlets handed out by nurses (under the direction of doctors) that relayed to women like Louise what they should be doing. Women are also told that they should alter their diets in these ways during their earliest pregnancy appointments. There are also social expectations for how one should take care of oneself during pregnancy, and women were cognizant of this societal (and gendered) pressure. Julie, a thirty-two-year-old woman with one child, explained it as, "[T]here was that kind of expectation but, you know, I don't smoke and I obviously stopped drinking, so there were those expectations that I would do that."

Sophia, a thirty-year-old woman with two children, had difficulty with the lack of control she felt throughout her pregnancy, though. For example, when talking about what she disliked

about pregnancy she explained, “I think giving up your body, you know, not having any control of how you look, how you are feeling, you know, just knowing that everything you are doing is for the baby, they kind of take over.” Sophia described her life and body as “for the baby” during pregnancy, no longer for herself. She felt controlled by the baby inside her, and was very explicit in her discussion of her lack of control. “You know, for nine months. I mean, things change and you are like, ‘I can’t do anything about it.’” Sophia directly expressed feeling a loss of control over her body during pregnancy, while other women felt they were “taking control” by following doctor’s orders and wanted to abide by that advice (even while, in the same breath talking about how they would get in “trouble” if they did not follow their doctor’s orders). Perhaps Sophia could see her lack of control more fully since she was discussing her second pregnancy and had had more time to reflect upon this topic. Furthermore, Sophia had high blood pressure throughout pregnancy and was monitored for this. Thus, her pregnancy may have felt more “controlled” than some other women’s pregnancies in this sample.

Women are also expected to gain certain amounts of weight at key points during their pregnancies, and are expected to lose the weight soon after delivery of their child. They are solely to blame if they gain “too much” or “too little.” Medical guidelines about weight gain during pregnancy becomes a prescription for their behavior regarding weight gain; medical procedures are also in place to monitor whether women are gaining appropriately. Pregnant women in my sample reported feeling the pressure to become the perfectly sized pregnant woman (Stern 1993). Colleen, age thirty-six with one child, felt this pressure very directly from her doctor. When asked about her pregnancy, Colleen mentioned that “I gained thirty pounds. [Doctor’s Name], I don’t know if you know him, he was pretty strict about weight.” To follow up, I asked, “How so?” Colleen explained, “Like one, ... over the holidays [I] gained like eight pounds in two weeks and

he kind of yelled at me. So, that was kind of hard, you don't tell a pregnant woman she gained too much weight." After walking out of the examination room Colleen could feel her eyes swelling with tears. "I cried when I got out of there." The doctor controlled expectations about "normal" weight gain in pregnancy and actively surveilled Colleen's weight. The pressure that Colleen felt was real, and negatively affected how she felt about herself during pregnancy.

Twenty-eight-year-old Alicia, with two children, came out strongly against others' judgments of pregnant women. She learned after her first child not to take it so seriously.

I think with the second time around you don't feel as, I don't know, like with [child's name] didn't do anything I wasn't supposed to cause I was so paranoid I was going to hurt her in some way. And then with [my second baby] I was like, I know I had some, I am sure I had caffeinated drinks.

Alicia worked in a diner and was thus was continually around caffeine. She told me a little about some of her customers. For example,

Like I, I know that some people would, when a pregnant woman would come in and get like a triple Grande people would say stuff to her and I am like, 'What does it matter if she wants to caffeine? It is not going to kill her; she can do it if she wants.' People are so opinionated when it comes to pregnant women, it is like, 'Hello? Are you pregnant? I am the pregnant woman. A little caffeine is not going to kill my baby.' I think cigarette smoke is going to kill you so you should worry about that. It always seems like the people that do bad things are the ones who say stuff, they are sitting there puffing a cigarette when I am drinking a pop. They just speak without thinking or knowing. Not smart.

Alicia felt that others had no reason to judge her during her pregnancy or any other woman during their pregnancy. She felt that she was continually judged when pregnant. It was as if pregnancy gave people an outlet to say what they thought. Possibly because they thought they knew what was best for the mother's unborn child, reinforcing the sense that women are incapable of being in control of their own actions during pregnancy. Both members of the medical community and the public reinforced women's lack of control during this life stage, and many

women in my sample voiced this idea. Feeling actively controlled by others during pregnancy was not something that women in my sample desired.

Bedrest

A handful of women in my sample experienced further restrictions and lack of control due to complications during pregnancy. Five women within the sample were prescribed bedrest by their doctors during pregnancy. This includes Ashley, Silvia, Julie, Jade, and Lillian. Thirty-seven-year-old Silvia, with two children, felt out of control while she was put on bedrest in the hospital. For two months, she was at the hospital being monitored.

It was pretty stressful, I was very, ummmm, I have kind of a controlling personality to begin with and I have some anxiety. I have some anxiety issues to begin with so with the pregnancy and with not being, with being away from my home and out of control, I was totally out of control for two months. I didn't know what was going on at my house, I didn't know what was going on, ummmm, with my son all the time, I mean, I was trying to coordinate exactly what was going on but I could only have so much control and different people were watching him and I didn't always agree with my husband's decisions.

Silvia would have felt better if she were closer to her family so she would know what was going on, and could feel as though she was still a part of her family. She did not mention the control the medical staff had but was forthcoming about how angry she was to be out of control of her home life and mothering activity. Pregnancy interrupted the control she had over other parts of her life. Sylvia particularly did not like her husband overseeing the day-to-day operation of their home life, suggesting that perhaps she was the one to control those operations before her bedrest.

Twenty-six-year-old Jade, pregnant with her first child, was sent to the hospital and put on bedrest. She was not even sure why she was on bedrest.

I don't know if it was because I was spotting or because I was dilated to one. I was eight weeks early at that point. So. So they sent me to the hospital, they admitted me and they were going to give me a steroid shot in case he was early to develop his lungs and that is a two, they give you one shot, ummmm, a day for two days and then they have to watch you for twenty-four hours.

Jade was sent home on and off more times than she could recall. After another check-up with her doctor she was sent to the hospital again where they had her stay for another day.

So, then I would be released on the Thursday. I don't remember if I dilated anymore while I was there. So, I left Thursday, I went back in Friday I think I was having cramps or contractions. I think I was dilated bigger than maybe a two on Friday but then they let me leave. Ummmm, so I just, but I was on bedrest on and off as they told me where to go.

Jade went back and forth between her home and the hospital depending on doctor's orders. She had little control or say on what would be done to her body or her baby. "They," presumably both her doctor and medical staff at her hospital, were always in control. She felt very much like she was at the mercy of medical staff at that stage of pregnancy.

A mother of four, Kathryn, age thirty-one, had preterm labor and shared a similar experience of going in and out of the hospital. She told me, "At like thirty weeks I started going into labor and was taken in the whole ambulance thing to [large city hospital] to a bed. I stayed until the next morning. I don't know how many times it happened. Maybe three times we went in?" Kathryn had continuous experiences with preterm labor until thirty-five weeks and went to thirty-nine weeks where she was then induced to go into labor. Kathryn received contradicting information from seeing different doctors, one doctor at the city hospital and her family doctor at a rural clinic in her hometown. "[The hospital doctor] said to go on bedrest until the end. Then [the baby] turned the wrong way. But my doctor said I wasn't moving enough and that is why he was upright. When I went back to moving he went into place." Kathryn had to choose which doctor to listen to. She chose the doctor that she had "had [her first child] with" and that allowed her to gain some control back during pregnancy.

Gestational Diabetes

Women with gestational diabetes expressed difficulties throughout their pregnancies, like the cases of women who are put on bedrest. Five women in my sample had gestational diabetes.

This includes Lisa, Prudence, Kayla, Margaret, and Kelly. Specific diets, as prescribed by doctors, represented a large controlling factor in these women's lives. Lisa, age twenty-seven with three children, told me,

I had to really watch what I ate, 'cause it was controlled by diet and I didn't want to do insulin. Had to stick to the diet and test my blood, which sometimes was a pain to remember while I was at work 'cause there were certain times I had to do that. But work was fine with that. It was just hard to remember what time I ate, you know, when to test, how much I ate, what I couldn't eat, or if did want to eat, make sure to know about it at the beginning of my day, portioned it properly.

Lisa's day was filled with keeping track of what she ate, planning what she should and would eat in the future, and testing her blood - a program set by her doctor. She accepted the control by following her strict diet, scared by the threat of possibly having to take insulin. To keep women with gestational diabetes on their specialized diets, some doctors reportedly used scare tactics. For instance, Alicia was threatened by doctors to stick to her specialized diet as she describes below.

They did the same thing with [my first child]. Because my numbers were so high with her, I think they thought I was like sneaking, you know, bags of donuts or something... [A]nd they threatened dead baby on [my first child] too. They actually said, ummmm, 'If you don't get your sugar numbers below 120, you are going to deliver a dead baby.' I really was freaking out with [my first child].

After her first pregnancy with gestational diabetes, Alicia assumed her second experience with gestational diabetes would be similar with her second child. She said,

Then [my first child] turned out fine, after all that alarm for no reason. So, with him I didn't, you know, I did sneak sweets, I was like, '[My first child] was fine.' I didn't gain any weight after twenty-eight weeks with [my first child]; I gained all my weight before. Because I didn't have anything at all to eat, what was I supposed to eat? It was horrible.

Having gestational diabetes led Alicia to being confused on what she could or could not eat during her first pregnancy. The threat of having a "dead baby" was also a lot for her to have on her mind with her first child. Although her doctor used the same controlling tactic with her second child, Alicia took it less seriously with her second -- perhaps understanding that she did

not need to let her doctor completely control her thoughts and actions. She learned from her own experiences and prioritized her own ideas over the orders of the doctors the second time around. This was a common thread throughout the interviews with mothers who had more than one child. Women who recently had their second, third or fourth child were less controlled as first time mothers were.

I think it is just a scare tactic on women. Horrible. I guess I am not the only one who they have done it too. . . . [O]nly like, ummmm, like something like five percent of all pregnancies are gestational [diabetes] and of that five percent even a small[er] percentage is insulin dependent. And I am not a typical case. Normally it is women over thirty-five, overweight. So, yes, I snuck sweets. (Alicia)

Alicia felt that there were other women out there experiencing the same thing and that she was not alone, which made her feel better. Once she was educated about gestational diabetes and understood how it affected her first pregnancy, she also separated herself from other women by deciding for herself that she was “not a typical case.” Sneaking treats was one way she could resist control by the medical community and define her own actions.

On the other hand, Alicia was still monitored and controlled by doctors: “I was being monitored by three different specialists, I told one of them that I stopped [testing her blood] and they totally freaked out and put me in the hospital, so I was in the hospital from the Monday after Mother’s Day all the way until he was born.” Especially when different doctors were giving her conflicting information, she felt a loss of control herself. Alicia continued:

I was hospitalized and felt at a loss of control. It was frustrating because when you are dealing with gestational diabetes, the ob/gyn, hospital, and the endocrinologist are not on the same page and so I kept getting different information. So, it was frustrating because one person would tell me one thing and then another would tell me something different about what I could eat. And then the endocrinologist continued to tell me, if I didn’t get my sugar numbers below a certain point I was going to deliver a dead baby. So. Like well, ‘What am I supposed to do? I am eating everything I am supposed to.’ Just a carb causes your sugar to go up. So, I would just cut out my carbs completely. And then, when I thought I was cutting my carbs, they tell me I am going to cause brain damage to my baby. So, you just don’t win.

To advocate for herself, she demanded that her baby be taken out by cesarean. “They did amniocentesis to see if the lungs were developed enough and were able to take the baby out.” This made Alicia feel “in control” of at least one part of her pregnancy and birthing experience. She says,

That wasn't that much fun being in the hospital all that time. And they did, ummmm, 'cause I just told them I couldn't be pregnant anymore. I am like, 'I can't be pregnant anymore, you just need to get this baby out of me 'cause I am going to do something drastic,' so they did. They thought I was, like, crazy.

Navigating through pregnancy can be difficult. Losing control of your own physical body, losing control of yourself to doctors' orders, and losing control of yourself in the face of larger social norms as well can be difficult on individual women. This gradual loss of control, starting with initial check-ups with doctors and comments from others policing, slowly remove control from the pregnant woman and place others in control of her body and actions. Even when women feel “in control” while following or ignoring doctors' orders at times, they also admit being controlled by others at the same time. This loss of control gradually increases throughout the nine months of pregnancy. Women who experience difficulties with their pregnancy may face a more glaring lack of control in the face of members of the medical community attempting to exert greater control over their pregnancy. In the next section, I detail how women lose even more control over themselves when they are hospitalized for labor and delivery.

Labor and Delivery in the Hospital

When women in my sample brought up the topic of control in their discussions of labor and delivery, they were most likely to bring up their experiences of induced births, planned cesarean sections, unscheduled cesarean sections, appearance, privacy, and negotiations over newborn babies in the hospital. In talking about these subjects, they described being both in control and out of control. Some desired control when they did not have it, but others were content to be

controlled by others. Additionally, some interviewees felt more “in control” when medical providers controlled their births.

Induced Births

One way that women attempted to take control of the birth of their child was through scheduling a date to be induced. Four women in my sample were induced. This includes Jeanette, Diane, Kayla, and Heidi. Mother of two children, twenty-three-year-old, Avril was induced with her first child but not her second. She claimed “I like[d] the first one more. They told me what to expect.” Avril liked being induced with her first child more than going into it naturally with her second child because the first situation was a controlled situation where she was told what to expect. Although it meant that she was controlled by others, Avril did not resist this. It was a comfort to her to hand the control over to doctors during labor and delivery.

Sophia said, “I chose to be [induced] with the second one. Umm, ‘cause I, I like to be in control of when things happen, so when they asked me if I wanted, what I wanted to do, I was like, ‘Yes I want to be induced.’” She explained her reasoning: “with the baby I just thought, I want to know when it is going to happen. I have a three-year-old, people, like, watching her. I have things lined up and I just wanted to know.” Having a child or children at home was a reason that women might choose to be induced. They needed to have childcare pre-planned for the birth and choosing to be induced enabled this. Having the birthing process controlled by others in these cases made women feel more in control of other parts of their lives. In these cases, the women were more interested in being able to control other aspects of their lives, not their bodies or births. If we apply a medicalization perspective, we know that these women may have lost control in the hospital setting as they are induced for labor; however, they felt like they were in control because they actively decided to hand over this control. After listening to women tell their birth stories, I suggest

that women assess what they may want to have control over want control over, and it seems like those who want to be induced do not want control over their bodies. Women in my sample may want control over other aspects of their lives instead of control over their bodies and births. (This may also be related to the fact that medicalization of birth has become normalized enough that they do not think to question providers' control over birth, but I do not have the data to confirm this in the dissertation.)

The above findings do not suggest, however, that all women in my sample agreed to hand over control to doctors during birth. Some women did want to maintain control in the hospital setting. Women sometimes felt the loss of control over labor and delivery and were frustrated about that -- for instance, when inducement followed birth complications. Jennifer, age twenty-seven with two children, for instance, did not feel in control of her birthing situation. Jennifer explained,

I, with her, I was induced with [my child], she broke my water but my contractions were irregular, they didn't hurt, they were coming but they were irregular, and I was in labor with her for fourteen hours and then I had three hours of pushing. While to find out why was she came up face up. So. So, she had to be pulled out with the vacuum extractor, so. That whole thing, I just, I knew I didn't have much control of my body, the Pitocin pumped in me, the vacuum extractor.

After being put in the hospital and induced, Jennifer felt she became hospital property. No one on the hospital staff asked, "Is it okay for us to give you Pitocin?" and no one fully explained what that drug was. Nor did they ask, "May we use this vacuum extractor to deliver your baby?" In the moment, Jennifer felt she had to give up control for the safety of her child.

With my daughter, my first child, at age twenty-seven, I was also induced. After being induced with my first child I chose not to be induced with my second child. My memories of my first labor were:

A few days before I was at 39 weeks the doctor that I had seen at my last few check-ups asked me if I would like to be schedule for inducement. I was beyond excited. Pregnancy could end sooner than expected?! I was all for it. I felt he gave me control because I could answer “yes” or “no.” However, the doctor picked the date and time. It was a time he would be in, not one of the other doctors from the large city network I went to. I did not know what inducement included. As it was happening I learned it included: breaking my water, being pumped full of Pitocin causing contractions that barely had a moment between them, to the point of begging for an epidural which could not be inserted due to slight scoliosis of my spine. After this experience, I chose to wait for my own water to break with my son, even though I did have a child at home that needed to be scheduled around. However, by not attempting to control the second birth I felt more in control.

After a negative experience with attempting to take the “control” that my doctor gave me, which was no control at all, I tried to take control over my second birth by not being induced. I felt better about the second birth, however, this may just be because I compared it to the first birth which was quite traumatic because I had no experience or network of friends to tell me what to expect. I wanted control, but did not realize what I was attempting to take control of. Attempting to take control backfired into a feeling of being out of control of the situation.

A suburban woman named Kayla, age twenty-six with four children, had an experience like my own. She, too, saw a variety of doctors in a large city network. Kayla was happy to be induced because she had not enjoyed her pregnancy. However, once at the hospital she enjoyed labor and delivery even less than pregnancy. “I chose to be induced, the doctor said it was fine was going to be at the hospital a certain day.” When asked about going to the hospital and getting ready for the baby she told me, “First they took all my insurance information and ID. It was so formal. I was led through a door and weighed, I gained a lot. Then I put on the outfit and was strapped to a bed.” When describing being strapped to a bed, she was referring to the monitor put over her stomach to hear the baby’s heartbeat and the I.V put in her arm for fluids or future drugs she needed. Kayla expressed to me that,

On TV everyone gets to walk around the hospital! There was no way they were going to let me go any farther than the bathroom. And that was a lot and painful because of all the fluids going into me. I didn’t even see my doctor until, like,

seven at night and I had been there since seven in the morning. He was giving directions over the phone I guess. They put something inside to see [my child] better. Or maybe not to see her, I don't know, they just stuck something in me and also pushed water in me to stop the birth because the doctor wasn't there.

Kayla was not told exactly what was happening to her, or why or how. The only part she knowingly took part in controlling was giving consent to having an epidural. "I signed and got the epidural, or read something. They told me about that and all the things that could happen. Not that I remember." These excerpts suggest that sometimes women are unaware of how their decisions to acquiesce to one procedure may spiral into giving up total control to hospital staff. In each case, individual women report being surprised and uncomfortable with the extent to which they unknowingly hand over control in the hospital setting.

Cesarean Sections

Just as women planned to be induced and tried to control birth in that respect, other women in my sample planned cesarean sections. Women often thought that planned cesarean sections would make things easier, but that did not always happen as seen in the case of inducements.

Some women had planned inducements, but more women within my sample had planned cesarean sections. A total of ten women had planned cesarean sections. This includes Silvia, Louise, Lisa, Michelle, Pamela, Judy, Prudence, Noel, Margaret, and Kelly. Planned cesarean sections happen for a variety of reasons. If a woman had an unplanned cesarean section for her first child, it was likely that her subsequent children will be born via cesarean section as well. Also, if a woman has a health problem, doctors may schedule a cesarean section to make sure the situation stays safe and in control. By picking a date for a cesarean section, as with the inducements, women in my sample voiced that they felt "in control" of a part of their experience. However, the doctor still predetermined if a woman needed to have a planned cesarean section in most cases in my sample. Women may get to pick a date within a given range, or are given a

scheduled day, that they then can build their family's schedule around. In some small way, this gave women in my sample a sense of control over their lives (even if it did not mean that they held any control over the course of their births).

An attorney, twenty-seven-year-old Pamela mother of two, suggested that she took control of her planned cesarean section in both of her birthing experiences. Pamela says, "I had general anesthesia, so I wasn't awake when it was happening. I chose that for both. I hate needles, the thought of getting an epidural freaked me out and then..... they tried to talk me out of it twice." During both births, doctors attempted to change Pamela's mind, but she held to what she believed was right for her. As an attorney, she had a high social standing in her small community. She did not feel overpowered by the doctors and medical staff. They "allowed" her to choose how she was going to have her baby born, and she felt very firmly that she could choose cesarean sections over other birth experiences.

Some women, such as Kelly, age twenty-seven with two kids, who was set to have a planned cesarean section, chose not to find out the sex of her newborn until the birth, to enable herself to have one part of the experience be a surprise. She had a previous cesarean section and knew what to expect. Kelly said, "We wanted a surprise. 'Cause we already knew everything, 'cause I had to have a cesarean. We already knew the date and all, so we needed some kind of surprise." Kelly felt comfortable with the strictly planned nature of her birth overall, and the "surprise" of the sex of her baby was described as a treat of sorts within this atmosphere of strict control.

While thirty-seven-year-old mother of two, Silvia, was satisfied with the planned nature of having a cesarean section, she was dissatisfied with how out of control she felt afterwards.

Well, my first child I had a cesarean section too, which was an emergency C-section. I mean, we had a planned C-section but he came a day early. Ummmm. It

just made you feel very out of control that you couldn't control what your body was doing, couldn't control the bleeding episodes.

Silvia focused on the loss of control she felt due to a cesarean section incision that continued to bleed during the postpartum period. She “stopped even going for the little walks they were allowing me to do” because of the “bleeding episodes.” Thus, even though she could plan her latest cesarean section, the bodily experience of recovering from this surgery made her feel like she was lacking control. Many women like Sylvia first had an unplanned cesarean section and then had planned cesarean sections with all subsequent children. While they may have felt like they were taking some control over their births by making these choices, Sylvia's story is indicative of the fact that this was not always the case, because bodies may still feel out of control afterwards. Some women in my sample felt even more out of control during unplanned cesarean sections, as discussed below.

Four women within my sample -- Cassandra, Asia, Julie, and Noel -- reported on recent experiences with unplanned cesarean sections. Unplanned cesarean sections happen when either the baby or woman is in distress, or if labor is not progressing per doctors' determinations. The women in this sample who had recently experienced unplanned cesareans felt as if they had no control during their surgery. Only in small ways did they attempt to maintain some form of control during birth, and women's attempts to control their own experiences were often ignored by the medical staff.

Cassandra, a thirty-year-old suburban woman with one child, who works in a large city hospital herself, explained that a cesarean section “was like having something done to you where you are not an active participant whatsoever.” To her, the process was “inevitable” and she wanted it over. She explained further,

I remember, and then, I mean, I was, they gave me like a bowl of some medication in my IV because I had a spinal from the epidural, so they just gave me a bowl of something and it makes you shake so I was just, like, trembling. And then they put you on a big table and you are looking up and there are all these lights and there are all these people. They roll you down to wherever. And my husband stayed next to me. And, he was interested in watching what was going on 'cause he is a nurse so he didn't care about all the blood and whatever. I was, like, "Get up here, you're holding my hand," [because] I was scared. But it was one of those things where I kept thinking about [how] I just need to get through this and then afterward I can be upset. Afterward I can cry if I need to or whatever.

Importantly, during the surgery, Cassandra was only spoken of, not to. She describes this experience:

They [the medical staff] are, like, "You need to take her wedding ring off," and I was like, "Good luck getting it off my swollen finger. I can't take that thing off right now," and my midwife was like, "She is not taking the wedding ring off." I just remember little things like that.

Cassandra had a midwife there to advocate for her, which did give her some voice within the situation. Within the negotiation of the wedding ring, the midwife was trying to retain a small amount of control for Cassandra within the situation. During the surgery, however, "My midwife, Annie, was like, "You shouldn't have that much pain." It was [a lot of pain], it was a lot, it felt a lot more than it should have felt when they were cutting into me, when they pulled him out. She told them I could feel it." Both the midwife and Cassandra felt that she needed more pain relief, but the doctors and nurses did not listen to them and continued with the surgery.

They are pretty rough when they do that, they pull your whole, like, uterus out. You know, and then put it back in. And when they put it back in, it doesn't feel good; they just jam it back in there. [My husband said] it was like they are stuffing a turkey; I was, like, "Thanks a lot." So, that, that experience, actually having the baby and getting to the part where I was getting close to having the baby, that felt more like I was not in control of that situation. I didn't like that. I like to be in control.

Even with an advocate voicing resistance the patient and midwife were ignored in their requests for more pain medication. The medical staff was likely working quickly to make sure the

baby was born and both mother and child survived yet, in the process, Cassandra felt as if she was not in control. It did not seem to matter to the doctors and nurses that her physical body could feel what was being done to it. What little control her midwife gained for her in keeping on her wedding ring was lost in the pleas for pain medication.

Also with an unplanned cesarean section, Noel, age thirty-six, told me that, throughout the surgery, she felt:

Very scared. And, ummmm, and, like, I had a friend who had a baby five months before me and she had a C-section. And I was thinking about her, like, if she can do it I can do it, so that made it easier. But you can feel it, like, opening, obviously opening up your stomach or whatever. But you can't, you can't feel it, but you sort of can. So, that was kind of, I'll say, scary. You know. Startling.

Noel was not told what was happening to herself and the baby. The hospital staff was at work, as if she was not in the room. This disconnection from the situation felt scary to someone who knew that her body was at the mercy of others. Women like Noel and Cassandra eventually just wanted to get the surgery over with, once they realized their lack of control over the birthing situation.

Appearance during Hospital Birth

Women did bring up the subject of their physical appearances during birth; other researchers have noted similar conversations in interviews about hospital birth (e.g. Martin 2003). Some women in my study took no control over their appearance and did not care how others assessed their appearances. After having their baby and seeing the photos, some women wished in hindsight that they had taken care of their appearance. Other women in the sample were very aware of their appearances throughout their time at the hospital. Only a few went to lengths to accomplish any form of beauty work during birth, however (Martin 2003). For instance, twenty-

eight-year-old, suburban, mother of one child, Leslie, had her water break and headed into her bathroom to do her hair and makeup so she would look good in photos that might be shared.

Like two weeks before I was due, I just decided that I was going to make sure I was going to take a shower every single night because if I go into the hospital in the middle of the night I want to look decent. So, when I was getting ready to go to the hospital, I did my hair, I did my makeup, I did everything. I went in at three o'clock, and when I got there the nurses were like, "You look way to pretty to be having a baby right now." So, I felt good about myself at the moment, just because I tried and made sure. I learned from [my twin sister's] experience. She looked like she had been dragged behind a semi. She didn't want any pictures taken, she didn't, she felt horrible. I wanted to [be] completely opposite of that, feel good and look good, so I could take pictures and feel good about that time, not like her and not show anyone. I wanted to share them with everyone on Facebook.

Leslie had little control over her pregnancy and birth. Her husband was a doctor who kept a close eye on all that she ate and made sure she was getting enough exercise and rest. He demanded that she deliver the baby naturally, with no pain management medication. Perhaps making herself look "pretty" for pictures was the one thing that Leslie could control herself and took her opportunity.

A suburban mother of one at thirty-six years old, Asia, wished she had applied make-up before going into the hospital: "I looked back at my pictures and wish that I had but I didn't do any of that. In my pictures, I had a popsicle, so I had like orange lips and hair everywhere." In hindsight, she would have liked to look better in her post-birth photos.

I, myself, had an experience like Asia's. My daughter was induced; thus, it was planned and you would assume I tried to look nice heading into the hospital for her birth. But I did not. I knew I would have to wear a birthing gown given by the hospital and that things could get messy. I put my hair in a messy bun on the top of my head so I would be able to lay easily on a pillow. I suppose my appearance could be called "functional" for the day. The only time I remember being aware of my actual "beauty" was when my mother wanted to take a photo after my daughter was born. In this photo, I have sore, chapped orange lips (from popsicles), a knotted-bun on the top of my head with wisps of hair sweeping in every wrong direction possible, two broken blood vessels on my face from pushing so

hard, full cheeks, and I am white as a ghost from hemorrhaging. I did not attempt to take control of how I looked. Going in, I knew it was going to be difficult and I thought, 'How could makeup and a hair do possibly hold up through that?'

Leslie, Asia -- and I, too -- all speak of beauty during and directly after birth. Leslie planned and took control to make sure that her appearance would be good in photos. For both Asia and me, control of our appearance was not something we were concerned about while we were in labor. In retrospect, we wished we had taken some control.

Some women, such as thirty-one-year-old Kathryn, who had her fourth child, have parts of their body that were not “fixed” “correctly” by the doctor after birth, and they think of these body parts in terms of both beauty and function after the fact. After giving birth most recently, Kathryn found that she “tore”: “My doctor said it wasn’t too bad, that she wouldn’t stitch it, that it would hopefully heal itself back together. I wanted it sewn. I wanted it tight. But she didn’t do it.” Kathryn voiced her opinion to the doctor, but her doctor decided otherwise. Katherine wanted to be stitched both for appearance and functionality. “Now I have this tear, [and] it never healed. [Her doctor] said,” Just don’t move around.” But I have four boys now! I can’t just sit with my legs tied together.” When she voiced her concerns to the doctor, she was told “not to worry.” Kathryn said that she now must live with this “tear” for the remainder of her life because her doctor’s decision superseded her own.

Privacy in the Hospital

Women enter the hospital in a variety of ways. Some come scheduled, such as for an inducement or planned cesarean section. Other women come wondering if they are in labor or not. The latter are put in a room to be “checked,” and the decision of whether they can be admitted to the hospital or are sent home is postponed. When in these “waiting” rooms, they may be placed

with other women. Even when women are admitted into the hospital in active labor, however, they reported being assigned to birthing rooms specifically designated for them, either alone or shared with other women. Nurses, doctors, interns and other medical staff filter in and out of these rooms. Family members filter in and out of the rooms as well. The pregnant woman is the center of attention in the room, but she is often talked over and not treated as a fully conscious individual with emotions and concerns about privacy. Women in my sample also felt that their bodies were probed and touched too abruptly by people they did not know. Many went along with it, following orders. Others were less likely to relinquish their bodies at first. For example, Judy, age thirty-six with her first child, explained how it feels to be a woman in the hospital, conscious of what others are seeing.

I started thinking about people seeing me, seeing all [of] who I am. Ummmm, and in that sense, I had thought about, just kind of the privacy issue in seeing my body and that's, since, the, not in the sense of being ashamed of my body or anything, ummmm, just the fact that, "Hey, I don't know you, this is the first time we met, you need to hold on for a second." I, ummmm, was in the hospital room, and an intern comes in and he was kind of running the whole show. And he went to check my dilation, how far I had dilated, and, I was like, "Okay, you have to give me a minute," I am like, "I don't know you. This is my first time meeting you. You need to give me a second," you know!

Judy was also aware of what she looked like as she was meeting new staff at the hospital. "The only other thing I thought of was my appearance. I didn't want my hair looking crazy, I need a pony tail holder, I need to pull my hair back, I don't want to look crazy!" Judy spoke up for herself, maintaining some sense of control over her own bodily space. She made the intern wait on her.

Twenty-four-year-old Kayla felt like she was "practice" for interns when the doctor was not there to check her. She said,

I lay in bed and one intern jabs her fingers into me and says some numbers. Next [intern] comes to put hers in me too. "Did they both have to?", I asked, and they said, "Yes." There was no reason they both had to except for practice! The second one put her fingers in [the wrong place].

Kayla had never met these interns before and was expected to allow them both to check how dilated she was. Kayla was not okay with this and she was never asked by either intern if she was okay with it. She had even inquired “if they both had to,” but was overridden. Women in my sample often lost control over procedures and hospital routines, as evidenced by many of the women quoted so far. Loss of control over how many medical professionals touched their bodies, however, was another concern.

Asia did not want others seeing her body any more than was necessary.

I would always make sure I was as covered as could be. I made sure that nothing that didn't need to be seen was seen. I never got to that point, like my sister has three kids and my sister would always say, ummmm, “It's a humbling experience.” That is what she would always say because so many people come and examine you and everything is on display. My sister really wanted to be in the delivery room and I really didn't want her to be. I remember thinking before I delivered, like, “I just really want to be me, my husband and the doctor.” Just cause I didn't want everyone to see that. So when they checked me I did make sure, like, my thighs were covered; they only saw what they needed to see.

Similarly, twenty-eight-year-old mother of two, Tiffany, did not want everyone seeing her body either. When I asked, “Who was in the room with you when he was born?”, she said, “Just my husband. Ummmm, I was too modest of a person to have anybody else in there. And I needed him just there for support, just to be the person that I had.” Generally, women in my study were most comfortable with just their husbands in the room and possibly their mother or sister. Few women desired more than this.

Jade, a suburban woman age twenty-six having her first child, began to feel comfortable with people seeing parts of her body, however, this was after being in and out of the hospital so many times.

I guess because I had already been in the hospital for like a week before that and they had all seen it already, at that point I was pretty comfortable with it. Ummmm, I guess normally I am a little like shy about it. I remember when I went in for my

first, ummmm, gynecologist appointment when I was pregnant [and] I was really nervous. Really uncomfortable with it. Ummmm, but then I guess it taught me that they look at this stuff everyday so I am a lot more laid back about it now than [before]. Just, like, I don't know, it is just a body instead of, it's just, it's just these parts that they, they don't look at them as, I guess not in this case, like sexual objects.

Jade became accustomed to being an object that was probed and checked. Through repeated hospital stays and examinations, Jade became accepting of the fact that the doctor was in control. Just as women learned to accept being controlled by doctors, they often had to learn to let the medical staff be in control of their newborns immediately after birth.

Newborn in the Hospital

Newborn babies are whisked away from their mothers, often right after birth, while doctors clean them up, apply topical medication, and take basic diagnostic measurements, among other things. Some women get to hold their baby soon after birth. Others do not. If the baby or mother is in distress, it may be hours or days until the mother gets to hold her newborn. Women who birth in the hospital are often expected to follow the doctor's or nurses' orders about contact with their newborn, and are not allowed to question what the doctor orders for their newborn during the first few hours of life.

When in the birthing room, after my first child was born, I felt an extreme loss of control over both my body and my newborn daughter.

After my daughter was born I started hemorrhaging. My daughter was fine. As I was being "worked on" by a variety of people, nurses and family members were passing my daughter around, meeting her. She was taken just outside the room and introduced to my husband's step family. I was so angry. Why didn't I get to meet her first? She was my daughter. I was supposed to be her mother and have her laid on my stomach and be the first to meet her. I would have liked only my husband, my mother, and I to have been in the room. I did not like it that, while the doctors were working on me, they readily handed my daughter off to any family member who wanted to hold her. Also, my doctor was telling an intern how to stitch me up. He [my doctor] wouldn't do it, he wanted her to learn. It took hours. My daughter

was born at 9pm and I didn't get to hold her until after midnight. At the time, I didn't know I could object to an intern "learning" on me. I certainly wanted to but was afraid to express myself. I remember laying there silently crying watching my newborn daughter meet her family.

Women in my sample often felt that doctors and nurses had more control over the care and choices of their newborn child than they themselves or their partners did. Denise, a thirty-two-year-old suburban mother of two, said, after her second child was born,

I was arguing with them because they wanted to take the baby to the nursery and I was like, "I just had a baby, I want my baby," and they were like, "You are in no condition after all that to have the baby with you when nobody is here to, you know, be with you, what if the baby starts crying?" 'Cause I couldn't do much. I remember after the next day I didn't let them take her away after that. I just remember cuddling with her. I slept with her in the bed.

Although the doctors and nurses may have been doing their job and "what was right" for both Denise and her child, Denise felt out of control when her child was placed in the nursery, and felt much more content and in control when they allowed her newborn to stay with her in the hospital room.

Some of the women in my study felt out of control when they were unable to make decisions about their newborns after birth, within the context of doctors' and hospital staff members' clear authority. Judy, age thirty-six with one child, reported an extreme loss of control after her child was born. Her child was jaundiced and, therefore, she had difficulty getting her baby released from the hospital. The hospital released Judy but her newborn was to stay in the hospital without her, per the doctor's orders.

Let me go but keep her. And I just was crazy about it and they were also like and "you are trying to breastfeed her?" and "you need to give her formula" . . . , so I was forced to give her formula, using a nipple and I didn't want that for her. I wanted to breastfeed her. I didn't want any nipple confusion. I am like, "This is what I am planning to do."

Judy was highly educated and had done research about breastfeeding before she went into the hospital to have her baby. She knew that she did not want the possibility of nipple confusion, but the doctor continued to overrule both her and the nurses:

The neo, the chief neo, ummmm, neonatologist came in and he reeked of smoke! Of cigarettes, and I am just [thinking] “How can you be the chief of neonatology and you smell like a cigarette?” But he comes in and says, you know, “I don’t know, what is wrong with you all?”, this is what he said. “I don’t know what is wrong with you all, you want to breastfeed.” And then one of the nurses was like, “Don’t use a nipple, we will just give it to her in a medicine cup and let her lap it up” and he says, “I don’t know why you are doing that, that is just counterproductive, that is not helping anything at all.” And I am thinking, “this man who has never had a child has never been pregnant and is trying to tell me what is counterproductive” and, for the long run, you know, “I am in the hospital with you for three days and I am with her for the rest of her life and these are decisions I have made as her mother.”

The doctor let it be known that he was the authority on what needed to be done. He did not care to listen to Judy or the nurses. She finishes her story:

They pricked her foot, they pricked her foot I don’t know how many times to measure the blood level whatever, and finally I was like, “I have to get out of here, I cannot stand this hospital, you know try to breastfeed her in the hospital.” People come in every hour, every hour to do this, to do that, it was just unbelievable. I was just freaking out. And I was like, “I have to get out of here.” And that was the first time in my life that I ever felt powerless because of my gender. I had never felt that before. That these men, the, ahhh, were making the decisions. And not paying attention to what I said I wanted as a mother, to what the nurses were saying. These men, these doctors were the ones who had the final say. And if I wanted to leave with my baby, then I had to acquiesce and I had to do what it was that they told me to do, and that was the most horrible experience ever.

After extended bedrest in the hospital, Silvia, age thirty-seven with two children, rural, had difficulty bonding with her newborn while in the hospital. First, she was worrying about her older child who was at home. Second, the newborn was early and in an incubator. She said,

I didn’t feel connected with him [the baby]. Not right away. ‘Cause I don’t know what, part of it was I was missing my other son so much. I don’t think I was mad at the pregnancy, I was upset I had to be over there, and I couldn’t be with my other son and then, ummmm, and then I wasn’t able to hold him for five days which was really weird. I could put my hand in the incubator after five days or whatever and

touch him, but if I touched him I couldn't talk to him and [if] I talked to him I couldn't touch him 'cause they didn't want too much stimulation.

Silvia's experience of holding her newborn was vastly different from other women's experiences – i.e., women who get to hold their newborns immediately after or even within hours of birth. “I will never forget the day I could finally hold him, ummmm, but it was just strange. I was holding him, you know, the nurse right there, and it was just different and he was always hooked up to so much stuff.” Silvia was “allowed” to interact and hold her baby when she was given permission. As a result, she felt it was difficult to bond with the baby. Under such a highly controlled atmosphere, Sylvia was unable to direct how she bonded with her newborn and was unable to do it on her own terms.

After I could hold and nurse my daughter, I was willing to let the hospital staff take her and allow me to rest. However, each hour my blood was checked, and I did not truly get any rest. All the blood lost and my fuzzy memory from the night before made the naming process for my daughter difficult, and I lost control of what she was named.

Early the next morning after my daughter was born, a lady came in to get my information, as well as my husband's, and we were to name our daughter. We had a name chosen but were in somewhat of a haze from the difficult night before. We told her the name and she typed it in. We told her the middle name and typed it in. I said, “I would like there to be two middle names.” That I wanted my family name as a second middle name, and my daughter would then have my husband's name for a last name. The woman could not comprehend what I was trying to explain to her. I didn't see the difficulty. It may have not gone with traditional naming patterns but, how hard was it to create two middle names? I knew that people of different religions sometimes had more than one middle name. I think it was the fact that I wanted my last name to be a second middle name that the woman could not get over. I was so tired that I just gave up. She simply has one first name, one middle name, and my husband's last name. Looking back, I am angry that I didn't fight harder and help the woman understand what I was asking for but, at the time, I was too tired to try any longer. This sleepy, out-of-control introduction to motherhood was fitting for the future postpartum experiences I would have, and other women in my sample suggest the same.

Early Motherhood

To elicit women's stories of their early postpartum life, I asked women a variety of questions. The questions that elicited the most insightful answers included: 1) Can you tell me about the time since you have been home with your baby; 2) Have you seen or called a physician about your own health since the birth of your baby; 3) Are you getting the postpartum care you need; 4) Are there any resources you wish you had; and 5) Who do you get your information from. Within their answers to these questions the topic of control in the postpartum became very tangible and relevant. Specifically, women in my sample spoke of a loss of control during the postpartum and a need for help. It became clear within my data that women need informational and support resources during the postpartum. After nine months of doctors checking their health monthly and then weekly, and then twenty-four-hour surveillance for a day or two immediately following birth, women are released into a new world of motherhood that they still need to figure out how to navigate, and are left to their own devices without information or emotional support. Some of these women felt symptoms of withdrawal, or even anomie, as a prisoner would after being let out of prison. Women were often truly docile bodies in the face of the medicalization of pregnancy and birth (Foucault 1970), and reeled from the fact that no one was watching or monitoring them anymore once they left the hospital.

Unlike in pregnancy and birth, most women are not monitored very heavily in the postpartum period – at least by the medical community. In the first two sections of this chapter, women tell stories of how they navigate the authority of medical professionals and whether they can control what happens to their bodies and babies during pregnancy, birth, and hospital stays. For the most part, after leaving the hospital, however, women in my sample were on their own. Women in my sample had a standard six-week check-up with their doctor. If they had a cesarean

section, they may have had an appointment sooner, at approximately two weeks. One women received a phone call from a nurse asking how she was doing, and one woman who birthed at a large university hospital received in-home visits from nurses during the first week. Eleven women in my sample were part of the Women, Infants and Children's Program (WIC) and received in-home visits and some resources in the postpartum; while these were the poorest women in my sample, they ended up receiving more resources than other interviewees because of their participation in WIC. A few other women spoke of supportive social networks, such as friends and family members who were helpful in the postpartum, but most interviewees did not have such information or social support.

Women with Resources

Only thirteen women explicitly told me that they were happy with their postpartum care. This included women who were part of the program Women, Infants, and Children (WIC), one woman who received postpartum at-home check-ups from her hospital, and a few women who discussed their social networks as being a resource in the postpartum. Informational and social support resources helped women navigate their transition into early motherhood.

Ashley, a rural women age nineteen with two children, told me, "I have a WIC nurse that comes to our house." I asked her, "What kind of things does she help with?" Ashley said, "Ummmm, birth control, and food for [the baby], what I can give her now, and, like, developmental things, what she should be doing. And things have actually worked with her." Similarly, Lindy, age twenty-one and mother of one, told me,

WIC came out to my house. A lot. Yeah. Like, I want to say three times a week she came over. Yeah. . . . and I think it was more so 'cause I breastfed this time around so it was a lot to make sure the breastfeeding was going okay. They would check [the baby's] weight and, you know, just kind of be a friend, which was really nice.

When breastfeeding, monitoring weight gain in the baby can be stressful because medical guidelines suggest very strict benchmarks for newborn weight gain. Having someone come to weigh your newborn, to let you know if they are gaining weight, gave women in my sample the confidence that breastfeeding was working. Kimberly, a rural woman age twenty-four with her first child, said, “Um, the breastfeeding consultant and the WIC [employee], they both came out to the house the first week and helped [me] get situated. They came in extra and checked her weight to make sure she was gaining so I would feel less anxiety about that.” Women in my sample who were single, had little money and were of a lower social status, then, could get help with their newborn through a federal program. WIC employees also tried to help women with breastfeeding. The WIC program continued to monitor women’s lives after the child was born, and the women exposed to this monitoring seemed to like and benefit from this. The mission of WIC programming in the postpartum may be more about trying to prevent increased healthcare costs and keeping babies healthy, rather than helping mothers. WIC programmers may also assume that women with low socioeconomic standing do not know how to mother or have their own resources. Nonetheless, the result is that women enrolled in WIC in my sample have more informational and supportive resources than women of higher socioeconomic standing in my sample. Perhaps the assumption is that women of middle and upper class standing have enough support to survive the postpartum stage, but my data suggest that this is not always the case. The pre-natal classes women in WIC were expected to attend also tied them to future social networks that could help them in the postpartum. Despite the potential negative connotation attached to continued surveillance into the postpartum, women generally seemed happy to be receiving WIC services. From interviewees’ stories, WIC does seem to serve a purpose that is helpful for the women, especially in their transition to early motherhood.

Only one woman who was not part of WIC received at-home checkups and felt at ease calling her doctor about any problems she encountered. Summer was part of a family of four, with both parents working, living in the suburbs, and had an income of somewhere between \$75,000 and \$99,999. I asked Summer, “Have you called the doctor for your own health at all since he has been born?” Summer replied,

I have. Just to make sure that, ummmm, like the, the bleeding that I am experiencing, has it gone on too long and, ummmm, but. . . [the large university hospital], they have a clinic that you can call any time during business hours and talk to the nurse, any of the nurses, and they are really good at talking you through things and diagnosing you to a point that they feel comfortable doing over the phone. So, I think it was last week that I called just to make sure that everything was okay. And, you know, they asked me questions and they assured me that everything was fine.

To probe a little farther, I asked Summer, “Do you think you have gotten the postpartum care that you need?” Summer replied,

Yeah. I feel, it’s available to me, especially through [the large university hospital] is where all of our doctors are from, and I will have my six week [appointment] and I don’t know if all hospitals do this but [the large university hospital] has a nurse come to your house within two or three days after you leave. So, we left on a Friday and on that Sunday -- they do it seven days a week because it was Easter -- she came. I was like, “You don’t have to come on Easter.” But she was like, “We are open, I have to come.” She was really nice. So, she came to our house to check on him and to weigh him . . . and to check on me to an extent. Yeah. Definitely think it is available.

I was curious if Summer had called the hospital nurses with all her questions so I inquired, “What if you have questions, who do you ask?” and Summer answered, “If I had medical questions my doctors and nurses are the best.” I probed, “What about mothering questions?” Summer replied, “I am pretty good at using the internet and *What to Expect* books. Yeah, the internet is usually where I go first. And I have a good network of girlfriends who are also mothers and ask them.” Summer proposes that social networks, such as friends, can serve as a resource for postpartum women.

Similarly, thirty-six-year-old Noel, with two young children claims,

When me and my friends get together [friends with babies] most of us have not showered in at least a day, gotten ourselves ready, our houses are a disaster and our children eat food off the floor, and we talk about not having time to do anything. It is nice to get to talk with people who are going through what you are.

When Noel gets together with her friends she feels free to talk about mothering difficulties with her friends because they are in similar situations. Both Summer and Noel would most likely be defined as middle class or upper middle class, and both have a network of friends to serve as resources in the postpartum. However, besides Summer and Noel and the women enrolled in WIC in my sample, most participants in my sample needed more resources than they had and felt less in control of the postpartum period.

Women in Need of Resources

Unlike the women above, much of my sample did not receive any postpartum care that was helpful until their follow-up appointments with their physicians. Most these women were economically stable. They held decent jobs and had completed at least some college education. Despite this socio-economic stability, they struggled in the postpartum. These women made too much money to qualify for pre-programmed, federally funded services like WIC but also did not have the resources from a university hospital or the social networks that Summer and Noel reported.

I asked Kayla if she had seen or called a physician about her own health since her baby was born. She said “I saw the nurse practitioner for my follow-up, like [at] my six week. [I] didn’t even get to see the doctor that delivered.” I then asked “Are you getting the postpartum care you need?” She explained to me,

About a week after he was born, the hospital called. Or a nurse, a nurse from the hospital, called. She asked how I was feeling. I was feeling down and felt bad saying it but did tell her that I was feeling depressed. I wasn’t in control of my

emotions. Just crying whenever. She just said that I had a little of the baby blues and it should go away soon. If it didn't, to call my doctor. That was it. She didn't even care that I just told her I wasn't feeling well. Tears were actually in my eyes. Hormones were all over the place. She just said, "Bye, and take care," or something.

Kayla's hospital appeared to reach out to women who had given birth recently and ask how they were feeling. However, when Kayla did say she was not feeling well, the only answer she got was to call her doctor if it continued. The nurse let her off the phone without making sure she was indeed okay. Kayla did not find the nurse's phone call to be a useful postpartum resource as result. Continuing, I asked Kayla who she gets her information from when she has a question regarding her health. Kayla replied, "I google it! If it isn't anything too weird I ask my mom." I then asked what she has needed information about during the postpartum, "Well, the baby blues as I told you about. And like, when would the bleeding stop. Lots of questions about nursing I have looked up. I have some books too." But, Kayla did not feel like her questions were answered in full; these resources were not enough.

Sophia, a middle-class teacher, whose husband works as an engineer, when asked about her postpartum care told me:

I guess with [her first child] I probably felt like I wanted to go talk to somebody but I didn't get a chance to. Ummmm, but I think that physically I got enough care postpartum, postpartum I probably could have been asked how I was feeling you know, more. Umm, but, I guess doctors don't do that as much anymore, they don't call home to figure out how you are doing or anything like that. Sometimes I think that after your second baby I think that they think that you just know what is going on so you don't need any help and I think even after the first one to a point you are kind of left, left to your own devices, I guess.

Sophia mentions that she would have liked someone to talk to with both her first and second child postpartum. With her first born she did not get a chance to. Physically she was fine, but mentally she was not sure. After she had her second child, her son, she felt there was less help in terms of what she was "feeling." Possibly when women have their second, third or fourth child the medical

community assumes they do not need the same care as someone who is on their first child. Just as it is assumed that someone with less money needs more care than someone who has a little more.

Similar in social standing to Kayla and Sophia, Cassandra worked in a hospital as a physical therapist for the elderly. Her family income was between \$50,000 and \$74,999 with her husband in graduate school. I asked Cassandra, “What is one thing you wish you knew about the postpartum that you didn’t know before you experienced it, that you think other women should know?” She responded with,

I think that, I think that there are postpartum doulas and I mean, you probably know what a doula is. I think there are postpartum doulas because when I was at the doctors there was a sign above the wall that said something about a postpartum doula, and I thought, ‘There is someone out there who can help you after you have a baby! Why am I not having this person in my life?’ And I was at the doctor’s office that day and I talked to him that day and I said, ‘What is up with the postpartum doula?’ And he is like, “What, what is that?” He didn’t even know what it was. Like, you have a sign on your wall about it and you don’t even know what it is? And then I never really got to look into it, I guess, I don’t know what happened. I think that women should know about that if they exist. Because lord knows that you could use somebody to come to your house and let you sleep for a couple hours or take a shower for an hour or whatever, and that could be like life changing for some people, you know?

Cassandra was not sure what a doula was, even though she worked in a hospital environment herself. However, if it was someone who could come and help her out Cassandra wanted one. Her doctor was unable to help her with this, nor did he even know what a doula was. Cassandra makes it clear that getting help for a few hours would be life changing for a postpartum woman. Cassandra proclaimed that women such as herself are not getting the resources that they need.

This group of women I feel like is not getting what they need. We are just sort of expected to be able to take care of everything. Or something like that. I didn’t even know it existed. If there was such a thing as a postpartum doula, well, jeez, that is what I need.

Cassandra liked the idea of outside help, even if paid for, because she did not like having to depend on family. She also felt like she was taking advantage of her husband's family with the help that they had given her.

That pressure of when you are asking people for help and they are family, you sort of feel like, depending on who you are, like, you owe them something. Like I do. But, if you could kind of get past that that is great, you know, you know what I mean? Sometimes it is easier to have someone you don't know. 'Cause then you are like, 'Well, I am paying you so this is what we are doing. (laugh) I am taking a shower now.'

I finally asked Cassandra, "Is there anything that I haven't asked you about the postpartum that you think is important?" She replied,

Now, maybe in a couple years when I have more time for myself, if I had a friend that was having a baby, I so would love to just commit to going over there like once a week or twice a week and say, 'Here, I am going to give you like three hours, you go do what you are going to do.' I think that, like, it makes such a difference in someone's life, a huge difference, like, I appreciated things so much, things that people have done for me, they don't even know. John's mom, they don't even know how much they are helping me right now, it's not just kind of helping me, it is a big deal. I would love to be able to do that for people, because it is huge. I do wish they had some program that could happen for people. Be more available, be something that your OB-GYN talks to you about before you have the baby. 'Cause it's okay to struggle, it is going to be a struggle, a lot of people don't talk about the hard things, just the good stuff, you don't necessarily hear the hard stuff until it happens and then everyone tells you their hard stuff.

While Cassandra did get some support from her family members, especially her husband's mother, getting help from family members is often a mixed blessing with strings attached. In addition, her comments make it clear that there have been times during which she has not told her family members exactly what kind of help she needed. If more non-family postpartum resources were available, perhaps Cassandra's experience of trying to get help during the postpartum period would not have been as strained.

My experience with the birth of my first child matches most with Cassandra's. At that time, as member of a self-identified lower-middle-class, educated family, we received no resources or help beyond what my family, who lived four hours away, could offer.

After getting home from the hospital my mom stayed with me for a week to help. It was nice. But the day she left I remember looking down at my daughter with a deep feeling of fear. That now I was the one to care for this child. It was me. My husband was at work. Living four hours from our closest family members and having no friends with children who understood my current situation, I was alone. There was no social network. If I lived near family, there may have been a social network. But in the city where we were living, specifically so I could attend graduate school, we had no one. My husband and I only had one another to depend upon to get through the first year. I had my six-week checkup and did not go back to the doctor again until I was pregnant with my son, more than two years later. Books and the internet were the resources I depended upon. Not until my daughter was two and we attended community programs did I begin to have a social network of "mother" friends whom became very important and helpful in my daily life.

As the women were transitioning into early motherhood there were specific aspects of their experience that led women in my sample to feel a loss of control. Once home with a newborn, women reported a void of control. Specifically, women in my sample felt an absence of control from others. They also blamed themselves for being unable to manage or deal with their postpartum lives. They thought they should feel more "in control" than they did.

Transition from Hospital to Home

The transition from hospital to home was particularly hard for some women, for instance, Silvia spent weeks on bedrest before her baby boy was born, with her older son at home with his father. Once both she and the baby were deemed healthy to go home, Silvia went home for the first time in weeks.

I was really out of it for that first week anyways, with the way my blood [loss] was. Ummmm, so . . . then I went home and I was just really tired and, ummmm, I had a lot of anxiety about what was going on in my house or not going on in my house.

And I couldn't find things and my house had been moved around, stuff my husband decided, to move things around, ahhhh. So I think, and my friends thought, I had a little postpartum thing going on and probably a little depressed and my anxiety level was probably through the roof, so I ended up going on an anti-depressant slash anxiety medicine.

Silvia's doctor said,

You have a little bit of postpartum depression so let's just try this for a little and see if it helps. So, I did. I don't know if it worked. Let's see. So, how has it been? With my first son, I was able to have a lot of structure and set a schedule and, ummmm, I felt like I had more control over what was going on and now I feel like I don't have as much of a structure, routine, and I am just going of the seat of my pants half the time. Which is why I feel like he is not sleeping good at night because I don't have him, I haven't tried real hard on a schedule either.

Sylvia blamed the lack of control and structure in her home on herself. Although the doctor told her she may be suffering from postpartum depression, she blamed herself for the difficulties at home. She felt out of control and she felt that being out of control was her own fault.

Kathryn, middle class with a total of four children, had difficulty adjusting to a new home situation as well: "My three other sons, I don't want them to resent him. I have to pay attention to all of them. Changes have been made. Like they have to ride the bus home. I try not to make them resent him or me, but I just have to figure it out as I go." Throughout time Kathryn was hopeful that her family would fall back into a routine as they had experienced previously. She had three previous children which may have led to her positive mindset, and she seemed to be gaining back control through an adjusting family routine, but her story shows the careful negotiation she was undertaking with her family and schedule to feel protective of other family members and in control.

Women in my sample who were stay-at-home moms sometimes felt a form of control over how their child was being raised. Megan, age twenty-five with one child, decided, "I got to control when she would go out in public and anti-bacterializing and all that kind of stuff." Megan was

very happy to be in control over these aspects of childcare, while other women may have never given the issue a second thought. Amanda, age thirty-six with two children, tried to change her perspective and need for control upon motherhood, once she realized that she could not control her home life as much as she did before the baby.

I've really had to step down from my type A personality after [child's name] was born. It would drive me crazy if things were not in place or neat or organized or followed a schedule. So, about a couple weeks after he was born I learned to develop a 'go with the flow' attitude. Which is still the motto of our house. And since that, I have been less stressed and crazy and we just roll with it over here. That has really helped me accept that, with the kids, there really is not order or control. I mean, we have set bedtimes, nap times, meal times, and activities. So, in that regard, we have order and organization. But when it comes to having toys on the floor, finger painting projects, messy craft projects, craft projects, dirt tracked on the floor from when they come home from outside, etc., I've learned that is okay. It is okay to have a messy house at times and that I can't allow that to cause me stress or to make me feel like I am losing control. I've realized it's all about perspective. And as long as you feel comfortable with the perspective, then it's going to be ok.

Control over the Physical Body

Diane, six months postpartum and mother of two, talked further about the lack of bodily control she felt in early motherhood.

Then on top of that you just have no self-control. Like, you know, your boobs just flare up and are in all this pain. Then you, you know, your stomach just turns to a mush pot which is a horrible feeling, your clothes don't fit. Like who still wants to be pulling on maternity pants after, you know, you don't have the baby anymore? You see all this stuff on TV about all these women lost all their baby weight in like six weeks, she is a Victoria secret model again. I am like, "Well, you know, I am no Heidi Klume, that is a lot of pressure, that is not going to happen." And then trying to deal with all the emotional stuff as far as yourself. And then you know, your marriage and then, you try to take care of the baby and your body, you know, looks and feels just out of control.

Diane was not the only one who felt like she "looked and felt just out of control." Judy also felt she had no control over their weight after the child was born. Leslie felt similarly for the first nine months until she took control of her weight loss by enrolling in a weight loss program. Julie, twelve

months postpartum, reported being unable to control her weight gain during pregnancy and has been unable to lose the weight postpartum.

Twenty-seven-year-old Alicia, however, took control of her weight loss and successfully lost the weight she felt she needed to lose.

So, I started doing Weight Watchers and going to the meetings and in four months I lost 47 pounds. So, I lost all of it. All the baby weight plus some, I got down to like 116 [pounds]. I think, I really think the reason that it worked is because you go to the meetings and you weigh in and you never want to go, you are held accountable by someone that you don't know. I can justify cheating in my mind, like, 'Oh, it is just me seeing my weight,' but if someone else is seeing you and your weight, you know, you think twice about eating that donut, so. That is what worked for me. Cause I apparently care too much about what people think. So, knowing that someone is going to see that weight and know you know that you weren't going to have a good week. Plus, writing down everything you eat so you can visualize it.

As found on the demographic questionnaire (see Appendix), overall, my sample felt that getting regular exercise was “important.” Despite this, when asked how often they exercised the average response was between “occasionally” and “rarely.” The sample felt that it was “somewhat important” that they could fit into their regular clothes, take off any extra weight gained during pregnancy, regain their pre-pregnant body, and eat foods that are good for them. The sample claimed to “occasionally” diet, thus not controlling their diet. Alicia did try to take control of this. Other women who attempted to control their diet include Sophia, Pamela, Jeannette, Leslie, Asia, Prudence, Christie, Margaret, Ruth, Kathryn, and Amanda. These women all answered that they dieted “all the time” or “occasionally.”

Women did have a variety of ways in which they tried to regain or achieve control in the postpartum. Lindy, twenty-one years old and three months postpartum, reported taking control by making sure that she gets at least a few minutes to make sure she herself is clean.

I make a point to do that. I realized it early on that she would not make that easy for me, that there are times that I just have to do it, I have to. If no one else is home,

I will just put her, if she needs a nap, I will put her in her room, even if she is crying, and I don't feel bad about it, because it is important for nursing, it is important for me to be clean. And to do my hair and, I definitely, you know, I don't spend as long as I used to, everything I do is really fast. I got a haircut that makes it fast, everything I do. But, I, I, make a point, every day I get up and I get ready like I would any, even if I was going to work, because it is important.

Four women had a routine where they worked out at least five days per week. Fourteen women took the time for themselves to work out between two and three times per week. Most of the women's workout routines consisted of walking. A few women did workout videos or used a workout machine, such as a bicycle or elliptical, within their homes. Two women did their workouts outside of family life. This included Diane and Denise who both made sure to go to the gym directly after they had already been out of the house for paid work.

As a postpartum woman, myself, with my second child at age thirty, I found the act of taking control over my own body to be very difficult. The only way I found I could control it was to do so within the confines of my family activities, as many of the women in my sample did.

I attempted to make a routine when my son was a newborn and daughter was three. Each morning I would get them into the double stroller and take a couple mile walk. Sometimes my son would start screaming. But I made the walk go in a loop that I had to finish whether he was crying or she was whining, there was no way to take a shortcut. Once home I would attempt to get everyone situated and quickly wash my face, and sometimes brush my hair into a new messy-bun. That is as much of my beauty as I took control of. I wanted to be fit and keep my skin clean. I felt I had to work this around the children—they had to be happy first.

Paid Work

Twenty-three women interviewed were currently back at work, while nineteen were not. Nine of the working women were back to working forty or more hours per week. Only one woman worked entirely from home, while four women split working time between their homes and their offices. Women who were back to work fulltime at their physical worksite were in professional

occupations such as teaching, pharmacy, nursing or business. Less educated women were more likely to work part time. It is notable that women who were back at work were more likely to have very controlled daily routines, and these routines included getting ready for the day and, often, exercising as well. Pamela, an attorney, took the shortest time off work of my sample, having taken only two full weeks off work after her caesarean session. As the breadwinner of her family, it was important to Pamela to be in control of her career, while also controlling how her child was doing when not with her.

I went in for my six-week checkup and told [my doctor] that I had been working for the past four weeks. Just some people can't afford to take time off. I worked hard in my career. I work with all men. I didn't want to be looked down upon because I had to take time off just because I had a baby. It's not like I wasn't in control of my baby. I was likely, like, my husband was unemployed at the time so I was leaving [my son] at home with his own father. I can't imagine leaving them in daycare at that age. I want to know what is going on. I want to know everything is okay at home so I can concentrate on work.

Not all working women were able to control early motherhood as much as Pamela could, however. At seven months postpartum Cassandra told me about her colicky baby who cried all night and day. She said,

'Basically you just have to get through this period,' is what he [doctor] said. And my baby probably slept, ohh, one and a half hours, two hours at a time. For at least three months, all night long. It was a lot of stress for me and I love my baby so much, but it was very hard the first three months.

At home Cassandra felt out of control of her life, but pieced her routine together with the help of her husband's family. She went back to work as a physical therapist after three months at home with her child.

Then, I went back to work and it was a little better 'cause I felt like at work I could have some time for myself. Even though I am at work and even though I am doing all this other stuff I can have two hands free and sort of be in control of my day where, at home, it was like I had to take care of this baby and he was really needy, you know.

Paid work life seemed more controlled than home life to other women in my sample as well. However, not all paid work situations were the same. For instance, Diane, age twenty-six with two children, was a nurse in the army and felt very strict guidelines placed at her at work as well as at home. Detailing the lack of control, she also feels at paid work, Diane explained,

That is what sucks too, it's like being in the army takes even more time than someone who can go to work and just work eight hours and come home. You know, people who are school teachers, like the school doesn't tell you how much you can weigh or how many push up and sit ups you can do, or say, hey, here is a two weeks' head notice for whatever. So, I feel like there is a lot of pressure on me because once I do make the height [and] weight standards, they can just deploy me at any time, and I just have no say in it.

For Jeannette, low-income and rural, part-time work as a waitress was a necessity, and it was out of her control. In attempt to control the situation she was trying to start an out of home business. "Yeah, just part time, I have to. To finish paying the car. But, umm, I do own a [makeup vendor] business. I will show you. If you work on it for a couple years, it can become long term income and I can give up work at [restaurant]. Have money and be with the kids." Jeannette's goal was to be able to work from home to be with her kids.

Thus, while some paid work environments brought solace to new mothers because they brought women a sense of control, other paid work environments worked against women's sense of control. Women such as Jeannette should work to pay the bills and may be working toward better or easier, family friendly working situations. Diane also talked about the loss of control she felt over her physical body in the postpartum, which added to her stress about paid work.

Conclusion

Some of the women in my sample felt out of control in the postpartum specifically because they were reeling from the lack of control they felt after leaving the hospital, and not being monitored anymore. Women who voiced these concerns are likely those who do need more

support during this transition. There was a second group of women in my sample who were just acknowledging that they can no longer control their home lives, bodies, or personal lives as much as they did before, and chose to discuss this with me. Some women still mourn the control they once had, yet some women have gotten used to their new out-of-control home life. It does seem to matter what their job is, how many family members and friends they have who can offer help, how many children they have, and how far into the postpartum stage they are. Additionally, there was a socioeconomic difference within my sample in terms of amount of support that women receive; specifically, women who had lower incomes and were enrolled in WIC were involved in a postpartum support program that benefitted them and made them feel more secure (and more in control) in early motherhood.

The metaphor of women navigating a new pathway, or going on a long journey, on the way to motherhood can help others to understand the difficulties women throughout the experience of pregnancy, labor and birth, and finally the postpartum. Generally, women feel somewhat in control of their lives pre-pregnancy. Once becoming pregnant they slowly lose the control they have over their bodies to the medical community. The peak loss of control is during labor and delivery of their infant. When they are sent home new mothers they are literally “dropped.” The women no longer have someone telling them how to follow the path, or forcing them to follow the path in a specific manner. New mothers learn how to navigate this new life. After a while their level of control will plateau as it did pre-pregnancy. Some women were exceptions to this, however, specifically women who experienced difficult pregnancies with bedrest or gestational diabetes.

CHAPTER 6 CONTRASTING MATERNAL EMOTIONS: GUILT AND PRIDE

As humans, we feel and express a variety of emotions. Women who are pregnant, in the process of having a child, and new to motherhood are no exception. As my study progressed, the “essence” of the women’s experiences went beyond the subjects of my interview guide. While exploring conversations about maternal guilt and pride was not the purpose of my original study and while my interview guide included no questions containing the word “guilt” or “pride,” discussions of these feelings came up completely unprompted in the data. Women consciously and purposely told me about their feelings, well beyond how my questioning prompted them. For instance, discussions of feelings such as guilt came up so often that, at times, it soon felt like my study was about mothers’ guilt. After concluding my final interviews, I realized that over half of my respondents had expressed feelings of guilt. For comparison’s sake, I then sought to find instances in my data in which women felt proud of themselves. After thorough analysis, I found only a few instances of women saying they were proud of themselves, however. Women were much more likely to express guilt than pride in the interviews.

Of the women in the study who expressed guilt or pride, some expressed both feelings and other women expressed only one. Numerous women also discussed feeling guilt or pride more than once during their experiences. For example, certain women expressed feeling guilty about varied issues. Women explicitly expressed guilt by using such phrases as “I regret.....,” “I wish.....,” “I feel guilty.....,” “I feel bad.....” “I blame myself.....,” or “It’s my fault.....” Expressions of guilt arose throughout the interviews in response to a variety of different questions about pregnancy, childbirth, and the postpartum. As in the previous chapter, I divide findings by life stage (i.e., pregnancy, birth, or the postpartum).

Before Baby Comes

Women in my sample often described pregnancy as a time of emotional difficulties. Interviewees characterized pregnancy emotions as “up and down” and as different from their pre-pregnant emotions, likely because of both hormones and new expectations placed on them and their bodies. Women who expressed guilt in pregnancy often reported feeling scared. Also, the women who expressed guilt also discussed other people making them feel guilty or situations that were out of their control that made them feel guilty. Thus, both oneself and others could drive the guilt. Women who expressed pride in pregnancy were pleased that they were going to become mothers. These women also embraced or enjoyed their pregnant bodies.

Guilt during Pregnancy

Some women expressed feeling guilt throughout their pregnancies. On the questionnaire women were asked to rank themselves from one to four on whether they agreed with the statement, “I felt scared when I found out I was going to become a mother.” Women could choose “strongly disagree,” “disagree,” “agree,” or “strongly agree.” Women averaged a score of 2.3/4, meaning most women agreed that they were scared when they found out they were going to become mothers. A total of ten participants, or twenty-four percent of the sample, strongly agreed that they felt scared when they found out they were going to become mothers.

Lindy, age twenty-one with her first child, claimed others, specifically her family members and church peers, attempted to and made her feel guilty throughout her pregnancy. She was unmarried when she became pregnant and her family did not agree with this.

It was very up and down. It was very rough when we first found out. Very rough. Lot of questions [about] what are we going to do. That we were not married, I am from a very strong Christian family background and that was unheard of. My family made me feel guilty the whole pregnancy. They still try to make me feel guilty about it now. But I believe now that she is a blessing from God.

Also with an unplanned first pregnancy, I live with a great deal of guilt. I feel guilty at the remembrance of the pregnancy and actively felt guilty during my first pregnancy.

My entire pregnancy is one big pile of guilt. I would be twenty-seven. My husband had a decent job and we both had advanced degrees. However, I was still working on my doctorate and had no friends who had children. I did not even know if I ever would want to have children. I didn't like children. So, when I found out I was pregnant my immediate thought was, "What should I do?" I was so confused at my doctor's appointment why they didn't ask me, "So what do you want to do about this?" But all they said was congratulations. Taking my age into account and our social standing, my husband and I were supposedly sufficiently "fit" enough to have a child. My mother was disappointed in me. She always told me that someday I would "have" to have children or I would be "lonely," but she was not happy I had not finished my schooling.

My guilt goes deeper than this. Almost daily, throughout my first pregnancy I would look up abortion on the internet and do searches for centers in our area. One day I even called to make an appointment but didn't after they told me I had to have a counseling appointment and ultrasound first. If I had gone through with this, I do not know if I would have ever felt guilty. I was so depressed during pregnancy that it may have been a relief and an easy end to the situation. But since I did have her and I remember the pregnancy, my mind fills with guilt on how much I did not want the pregnancy. Writing and re-reading this makes me cry. I feel guilt knowing that one day she will find this out. Despite this, I also want her to know the truth of how she came to us, but I never want her to feel unwanted. For me, I didn't love her while she was inside me as some mother's claim, but I loved her the moment I saw her.

During this time in my life I did not have a social network of friends with children. I was alone and pregnant with an unplanned child. Other doctoral students made comments such as, "I am waiting! What are you doing? Did you think of this?", "I can't believe you are doing this to your body, I never will" or "Why aren't you waiting until you have a career?" As graduate students, my husband and I had no night of the week that we could both attend classes to learn about being a parent or the childbirth process and, thus, made no social connections with other to be parents.

I was unable to even confide in my husband. He thought I was being ridiculous and just wallowing in my own world when in fact it just would not go away. During no time, do I remember a nurse or doctor asking how my mental health was doing. Sure, there was the "Hi, how are you today?" but nothing beyond this that would allow me to confide the difficulties I was facing.

In this situation, a simple friend, nurse, doctor, anyone, may have been of benefit. However, I did not know where to find this. Also, at the time I did not realize that this guilt may not be normal, or it is normal and I did not have a chance to find that out. I had nothing to judge my current position from besides for movies and television that show pregnancy as something women desire and enjoy.

A few women within my sample expressed not enjoying pregnancy either. For example, a suburban mother of two age twenty-eight, Tiffany described how she felt during her first pregnancy:

I looked miserable throughout most of it. And I think just because of my attitude with the way I felt about myself. And it was winter. So, umm, basically that is about it. I mean unfortunately I wasn't active like I should have been. I didn't really work out or anything like that or try to be healthy like my sister did. She made sure to let me know, you know, that over the phone.

Like my situation, Tiffany lived in a suburban area away from her family and support system. Furthermore, having a twin sister who loved pregnancy helped make Tiffany feel that much worse about her situation. One sister, Leslie, lived among friends and family. Thus, she had a support system of women.

Another suburban woman away from her family, Cassandra, while pregnant with her first and only child, felt guilt while at work as a physical therapist. She was unable to perform her job as well as she felt she should and felt badly about this.

So, it was pretty life-changing as far as hormones and feeling like, ummmm, sick all the time, nauseated for about 4 months, and it wasn't like morning sickness, it was like most of the day . . . and I was working and it was winter so it was, ummm, very hard because normally if I felt like that on any given day I would call in sick but I couldn't. You are kind of dragging yourself through work every day. So, being at work and then having to answer a phone call, telling the person on the phone, 'Excuse me for a second, I need to go throw up,' and then come back and talk on the phone again, there is nothing like that. It was no fun and I did a poor job. So, a lot of people say 'I love being pregnant, it is so great,' [but] I didn't love being pregnant.

Pregnancy seemed to get in the way of Cassandra doing a good job in paid work, and this weighed heavily on her. The status of pregnant woman and paid worker seemed to compete for her. Paid work suffered. Lindy had family and her religion weighing in on her guilt. Both Tiffany and I lacked support systems throughout pregnancy. All of us were with our first child and did not have previous experiences to compare our feelings to.

Pride during Pregnancy

On the questionnaire, all women were asked to rank themselves from one to four on the statement, “I was proud when I found out I was going to have a baby.” On average, women answered that they “agree.” Twenty-five women in my sample agreed to being proud during pregnancy. The remainder of the women reported feeling in between, answering with somewhat agree or somewhat disagree. None of the respondents chose “disagree.” However, to tell me that they hated pregnancy would have been socially unacceptable. Most women answered that they were “proud” that they were going to have babies even if they did not express it in the interviews. Perhaps not every woman was proud but felt obligated to answer that way.

Despite this notion, three women expressed feeling proud during their pregnancies in my interview conversations with them. Lillian, seven months postpartum, was asked, “with your other pregnancies how much weight did you gain?” Lillian answered “I probably gained about forty with some of the other pregnancies and I think this one I only did about twenty-five or so. Wow, I was proud of that! (laugh). Yay, I didn’t gain as much. It was an accomplishment.” Megan, six months postpartum, who received fertility treatments, said of her doctors, “They were pretty happy! Every time I went in there they are, ‘You are right where you are supposed to be, your pulse sounds fine.’ It was just like, I don’t know, I always, I don’t know what I expected to hear but my scale is off so I never knew exactly where I was at, but I kind of had an idea. But they

were just always like, ‘Yup, you are doing good, keep it up and we will see you next week.’” As she talked about this, Megan looked and sounded proud of herself. Gaining the “correct” doctor-determined amount of weight or very little weight made Lillian and Megan feel good about themselves, as if they had accomplished something very important.

Summer, just one month postpartum with her second child, said,

I enjoy[ed] being pregnant, both times. Because of body image, because, I, I tend to have more around my waist ‘cause, you know, that apple shape type body, and so when I am pregnant I don’t have to worry about it anymore because, you know, your belly is there. You know, you tend to be proud of your belly and you don’t worry about that extra weight there. So being pregnant for me is actually a relief. I don’t mind going clothes shopping because it is fun looking for maternity clothes, I don’t have to worry about looking skinny in that area or anything.

For Summer, pregnancy was a break from the appearance ideals to which non-pregnant women are held. She could finally be “proud” of her shape; in fact, pregnancy represented the only time during which she could be proud of her body.

Women felt guilty because of different social situations. For example, Lindy felt guilt pushed upon her by her family members and her faith. And Cassandra felt her pregnancy got in the way of her work. The women discussed as feeling guilt had unplanned pregnancies. On the other side of the spectrum, women who expressed pride in pregnancy had often planned their pregnancies, or claimed to have planned them. They also felt that they looked good during pregnancy, and this pride in appearance added to their self-esteem. They either liked the way pregnancy changed their bodies or enjoyed the way pregnancy was a cover up of their non-pregnant body.

Childbirth

Twenty-five women (60%) had a birthing experience like they had planned. Seventeen women (40%) had a birthing experience that they reported as unplanned or unexpected. Much of

women, thirty of them (72%), had vaginal births. Twenty-eight percent of the sample had their baby by cesarean section. Women who had their birthing experience take unexpected directions often expressed guilt, while women who had births that went along with their birth plan sometimes expressed pride. Guilt and pride conversations about birth sometimes revolved around women's ability to have a "natural" birth. For women in my sample, a "natural birth" is considered a vaginal birth without any pain medication.

Guilt and Childbirth

Nine women expressed guilt in relation to childbirth. For example, a twenty-five-year-old, Megan, six months postpartum, utilized fertility treatments to become pregnant. Megan experienced a cesarean section instead of her planned natural birth, and she was disappointed not to experience a natural birth with her first (and possibly only) child.

I felt like my only, my one function as a woman is to be able to have a child and I did feel there was a time when I was in the hospital and a time when I got out of the hospital, I felt ashamed of the fact that I couldn't have him normally. I felt like that was the one thing that my body was designed to do and I couldn't do it.

During the birth of her first child Summer also experienced a disappointing birth because she had both an induced birth and an epidural. At one month postpartum, with her second child, she told me,

Somebody has said this to me: the way that the baby comes into the world can affect . . . how they [are]. Their personality. And so far, it seems like that holds true. [My first child's] birth [was] very traumatic. Very long. And disappointing in a way, we weren't disappointed to get her and we weren't disappointed that she was healthy, but [it] just wasn't that natural birth experience we had hoped for. So, getting past that was a lot, was hard for us. You know, it took us four years to even consider having another.

After her first childbirth did not go as planned it took years for Summer to bring herself to try to have another child. With her second child, she also had a precise plan for how she wanted the delivery to go. When birth went as planned women in my sample were satisfied and usually guilt-

free yet, when birth went dramatically different than expected, some women experienced anger, guilt, questioning, or confusion.

Pride and Childbirth

Six women said they were proud of their natural births. Summer, with her second child, expressed pride. “I remember looking up and I was smiling and I was so happy and I was just so ecstatic that everything had went as planned.” That her plan went as desired caused Summer to feel elated and proud. As with Summer, Denise, eight months postpartum, was thrilled to have her baby naturally as well. Denise said, “I ended up doing it, it was amazing.” She further explained what was “amazing”: “I just loved it because afterwards I was one-hundred percent back to normal, no, there was no side effects of drugs, there was nothing. I had a little tearing but it was nothing compared to what I had the first time. I thought it was a breeze the second time.” Like Summer, Denise compared her second birth to her first and was much more satisfied with her second birth. Thus, pride sometimes comes after an earlier experience with guilt.

Only six women in my sample (15%) let me know how proud they were, but these women were not afraid to let me know. Leslie, eleven months postpartum with her first child, said, “When I had her, it was the best thing in the world. I had so much pride. I did it all with no help, no medication, no nothing. So, it was such an amazing experience to do that. (Here, telling the story again, she becomes emotional.) And now I did it all by myself.”

Leslie’s twin, Tiffany, ten months postpartum with her second child, was especially proud of her birthing accomplishment of her second child (after her sister had her first child naturally).

I thought it would be, I mean it was definitely one of the hardest things I have ever done but I thought it would be even harder for me than it was. I feel pretty proud of myself for doing what I did, especially the second time around because by choice I did it drug-free -- no epidural no drugs, I did it completely natural. And I was impressed with myself and I felt so much better doing it that way than I did the first time around when I did have an epidural. Ummmm, I think that gave me a little bit

of a confidence boost to be honest because I was so proud that I didn't have anything, and people were really impressed with that. I was really happy about it and I feel like it was something that I accomplished, you know?

With her first child, Tiffany received an epidural. Leslie had her baby before Tiffany had her second, however, and Leslie's natural birth may have led to Tiffany's attempt for and pride about a natural birth. Tiffany felt it was a big "accomplishment" and something that gave her "confidence" going into motherhood. Harkening back to the previous chapter on control, women in my sample seemed to feel proud when they felt in control of the birthing experience, whereas they felt guilty when they were ultimately not in control of their births. In this way, the data I presented in Chapter Five may influence the data that I present in this chapter (Chapter Six), in that women's emotions may be connected to how "in control" they feel during births; I do not have the data to specifically examine this assumption in the dissertation however.

After Baby Comes

After the baby is born women enter another possibly difficult stage of life, that of the postpartum. Women in my sample expressed guilt over breastfeeding in relation to difficulties with the act of nursing and discontinuing breastfeeding earlier than desired, often due to difficulties with it. A few women expressed pride in their ability to produce milk. Learning to navigate the role of mothering a newborn along with other roles such as being a mother of multiple children, being a spouse, or a paid worker created a sense of guilt in several women. Much of the guilt came from the learning process and the difficulties of this when transitioning into motherhood.

Breastfeeding

Women frequently reported their feelings about breastfeeding, and felt guilt about a variety of breastfeeding situations involving breastfeeding. This includes having trouble while breastfeeding, weening earlier than desired, and being disappointed that they had to pump their

milk instead of physically nursing their babies. Women who expressed pride in relation to breastfeeding were proud of their ability to produce milk for their infant.

Questions that elicited talking about guilt or pride in relation to breastfeeding included: “Why did you choose breastfeeding?”; “How did pumping make you feel?”; “Tell me about the time since your most recent birth?”; “Have you altered any part of your life to accommodate breastfeeding?”; and “What has been the most difficult thing to accept postpartum?” Twenty different women (48%) expressed guilt in relation to breastfeeding without being prompted or asked about guilt. Of these twenty women, some expressed feeling guilty about multiple issues dealing with breastfeeding, while others expressed guilt over a single issue.

Breastfeeding was discussed very emotionally by my interviewees. I saw smiles and tears while women told me their experiences breastfeeding their child. Breastfeeding is just not a physical process that all women and children easily engage in. It is also a complicated, yet potentially rewarding, bonding experience. Women in my sample who had difficulties with breastfeeding also dealt with emotional and social guilt. Issues that induced guilt in interviewees included pumping, difficulties with actual breastfeeding logistics, weaning earlier than desired, and changing personal habits. Whereas twenty women expressed guilt related to breastfeeding, only four women expressed breastfeeding pride. Some women expressed both guilt and pride in their discussions of nursing. Below I show how I felt both guilt and pride in relation to breastfeeding.

When I first got home with my daughter I was not sure if she was getting enough milk. When breastfeeding it's not like you can visually see how many ounces a baby consumes. I was nervous about this. I kept notes on what time she ate, for how long, and on which side. I kept questioning whether I should just give her a bottle. My mother was unable to help me, as she had been advised to formula feed her children. The hospital had given me a small book that soon became my

“Breastfeeding Bible.” I referred to it with any question I had. For example, what foods might make babies fussy or get tummy aches? Well, it seemed like everything with my daughter. For almost two years I may have eaten plain pasta. After a little while I learned how my body worked in relation to breastfeeding, and in relation to what my daughter needed (such as how to hold her most comfortably). After a while I could tell by how my body felt whether she had eaten much or not. The first two weeks of nursing was difficult. But after this, I was awesome at breastfeeding, despite having to change my diet to very plain, tasteless foods. I still do not know if this was entirely socially constructed or if the food did impact my daughter.

After being “awesome” at nursing my first child I assumed my son would be no trouble. This was not the case. I did not remember how to nurse. How could I have forgotten? I do not know, but I did. I needed help arranging how I should hold him. He was a large baby and holding him was difficult. My body had to create milk for him, as it did my daughter, and this takes a week or so. I felt poorly and at times wanted to give up again. But just like the time before, after those first weeks, my son and I had figured it out. I was proud I could breastfeed my children for the “recommended amount of time.” I know this is not the case for everyone, and all situation are different.

Thus, in both cases, I felt guilt which slowly turned into pride as I learned what my newborn needed and how to make my body work with them

Other women may have felt as I did, at one time guilty and at another pride over one issue. Below are excerpts of what women told me when I interview them. Again, guilt and pride were not a part of the interview guide so I did not follow up and ask women if they felt guilt and then pride later, or vice versa.

Guilt and Breastfeeding. Women expressed difficulty nursing their infants. Seven women explicitly expressed feeling guilty about having difficulties. For example, Jane, age twenty-six, three months postpartum with her first child, stated,

I did [breastfeed] in the beginning just because I just thought it was something that every woman should be able to do. Just because you have them, it is there, it is natural but, so in the beginning I did. I just felt like, “What is wrong with me, why can’t I do this?”

With the help of the nurses, she could nurse at the hospital but at home she had difficulty on her own and she could not get the support that she needed to continue. Consequently, she weaned. Jane felt guilty about her difficult breastfeeding experiences because she associated breastfeeding with “natural” womanhood and felt as if she was not fulfilling her duties as a mother.

Pamela, the attorney discussed earlier, said of nursing,

It was hard, well, when I had her, ummmm, with the nursing thing. It was, I was kind of disappointed that it wasn't easier or didn't go better even though I didn't plan, with her I didn't plan on doing it that long anyway. But I wished, ummm, . . . it was kind of disappointing that it was not an easy thing. It would be working and then it wouldn't after back at work a few days.

Working full time and having to pump added to the difficulties that Pamela had with nursing. Over the weekends nursing would become easier; however, once she was back at her fifty hour a week job her child preferred a bottle. Additionally, working with only men pumping was a difficulty leading her to produce less milk. One woman, Julie, age thirty-two and one child, who explicitly spoke of her guilt over breastfeeding difficulties, said,

I tried it for a couple of months, I went on like that for a couple of months, it was really hard on me and I felt so bad because I felt like, 'Why can I not produce this for my baby?' You know? And so, we just kind of decided that it was not worth what it was putting me through emotionally to continue with one three ounces a day -- basically what we were getting for three hours a day of pumping, getting three ounces -- [we] just decided it wasn't worth it.

After a cost-benefit analysis, Julie decided breastfeeding was not beneficial enough to warrant the emotional distress she was feeling. Some of these women made it clear in their conversations that, if women received more practical help and information about how to breastfeed, their experiences might have been very different and much more positive. Guilt over breastfeeding was often the result of women's lack of understanding about how to overcome the feeding difficulties they were facing. The three women discussed here were all back at work when I interviewed them.

Some newborns have difficulties nursing because of certain physical conditions. This is the case with Diane, a nurse age twenty-six with her second child. Despite knowing that her child did have a medical difficulty she still felt bad about not being able to breastfeed as expected.

In nursing school, they tell you the first six weeks are the most important. My intentions were to do it as long as possible. With [child's name] she was tongue tied. So, she couldn't latch on so it was extremely painful. I mean horrible. When she would cry to be hungry, I would cry because I was doing this to her.

Megan had one planned child and had received fertility treatments to become pregnant. She said, "I wish I had not used formula as a supplement. I think that is why I can only feed her at night. But I was having difficulties. So, I was told to supplement by her doctor. Next time I will do it differently." Megan had listened to her pediatrician, assuming this was the correct thing to do. Megan's experience relates back to issues of control as presented in Chapter Five. After her first experience, she knows to try things differently and take more control for herself next time; she suggested that maybe the pediatrician did not know everything about her and her baby.

Eight women expressed feeling guilty about weaning earlier than they felt they should have. Lisa, age twenty-seven, one month postpartum and on her third child, explained that "There was a bond. And, er, a different bond. And then when I couldn't do it anymore I felt bad and plus, with all the, you know, "breast is best" and all the pushing and everything . . ." Lisa further explained:

I guess it was within the first week I felt bad and I started feeling guilty just like I did with my first two, so I tried it in the middle of the night when she was hungry and [my husband] went to go make her a bottle so I was like, 'Oh, I will just try it,' and she didn't want it. This time I didn't feel like I failed. Where with my first one, if you mentioned it, if I was breastfeeding or not, I would just cry. And for at least a month after quitting I would just cry about it. All of a sudden someone [would] be like, 'Are you breastfeeding?', and I would just start to cry. And so, with my second one it was a little bit of a touchy subject.

Lisa expressed a great amount of guilt over "failing" at breastfeeding three separate times. By her third child Lisa had learned to have to be content with bottle feeding.

Guilt about Pumping. Six women expressed feeling guilt in relation to pumping milk. For example, when asked “How do you feel about pumping?” Melissa, age twenty-five, with two children, twelve months postpartum, answered: “Like, I was taking the easy way out kind of. I felt bad.” She had a hard time getting her son to latch on the breast; thus, she felt forced to pump milk. Melissa chose to continue producing milk and pumping because she researched breastfeeding and knew that it would help her child’s immune system and help her lose her baby weight. Melissa pumped milk for three months. “I really wish I could have done it longer but he just, you know, I mean, I was constantly, like, pumping.” She felt that this was sufficient since it helped her to tighten her body and lose some of her baby weight, but still wished she could have done it longer. Melissa also felt some anxiety while pumping because she felt she was not getting enough milk for her child. “Just to assure that I was making more milk I tried putting it in a bottle to measure it, but that was making twice as much work I think.” Even with all this extra effort on behalf of her baby and body, Melissa still felt “bad.”

Diane, the nurse introduced earlier, felt pumping was time- and life-consuming as well. Pumping made her days stressful. She told me,

Something about breastfeeding gives me horrible anxiety and makes me feel bad, like, when should I be pumping? How much should I be getting? Keeping track of all if it, I was more worried about all that stuff than everything else that was going on. It was almost like it was all consuming I felt like. You know, we were trying to go places and everything was based around, are my boobs feeding up? Where can I pump? Where can I put the milk? I remember we went to a hockey game and I had to ‘pump and dump ‘and I was like, ‘I am wasting all this.’ It made me feel like a horrible person. You know..... And so, it’s not like the actual contact or the actual act of feeding with [my baby], it wasn’t as painful so it wasn’t really that, but it was just, like, consuming me so much mentally that I was like, out of ease.

Diane found both the act of breastfeeding and pumping all consuming. It was difficult to always be thinking about her breasts filling up with milk. She worried about how much she should be getting, where she could pump, where she could put the milk, and felt wasteful when she was

“pumping and dumping.” In sum, both breastfeeding and pumping created considerable stress for her and, like Melissa, made her feel “bad.”

Depending on their workplaces women can also have positive or negative experiences with breastfeeding. Pumping at work produced some anxiety and guilt for Pamela, the attorney. Pamela went back to work after two weeks off.

You know, the partners and things, they are used to just walking into your office whenever they want to so then if I had my door locked they knew what I was doing And that was weird, “Oh, great, they know what I am doing and can hear it, when I should be working.”

Pamela felt that her co-workers felt she was wasting time that she should be working. She felt uncomfortable in the company of all male coworkers and did not like the fact that breastfeeding marked her as doing something different. Similarly, Christy, a twenty-eight-year-old pharmacist with one child, felt guilty for taking the time at work to pump. Her workmates complained she was “taking a break” each time she went to pump during her eight-hour shift. As mentioned above, Christy also felt guilty when she felt nauseous at work during pregnancy. Any change in routine at paid work led some women, depending on their work environments, to feel guilty about any activity that marked them as a future or current mother. Not being able to follow norms at work led to their feelings of guilt.

Five women expressed guilt over the fact that they kept many of their “bad” habits while breastfeeding. For example, Silvia, age thirty-seven, seven months postpartum, mother of two, replied,

I’ve stopped taking some of my medicine -- some of my certain herbal things that I was taking for the cancer -- because I am not sure how they would react with him. . . . But I feel bad, I do feel bad, . . . as far as chocolate and caffeine, I’m eating that stuff and I probably shouldn’t be. I should be altering [my diet] more. My husband says it’s why he [the baby] doesn’t sleep.

Although Silvia had made some alterations in medications she felt it was not enough. Other women in the sample also felt guilty consuming “normal” foods such as chocolate or coffee. They are also judged by others for what they consume, as Kelly suggests in telling me what her husband thought.

Other women in the sample also talked about not altering their diets enough, and feeling guilty about it. Diane, who was six months postpartum, said “. . . [I]f I would eat Mexican or something then I would breastfeed and she would be spitting up, like I felt like a horrible person.....” Noel, age thirty-six, has a son just over a year old as well as an infant. She breastfed her son until her second was born. Thus, she had already been breastfeeding for just over a year when her second child came. Her second child had reactions to certain foods that she was eating. Noel told me,

I feel like I am being selfish if I am not breastfeeding. . . . I will not do it for six months because, ummmm, I can’t have cheese. And another thing the doctor said was cutting out chocolate or caffeine. So, yeah. So, it’s really just hard to eat.

Both Diana and Noel wanted to eat foods they enjoyed and felt badly that they wanted to prioritize their own needs. The act of putting oneself first (over baby) led some interviews to discuss guilty feelings.

Pride and Breastfeeding. Three women, on the other hand, expressed pride in producing breast milk. All three-mentioned pumping and how they felt productive because of breastfeeding. For example, Cassandra, seven months postpartum, when asked how she felt about pumping, replied, “I guess I feel good about being able to provide it. I feel good about, like, when I am done pumping I feel like, good. I feel, like, proud that, there it is. Like, now I can feed him some more, take it over to daycare. Feel good about it.” Even though Cassandra spend her days at work away

from her son she could provide milk for him. Her son went to a daycare within her workplace, a hospital, and she could walk the milk over to his caregivers.

Judy, nine months postpartum who was not yet back at work, said, “Yeah, I did some pumping. Especially toward the last couple of weeks [before weaning] I would pump, you know. And you pump and, oh, I got! Four ounces and feels like you accomplished, “Look at what I did.” Very protective over that breast milk. But, ahhh yeah, so I breastfed her exclusively for the first, ahhhhh, six weeks!” Being able to see what she was producing for her child was something Judy felt good about. Each woman had a timeline planned for how long they would nurse their child. The times varied greatly. Some women felt guilty over breastfeeding for “just” six weeks, while Judy was very proud of it. Thus, guilt was often linked to women’s exact expectations for their current stage of the process (i.e., pregnancy, birth, or postpartum) and the exact plans they had for activities and experiences during that stage.

Sandy, age twenty-seven with two children, had a goal of making it to six weeks breastfeeding the second time, after having a difficult time nursing her first son.

I think I just wanted to prove that I could do it longer than 6 weeks. I had no excuse -- no job, nothing. And I just, I got started at it and I was good at it (laugh). I know that is kind of a stupid thing to say. But I produce a ton of milk and, ummmm, I was actually able to donate a ton of it because I produce so much, I am like, okay, this is something I am good at, I don’t have to buy formula. I am going to save a lot of money by doing this and it’s just easier and it’s handy and it’s nice in the middle of the night when you can just stick it in his mouth, there is no mixing a bottle or anything.

After difficulties with her first son Sandy was proud that she could be “good” at breastfeeding. She was proud that she could produce enough milk to donate it as well. The extra benefits were the ease and low cost of breastfeeding, but the amount of milk she produced was what made her proud the second time around. Again, in this example, pride sometimes comes (with perceived

accomplishment) after a woman has experienced guilt (because of perceived failure) in a previous experience.

Guilt and Mothering

When becoming a mother one must learn to adjust to a new normal. One must also learn to adjust to competing roles and responsibilities. As a mother, wife, and paid worker there can be role conflict and women may have a hard time adjusting to this new lifestyle. They feel guilty as they learn to adjust. Four women felt guilty that they were no longer paying enough attention to their husband.

Changes with Partner Role. Specifically, two felt that they were not prioritizing their husband because they were putting their infant first, one felt she put too much pressure on her husband and had too high of expectations for him, and one felt badly that she did not have sexual intercourse with her husband. Silvia, seven months postpartum, suggested it was difficult “to prioritize your relationship with your husband. Which I don’t do enough of, which I always put my kids first but, yet, I know they need to learn how important it is, you know, that they spend time with daddy and this and that, but sometimes you are so tired.” Diane, six months postpartum, explained: “Like I expected him to know everything I wanted him to do or to help out and do all this kind of stuff. I put all these expectations on him and that was hard at first, so we would like bicker a lot just about, like, silly stuff, making us both feel bad.”

Tiffany, age twenty-eight with two young boys, felt bad about her current relationship with her husband.

The most difficult for thing for me I would say is I think the attention that I don’t get from my husband because all of our attention goes to our kids and I can sacrifice money and I can sacrifice things and I can sacrifice all those superficial things, that don’t mean as much, but I guess my relationship with my husband I miss a lot. Because we were so playful and fun and easy going with each other and now I feel like life you know is harder and so we’re, he’s always stressed like makes me

stressed and makes me feel stressed because I am staying at home. And, so there's always the underlying stress that makes life so much harder than it always was.

Tiffany mourns the old relationship she had with her husband, pre-children, when they were “so playful and fun and easy going with each other.” After having two children life is not as easy as it was before children, thus, there is more stress in their lives. Tiffany feels badly that she stays at home putting stress on her husband, a firefighter, to have to be the breadwinner of their household.

Cassandra, seven months postpartum, stated, “I don't have sex right now. . . . I am not really in much of the mood. If you aren't sleeping, when you aren't getting those basic biological needs like sleeping eating whatever, showering, I don't even care about the other things.” Cassandra felt that sex was not on the list of things to do when you have time to do things for yourself. “I want to sleep, 'cause that is the only time I have to do it. And, sex is nice but not right now.” She continued, “. . . then, when you are kind of resentful with your spouse about different things, you really don't feel like doing it. And he knows that is how I was feeling. I tried to explain that.” Cassandra was angry with her husband for not doing as much around the house with the baby as Cassandra expected of him. She was also afraid of getting pregnant.

There is always like that little worry that, you know, I forgot to take the birth control pills. They have, like, these have birth control pills, they are not as high of a dose, but you can still take them when you're breastfeeding, and then I am like, 'I forgot to take one and I do not want to be pregnant right now. I am just getting some of the feeling [of] normal.' I don't want [pregnancy so] I guess that is kind of a deterrent.

Silvia, Diane and Tiffany all recently had their second child. Cassandra and her husband had their first child. Both situations can change a rhythm of a relationship. It is also a new life stage. The roles of mother and partner may compete. The women in my sample do not seem to feel as guilty about their roles as partners as they do about other things that are more baby-related or work-related and might affect how women can mother, however. Thus, as much as they mentioned guilt about partner neglect, other forms of guilt weighed more heavily on new mothers I interviewed.

Paid Work Affects Mothering. Women expressed guilt over their work situations. This included feeling guilty that they had to go back to work when they wanted more time with their infants, how difficult it was to go back to work, and jealousy toward the caregiver who takes care of their children when they are at work. One woman expressed her desire to go to work for the first time since having children; however, she now had to stay home since she had another child and felt guilty for wanting to go out into the work world. Women's responses came from my question, "What was it like to go back to work?" Therefore, this interview question becomes the context for their discussions of guilt over paid work in the postpartum stage.

Sophia, eight months postpartum, said that it was: "Hard for me to leave [my second child]. I felt like I had a lot more time with [my first child]. Ummmm, I felt like it was too soon for him. I didn't, I didn't like it at first. Ummmm, even now it is hard." Sophia, a high school teacher, showed some guilt over leaving her son earlier than desired. However, she justified her return to work:

I like, I like working, you know, I like my job. I like being able to talk to adults, I like, you know, I always say I am not fit to be a stay-at-home mom, I can't, I would go crazy, I need to talk to adults, I need to have something else to do. . . [N]ow it is better but I felt . . . two months was too small, I just felt like, financially we couldn't do anything else about it, I had to go back to work. Eight weeks was a long time to go without a paycheck.

Financial need may have been the primary reason for Sophia to go back to work earlier than desired, but she also benefitted from the "adult" time that she acquired upon her return. Even though she felt bad about her return to work, she seemed to feel satisfied with the situation in retrospect, especially because she has good childcare.

Additionally, in terms of childcare,

I knew where [child's name] was going every day. [The babysitter] is wonderful. She is just like an extension of me, you know? She is, she is so awesome that I felt better about it. Because I knew where he was and I knew he was being well taken

care of and that kind of thing. I think sometimes she knows them better than me. She'll say he has an ear infection and I am like, 'No, no,' and sure enough he does. Sometimes I feel like she is more intuitive to him because she spends a lot of time with him.

Diane, a nurse and the breadwinner of her family, had to go back to work. As a child, her mother was in the same position. Diane did not want her children to have to deal with the same afterschool difficulties but she sees no other way. Paid work is a necessity for Diane and her family.

Like I wish I didn't have to work all the time and spend more time with them but, in reality, I can't. In a perfect world, I would be able to, even like I thought it was so cool when kids' moms take them to school and pick them up. I always thought kids who had to go to latch key, felt sorry for them, that would be so gross, wouldn't want to go to latch key. And now [where] we are at in our lives, if the girls were in school they would be kids in latch key! They would have to be at school and it makes me feel like a bad mom, like I feel horrible that they spend that much time with their baby sitter. Like at school doing other stuff and then I come home and hang out with them for a couple hours and I am tired and then we go to bed, you know.

Paid work and mothering both a necessity is conflicting, thus Diane feels bad. Similarly, Christie, a pharmacist, financially was forced to go back to work. She took three months off for maternity leave and got paid for six weeks of it, with the remainder of the money coming from their savings account to enable her to stay home longer. She felt that maternity leave should be longer and should be compensated, and voiced her opinion: "That is one thing that I wish they would change, you know. How horrible, whoever does that law junk." Christie is a first-time mother. Learning how to handle conflicting roles and realizing that paid work must change how one mothers is a major part of navigating the postpartum stage.

Guilt about How One Mothers. Some of my sample expressed guilt over how they mother in broader terms as well. Women felt role strain within the role of mother when they had more than one child. New mothers felt guilty because they could not calm a colicky baby or get the

baby to sleep in a crib, as well as for wishing their child was not so clingy and wanting time for themselves. When asked whether they compare themselves to other mothers, women in my sample also talked about how other mothers seem to do things well when they can't, thus making them feel guilty. Additionally, some women wanted time away from their children when their friends did not, also make them feel guilty.

Women expressed a guilt over a variety of situations as a mother. For example, women expressed guilt (and/or fear) over not treating their children equally with the same amount of love and attention. Women feared that they were no longer giving their older children the attention they needed. Other women felt guilty that they were not treating their newborns with as much love and attention as they had their firstborns. Within the single role of being a mother my interviewees expressed strain, or conflict, among all they were expected to do. This mainly dealt with women who had more than one child.

Silvia, seven months postpartum, with two children, had difficulties with “not having enough time, more time with my other son because I was so used to having so much time with him.” Amanda, age thirty-six, a stay-at-home mom of two children, told me,

There are days that I may have to be a little stricter and raise my voice because they don't want to listen. I feel guilty when I yell. So, I have had to work hard to remain calm. They don't listen better either way, if I yell loudly or calm. If I yell, then I have to apologize.

Amanda continues, “I hate when I yell. Sometimes I just get so upset when they don't listen on purpose.” If she should be able to control her own frustrations with her children, Amanda feels like she is falling short in her mothering. In this way, guilt is brought on by the same feeling of failure in mother work that women talked about when discussing breastfeeding. Feeling that one is not doing a good job at motherhood leads to feeling guilty.

Sandy, six months postpartum, mother of two, tries to be an all-inclusive mother. She finds this difficult and finds herself losing her temper and getting tired of trying to be a perfect mother.

I don't know, even motherhood of boys is different than I thought it would be. . . . It's a lot harder, motherhood of two is a lot harder. It's, I'm not getting nearly as much sleep. [My second child] has not been a good sleeper lately [so] we have been trying to do the whole sleep train thing, [and] we are working on it. I haven't been sleeping well, I haven't had a full night of sleep in probably three months. Ummmm, so trying to keep my cool with [my first child] who is incredibly inquisitive and he likes to know what is going on, like . . . he needs to know what's going on and what the plan is and what we did and why we do it, and, just, it's so hard to keep my patience with him when I am tired. . . . I guess I just thought I would have a lot more patience and I thought I would be better at it, I thought that there would be, I don't know, there would be less here and more exploring and more fun . . . and trying new things. And there are some days where I know and I know in the back of my head that we just have better days when we leave the house; when we stick at home . . . it is hard, we get bored. [First child] gets bore[d] so easily and when we are out and about, he just has so much better behavior and the day goes by faster and we just have a much better day. Some days . . . it just feels like so much work to get [my second child] in the car seat and get [my first child] in the car seat and then drive to where we are going to go and get back out and get the stroller out. Just feels like so much more hassle. . . . And I thought I would be the kind of mom who would be out more, I thought we would be just going everywhere, and when we go we have our three or four places that we always go to. (long pause) I would like to have more patience, . . . I don't know, I would just like to feel good.

Cassandra, seven months postpartum, also had a baby that was colicky. She explained,

My baby was colicky, he cried a lot. And I felt really bad 'cause I knew he was uncomfortable, gas, so I tried different gas drops. . . . And my baby probably slept, ohh, 1.5 hours, 2 hours at a time. For at least 3 months all night long, like he would wake up in the middle of the night and I would want him to go to sleep so bad and my husband had started grad school and so he was really, really busy and so it was kind of like a lot of pressure for me. So, it was very hard for me and I feel like other people didn't have the period that I had. It was a lot of stress for me and I love my baby so much but, it was very hard the first 3 months. . . . [T]hen I went back to work and it was a little better 'cause I felt like at work I could have some time for myself. Even though I am at work and even though I am doing all this other stuff I can have 2 hands free and sort of be in control of my day, where at home it was like I had to take care of this baby and he was really needy, you know. And now he is getting to be 7 months old now. And so, he is getting to be better, but now that he started teething some of that, some of that is, is back I guess, not so much the crying all the time, but more he doesn't want you to walk away. You can't leave him for very long, like if he is in his exersaucer or whatever, he wants you to be kind of close by, and, ummm, so that is hard on my husband right now. He is still in grad

school but he is trying to either cut back to part time or take a semester off. Because I think he is, I know that he is realizing that I can't, I am doing a lot, I am not doing all of it, even though I want to say that, I am not doing all of it, but I am doing a lot, and so I think that he is figuring that out. . . . That is what I am afraid of. What if I don't get him in his own bed before he can walk and then he is going to come and it is going to be harder for me if he is there saying 'Moommmm.' And then I'll be like, 'Oh, I feel bad.'

Cassandra shows that issues are intertwined and what women feel guilty about is often difficult to pinpoint. Lives are complicated when women are learning how to take care of a sick baby, keep up relationships, go back to work, and even maintain who they themselves are. While Cassandra starts off talking about being unable to soothe a colicky baby, she talks about many different worries within one breath, all of which represent a bit of separate yet interconnected guilt.

When asked, "What is one thing you wish you knew in the postpartum period that you didn't know before you experienced it?" Sophia, eight months postpartum, replied,

How much you would worry. About your kids. How much you would worry about little things they do, their cry, their sickness. Or anything like that. Ummmm, I worried so much with [my first child] because I just wasn't sure what she was going to need from me. She, 'cause she didn't, you know, I didn't nurse her, and that kind of thing. I just wondered if she was getting enough food and she was really thin and I was wondering if we were feeding enough. I worried about her more than I did [my second child]. 'Cause she was my first, you know, I kind of thought, 'Gosh, I wish I would have known how much I would worry.' And how to ask people the right questions.

Denise also explained, "You don't want to be away too long 'cause you feel, even society makes you feel like a bad mother if you are away too long and not craving to be with your kids. But you still need to get out there." However, as some women said above, "If I had to stay home with them seven days a week I honestly would be (laugh), I don't know what I would be right now." Women not only felt guilty about going back to work but also expressed wanting to go back to work. Women in my sample provided evidence of their internal struggles with these dualing emotions.

Other parents, friends, or even strangers judge how one mothers and can induce guilt in new mothers who are just trying their best. As for me: My daughter was colicky. She cried at least twelve hours a day. She was only happy while nursing. So, I slept while she nursed. She slept in our bed, as did our second child. Others had major opinions on this and how it should not be done. They tried to guilt me into having my child “cry it out” in her crib. At times, I did feel guilty, or was forced by others to feel wrong. But, all in all, this is what worked for us. It was the one way I could console my daughter, be with her in a relaxed atmosphere, and not feel stressed. Research on motherhood in other cultures endorses co-sleeping. So, in retrospect I take pride in doing what was right for us.

When I think of guilt this situation comes to mind. However, it was others who were trying to inflict guilt upon me to do what they felt was right. In the long run, looking back, sticking with what I felt was right for our situation makes me proud rather than guilty. Family and acquaintances used guilt as an attempt to control the way I mothered.

Asia, seven and a half months postpartum, felt guilt over not wanting to be an intensive mother all the time. She said,

I feel awful for wishing my kid wasn't so clingy. Like, that makes me feel guilty, like I feel like I am being a bad parent when I don't want to hold him all the time. And I don't want to hold him all the time. And I feel like, 'Did I miss something, did we not bond?' . . . I love him but I don't want to hold him all the time!

However, she continued,

Sometimes when he is sleeping, I just want to hold him. . . And I don't know what that is, I don't know if that is normal, if it is strange. So sometimes I do want some space and sometimes just for a moment, just a little bit of time, you know. And then when he sleeps I just want to go in there and stare at him so, I don't know, that is weird.

Noel felt terrible one night when she just let her baby scream while she took a shower, but she needed a few moments to herself.

One night [child's name] was being her monster self and would not sleep so I put her in her crib and went and showered. When I got out she was still crying and screaming. Screamed so hard she threw up. I cried because I felt so bad! She snuggled right up to me and was so darn sweet with her blotchy little tear-soaked face.

Noel is learning how to deal with babies and learning about herself at the same time. She is trying to salvage herself but sometimes she feels like she does so at the expense of the baby. What she is feeling guilty about is the fact that you must actively negotiate her own time against her time with her baby, and work out how you handle babies' needs versus self-care in the moment. Women tried to identify both as their own person and as a new mother, and were negotiating what motherhood means for them at the same time. This active negotiation induces guilt at times because women know they have not figured it out yet. Lack of knowledge, inexperience, conflicting statuses, and inability to solve all problems simultaneously create the guilt that women in my sample report.

Feeling Proud While Mothering. Some women in my sample were “just happy to have the kids” during the postpartum period. These women report that having children and engaging in mothering is satisfying, in comparison to some of the women above who felt more constant struggle. For instance, Jeanette, twelve months postpartum, mother of two, described being a mom:

[T]he kids put a lot of things into perspective, and they humble you a lot, feeling so happy to have them. Before being yourself was great, being your own self, I wanted to be a teacher, that had a lot of meaning to it, but now being a mom, dreaming of the legacy I will leave them. I don't know. I can't wait to even be a grandma someday, just to see my kids, to see, what kind of character they will have. If they will go onto educate, onto college, business, or I wonder if my son will be a pastor like his father. That is . . . really bigger picture stuff?”

Kathryn explained, “. . . I love my kids. I enjoy the simple things like the park, watching them play, hearing them laugh. I think we all try to balance kids by being a mom and our own individuality.” Similarly, Amanda shared, “For me, I consider myself a good mother for our kids and our family. Of course, there's always improvements to make and I work on them on a daily basis. But I love being a mom and it's something I take pride in.”

Being satisfied or proud of mothering does not mean that one cannot feel guilty about the little things. It is possible for women to feel guilty about certain things but still feel proud of mothering and raising kids overall. The two feelings can go hand in hand when transitioning to motherhood. Feeling proud is sometimes “the bigger picture” whereas feeling guilty is often related to the moment-to-moment details that are not going quite right, or related to the general trouble of transitioning to certain life stages and conflicting responsibilities.

Body Image

On average when I asked how happy the women were with their weight they answered “somewhat unhappy.” When asked how happy they were with their body shape they answered “somewhat unhappy.” However, when asked how happy they were with their overall appearance they answered “somewhat happy.” Perhaps “overall” women were somewhat happy with their appearances. But when questioned about specific, more micro areas of their appearance they answered “somewhat unhappy.” Like above, when women were in moment-to-moment situations they might feel guilty or bad about their appearances; but, overall, they might be satisfied, or sometimes even proud.

Diane, six months postpartum, expressed feeling “bad” four times throughout my one-and-a-half-hour interview with her. First, she expressed feeling bad that she did not look as she did before her last child.

We actually just looked at a video of spring break which would have been April and I ended up getting pregnant in October and looking at it I was sobbing hysterically. Like I, “Oh, my god, I can’t believe I ever looked like that.” I tried to do a push up and I couldn’t even do one push up. I felt so bad and pathetic!

Diane compared her pre-baby body with her current body, and felt “bad.” This provoked her to test her body and see what it was capable of by doing push-ups. She was not only disappointed in

how she looked but what her body was capable of. The comparison to her pre-pregnancy self-led her to feel guilty about the extent to which her body had changed. Diane continued,

. . . Like every picture that I am in, if I were to post them [to Facebook] on the computer, I take myself out of every picture or I delete them. [My husband] is like, “If you keep doing that there is going to be no pictures of you in Hannah’s baby book,” and I felt bad. I think, like, literally I was going through, I have like three pictures of me and Hannah. And that’s not something you can really get back so it does make me feel kind of bad.

Disappointment with her appearance caused Diane to almost erase herself from her child’s baby book. This is something she felt guilty about and knew she would regret in the future. When she went back and looked at pictures of her childhood, she said “I actually don’t remember anything about how my mom looked in old family photos. Except for the bad hair. What I remember more were the memories of that day.”

Diane also felt bad about taking time out of her day to work out. She did not know how to reconcile family time, work time, and exercise time.

[What] sucks about working out, like being in good shape is one thing but, like, taking two hours, like especially being a working mom. . . so, right now I am doing eight hour shifts but, like I said, after I drive them you are looking at, I should be there fifteen minutes early and am expected to stay fifteen minutes late, so that is nine hours, and then by the time you take them to the babysitter and get them back you are looking at 10-11 hours, and if I was working out on top of that, [it is] that much more time that I don’t get to spend with the girls so that makes it so hard to justify it. It’s a tough stream but then again you don’t want to be the fat mom. It is just kind of hard.

Leslie, eleven months postpartum with her first child, talked about the source of her pressure to lose weight:

I know a lot of it is myself. I think I am my biggest critic. I mean I, I struggle with self-confidence, I always have. You know, wanting to be accepted by people so I have a loud voice in my head that won’t go away, wanting people to like me. And that I always thought, like, ya know, if I was skinnier people would like me or whatever. And now my husband is a huge athlete, like he plays every single sport and he is always working out and is always playing and saying it is very important to him. And you know, when we were dating we would talk about how he was attracted to girls that were sporty, athletic, so I felt this unspoken pressure from him

because he would say I was beautiful. He would never say anything bad about my body but I felt like I know he likes those other girls. I know he likes people who are working out, that is the type of body he is attracted to is an athletic body, so there is no way he can be attracted to my flabby tummy. So, I felt pressure from him but it was more unspoken because he would never say anything or make me feel bad, but it was all those mind games I played with myself that make me feel bad. I wanted to make sure my husband still felt me attractive. So, I did it because I know or felt those ways, I know that's what he wants, for me to get back into shape.

In my sample, women who struggled with body image before pregnancy were likely to struggle with it afterwards as well. Leslie had struggle with a negative vision of herself from a young age and allowed others to shape her view of her body as well. She felt guilty in admitting to internalizing this pressure from her husband.

Tiffany, ten months postpartum and Leslie's twin, said,

She has just always had a harder time with it [her twin] and so I was actually, at least from what I had heard, I was always the twin who, . . . (pause) . . . I know it sounds terrible, I was always felt like the thinner twin out of the two of us and then hearing it, and having the tables turned and all of a sudden I am not makes me feel really, really bad about myself. I felt like I always had that attached to me. That was something that I could be proud of . . ., you know. I mean, she was always the smart one, I was, . . . (pause) . . . sounds terrible, I was the prettier one, and Leslie was the smarter one. Those were things, we were both pretty athletic, but you each have your roles to play. And if, if I, if I am not the prettier one, or if I am not the skinnier one now, I feel like what does that make me then? She is smart, she is athletic, she has all that stuff, and if I am not as thin as her, what do I have? You know? When it comes to the two of us. So, I think that's selfish, shallow, and it sounds wrong, but, in my mind it is how I feel.

Tiffany self-identified as the former "skinnier twin." Gaining baby weight and having her body change took this self-identification away. When I interviewed, she was struggling with these comparisons to her pre-pregnancy body and status. Her post-pregnancy body not only looked different but also changed how she viewed her place in the world -- no longer the "prettier one"?

Tellingly, there was no woman who proudly talked about her postpartum body. Because of the pressure to get their bodies back and the comparisons to pre-pregnancy selves, the bodily

changes that women experienced made it difficult to talk positively about one's body. Some women had managed to lose weight and did talk about that, but no woman talked about their postpartum body in ways that I could code as "proud." This is telling in and of itself, as there is considerable pressure on women to critique rather than be satisfied with their changed bodies.

Conclusion

Perhaps guilt is easier to recognize and express than pride. Possibly, women express pride through different words such as satisfied, content, pleased, or happy. Or, in our culture does not make one feel comfortable saying "I am proud of being a great mother," just as it is not often said, "I love my body. It is perfect." It is more culturally appropriate to think of ourselves as working hard for the ideal, and falling short of that ideal. It is important to further study new mothers and guilt to examine issues women are dealing with in this postpartum transition. By learning more about what women feel guilty about, perhaps we could intervene better in the postpartum period. Women in my sample often need more information and support resources than they receive, and an analysis of guilt conversations might allow us to pinpoint the types of resources that are missing in this life stage.

CHAPTER 7 IDEAL MOTHERS: APPEARANCE AND MOTHER WORK

As women navigate the road into motherhood, they learn to balance an array of new expectations and guidelines. My interview guide asked the question, “What does an ideal mother look like?” When this question was designed, I originally wanted women to answer by telling me only about mothers’ appearance. Instead, my participants understood the question to be more open-ended. Some women in my sample began answering the question by telling me what a mothers’ ideal physical appearance should be but continued to tell me what a mother should do or be, focusing on behavior by the end of the conversation. As I reflect on the data gathered in response to this interview question, I realize that I received a much fuller definition of what an ideal mother is, because women discussed both appearance and active mothering ideals. In addition, I learned that both appearance and behavior ideals prescribe action for new mothers. Looking a certain way as well as doing mothering, or involving oneself in the activity of good motherhood, result in a series of everyday actions. Appearance ideals specifically prescribe ways to look, exercise, eat, dress, and shop. Mothering ideals also prescribe how to be around children, prioritize children (and sacrifice one’s own needs), and care for children.

Following the general question about ideal mothers’ appearances were two probing questions: “Do you compare yourself to other mothers and if so, how?” and “Do you compare yourself to celebrity mothers?” These two questions brought out similar conversations, as women described the comparisons they made both in appearance and how other women do mothering. When it came to comparisons with other mothers or celebrities, the women in my sample concentrated more on appearance, however. This could be because appearance is what we notice first and/or because we are socialized to judge women first by their appearance.

Throughout this chapter I will discuss my participants lived experiences and stories by analyzing what they told me about what their “ideal mother” looks like and who she is. I will also discuss women’s descriptions of “real mothers,” as well as women who do “not want to look like a mother.” Next, I will describe how women compared themselves to other mothers and what this told me about what they think ideal mothers are. Finally, I will examine the ideals that the media portrays and how postpartum women react to these images of mothers.

What Do Ideal Mothers Look Like?

Participants in my sample answered the question, “What do ideal mothers look like?” by telling me what a mother visually looked like and then expanded by describing what the woman they pictured was doing, such as grocery shopping or at home with her children. Thus, the ideal they depict is both a visual appearance that mothers are expected to have as well as an expectation for what mothers are expected to do, which I will refer to as motherwork. To “look good” and to “mother” both imply and prescribe action. Ideals that women in my sample describe therefore include dual prescriptions for appearance and activity. Every mother I interviewed could talk about an ideal, and could discuss the appearance of a mother and the way to mother. Still, women differ on the specifics of their ideal in terms of body size, body adornment, and mothering activity. Nevertheless, all women discussed bounded ideals, in that all women knew that there are “boundaries” on appropriate appearances and mothering behaviors. As much as there might be a range of appropriate appearances and mothering behaviors, women knew which lines or boundaries should not be crossed. I discuss these ideas more fully below.

Noel is a thirty-six years old mother of two children. Her youngest child is almost two months old. Noel calls herself “average sized” and is a former school teacher. When I asked her what an ideal mom looks like, she described a mother’s ideal appearance and what motherwork is

expected: “I picture a well put-together thirtyish woman in some huge, tidy kitchen baking cookies while her children play a board game at the kitchen table. She is fit and healthy.” Here, Noel is telling me mainly about mothering activity, even though my initial question was about what ideal mothers’ appearances. Noel suggests that a good mother is expected to be in a clean kitchen tending to both the chores (here, food preparation) and children at the same time. Her children are engaged in an appropriate, educational activity of “playing a board game.” While in the kitchen and accomplishing motherwork, the mother also appears “fit and healthy.” Noel intertwines the appearance of an ideal mother with the activity of the mother, suggesting that ideals about what a mother looks like are not separate from ideals about what a mother does. The two ideals exist hand in hand.

When describing an ideal mother’s appearance, some women found it important that good mothers dress their age (or for their life stage). Heidi is twenty-four years old and six months postpartum with one child. Below she describes what a mother should look like with a focus on clothing.

I think she (an ideal mom) probably should dress her age, not like your all dressing like a nineteen-year-old like some of my friends still do. I mean, I think you can still be in style and dress your age. You can be fashionable and dress your age, but um, dress appropriately now.

Clothing (and other forms of bodily adornment) was something that mothers in my sample easily assess, and it became an important aspect of their appearance comparisons as a result (along with weight/fitness and mothering activity). Clothing was therefore used to define appearance ideals in part and was also used by interviewees to describe women who might not represent ideals. Unprompted, for instance, Heidi spoke of herself and her baby in comparison to mothers and families she knows. She told me what she does not like to see in other mother’s appearance.

I don’t really want to dress like, like some women, other moms, dress a little bit more provocatively than what I think they should be..... I wouldn’t want to be

seen with them. I would not be dressing like that. I mean, I don't think people should not look good but still.

As she talks about appearance, Heidi also organically mentioned parenting skills and mothering behavior, as she evaluated both simultaneously. After Heidi explained what a mother should look like she went directly into telling me what a mother should not do (instead of telling me what one should do), and she does this by assessing her sister's actions.

She is not there for her kids that much. And she depends on my parents a lot for everything. She takes care of her kids and gets things for them when they need them, but she works. She is not there for them, she, like, mother time, mother-children time, she just, my parents help her out a lot, she never takes them anywhere, she thinks it is too much of a hassle to take her kids anywhere.

By saying that her sister is “not there for her kids that much,” Heidi is describing the effect of her sister's paid work. To Heidi, a good mother does not participate in paid work at the expense of her kids. Similarly, referring to motherwork, a mother should be able to get both herself and her kids together to go into public places. According to Heidi, if a mother cannot get her family ready to go out of the house, then she is not doing her job as a mother. Heidi also suggests that it is not acceptable to depend upon your own parents (or perhaps anyone else, for that matter) to help with caregiving. In this case, we learn from Heidi about ideal mothering by learning about negative examples.

Another participant, Kathryn, largely focused on appearance when she described an ideal mom. Kathryn is thirty-one years old. She is a very thin dance instructor who describes herself as “boney all over” and “always have been underweight.” She recently had her fourth child, who is now three months old. When Kathryn pictured an ideal mom, she told me that, “Immediately I seen an average size woman with a warm glow. Brunette hair, but probably because I have it. Oddly I see someone more on the higher end of clothing with a big purse. But comfy clothes.” Kathryn is telling me about appearance, but moves beyond this subject a little when mentioning

the warm or happy feelings that motherhood is supposed to bring. Kathryn is also of lower income and is unable to afford “higher end clothing with a big purse” which is why she may be highlighting the social class bias built into both appearance and mothering ideals. As a result, ideals are unattainable for her, but she still wishes she could attain certain appearances. I followed up by asking Kathryn, “Do you look like an ideal mom?” and she replied,

Using the word “look,” I would say, no, I don’t. I know it should not matter how we look but I am always wanting to buy these simple yet fashionable, nice clothes that would make me like a more put-together mom, but they don’t fit me at the stores here. Walmart’s [size] 2-4 is the smallest size and is too big. I would have to say that does play a very small role in my psyche, when it comes to reaching the vision that I see. There is always Ann Taylor Loft but I can’t afford it for an entire wardrobe.

For Kathryn, “clothing” played a big role in how an ideal mom should look because an ideal mom should look “put together.” Yet, she has four sons and three step daughters with only her husband working, and a three-month-old baby at home to care for. As described above, Kathryn’s family was of low socioeconomic status with her owning a small dance studio that “is in debt.” She is able work out while dancing and can diet to attain other aspects of appearance ideals, but nice clothing is out of reach. She believes that other people do not see her as a “put together mom” because of her clothing. Thus, she infers that her clothing also sends messages about how she mothers, or who she is as a mother. She finds herself too thin for affordable, fashionable clothing, and does not believe she has an ideal body as a mother.

To answer the interview question, “What does an ideal mother look like?” I, myself, would answer in the following way:

I believe an ideal mom should look comfortable and happy. Like the women of my sample, this question does seem to make my mind wander to where is this ideal mom? I picture her at a grocery store with two children. She is wearing well-fitting, but comfortable and simple, clothes with ballet flats. She would have her hair combed and nicely put up, and possibly have a tiny bit of makeup on, that she

doesn't need to be wearing. Then I naturally start to imagine her kids. One child is a baby sitting nicely in the cart. The other is a little older walking beside her helping her shop. The kids are well groomed and dressed nicely, smiling and giggling as she speaks with them.

If someone were to ask me what I ideally wanted to look like, it would differ from this only slightly. I see everything I just listed, but I see slightly underweight. Because I am short and fine boned, average weight feels and looks overweight on my structure. Every physical body is different. This is what feels right for my body.

When I hear "mother" I do not automatically see the ideal I describe, nor do I see myself entirely. What I see is a woman in her thirties, average sized, tired, greasy uncombed hair pulled back, no makeup with bags under her eyes, possibly yelling or "nagging" her children as they whine for candy. She just trying to get the groceries to feed her family and get out of the store..... Maybe this is what I would describe as a "real mom" or a more realistic image of a mother today.

Just as some of my participants did, as I am describing an ideal mom I start by thinking of where an ideal mom would be. An ideal, good mother would be out doing something to benefit her family, such as grocery shopping. Even when I picture a "real mom" or a more realistic image of a mom, I still picture her in a grocery store. This mother is still putting her children's needs before her own. My ideal mother also had ideal children because she is a wonderful mother. If one is a wonderful mother, wonderful kids are a result – at least this is what women imagine.

Women in my sample imagined mothers in acceptable mothering locations. Specifically, women, myself included, placed their ideal moms in grocery stores or other locations that prioritize their kids' needs over their own. Each interviewee had a slightly different perspective on what an ideal mother looks like or does. For instance, my personal ideal differs in appearance, in that she is not of "average size." Kathryn, on the other hand, was clear that an ideal mother should be bigger than her and more average-sized. Ideal mothers, for the most part, however, were pictured in the public realm in mother- and kid-friendly locations. An interesting aspect of these pictured locations is that women were expected to represented the ideal in public. It may be, then, that it was harder to visualize how women ideally mothered in private. Or perhaps the reality of mothering was more appropriate to confront in private settings. Below I give two examples from

my own first year postpartum, to foreshadow how different the private reality of mothering might be from the ideals we try to match in public.

I have a friend, Mila [a pseudonym], who lived in the suburbs with me. Mila was approximately five years older than me, educated and wise—I respected her and looked up to her in many ways. Mila was an elementary school teacher pre-children and kept up to date on all things educational. Our daughters were the same age and our sons were the same age. In public places like the library, for story time and such, she did everything textbook perfect. With her son, then under one-year-old, she would get down to his level and show him objects speaking clearly and say things such as “Feel this? What does it feel like? Does it feel soft?” She continues never tires. It was just like “Baby Center” said to do. Would it be possible or sane to talk like this throughout your entire day, every day?

At our daughter’s gymnastics class, who were three at the time, we would be in the viewing room with our sons, both under one-year-old. I would call what we did “The Pacifier Dance.” There were other moms there who were acquaintances and some parents we did not know at all. Every time her son would drop or throw his pacifier she would rush to the bathroom to fully wash it. This, in turn, would make me feel as though I had to do the same. So, each time my son would purposely throw his pacifier, instead of getting angry or annoyed or just shoving it back in his mouth, I would run to the bathroom and clean off my son’s pacifier. We each probably went to clean them at least five times every class session. In all honesty, I didn’t even clean my son’s pacifier. I just rinsed it, if that. It was purely an act that I would put on to appear a “good mom.” I could care less about germs for the most part and if she weren’t there I am sure I would not have pretended to wash it. As we went through this repeatedly, we would complain about how tired we were.

The odd thing was, she did not do this in her own home. And it was not that her own home was not dirty—her house was a mess. Oddly her children were very badly behaved in both public and in private. Maybe she had to “overdo” her mothering in public because she knew that her kids would end up throwing horrible tantrums sooner or later and she didn’t want to be judged as a “bad mom.”

As I navigated the new waters of motherhood and learned from my friend, I saw an ideal mom as almost an “act.” That to be that perfect in life would not happen, it would only happen to make others think that I am “perfect,” but not “too perfect.” For example, I describe Mila speaking to her child. She would do this when we were around others but also complain about not getting enough sleep, thus she didn’t seem to be “too perfect.” It is not how she spoke to her children at all time. She would yell, she had a very messy house, and her children behaved badly. However, watching her at the library or children’s activities you would never know this, unless a tantrum occurred. She rarely let herself be a “real mom” “in public.

Women visualized ideal mothers mostly in public situations where they were prioritizing their children, such as I did above by placing us in the library and at gymnastics lessons. Contrary to these ideal images, however, some women in my sample told me about “real moms” versus “ideal moms.”

The “Real Mom”

Some participants expressed that there are “real moms” and not ideal mothers, in terms of both appearance and motherwork. This “real,” “normal,” “whatever she wants” or “comfortable” mother has difficulties handling children, family, work, and herself (specifically appearance and hygiene) all at once. These women see the ideal as something that individuals pursue, but not realistic to achieve. Despite this, women do add in anecdotes here and there about the things they desire or wish for. Thus, as women talk about “real” moms, they still sometimes use appearance and mothering ideals as a reference point.

One mother who tries to think of a “real mom” instead of just an “ideal mom” is Louise. Louise is a twenty-eight years old mother of one child. As I interviewed her, her eleven-month old daughter raced around the room full of energy and spunk. Her tone and emotions are what clue me into her true feelings about appearance and mothering ideals, and allow me to see how she feels that ideals are unattainable.

Umm, ideal mom, I would say (laugh), well, within today’s society, the ideal mom would try to get back into shape because, you know, that is all they have time to do (this is said sarcastically). (laugh) Ummm, but, no, I would say, takes care of themselves, with showers and hygienic-like stuff. Ummm, eats every meal with her kids would be great, just like we don’t all have the time for that, but it would be great. Prepares all the meals at home -- again we don’t all have time for that. Ummm, kind of like your whole Suzy homemaker image, you know. But, yeah, . . . the whole skinny thing too. Everyone wants to be thin! (laugh)

Louise spoke of “getting back in shape” first. However, she did so in a sarcastic manner, as if the reality of mothers would never match with this ideal. Moving to a more serious tone, Louise then talks about the things that new mothers have a hard time getting to do, but ideally should, including taking care of their own hygiene and eating meals with their kids. Louise recognizes again that there is not time for that with a new baby in the house, even as a stay-at-home mom. To conclude her answer, Louise brings the conversation back to weight and says, “the whole skinny thing too. Everyone wants to be thin.” “Skinny” is something she might desire but her laugh also suggests this is indeed just an ideal and not reality. For Louise, this is what was most difficult for her to accomplish. She has described herself as “obese both before and after pregnancy” and “unable to lose weight.” Like Kathryn who had little money for nice clothing above, the body that Louise desires is difficult for her to attain.

Another respondent who tried to be realistic is Jane. Jane is a twenty-six-year-old mother of one. She is almost three months postpartum. Below she tells me who she tries to be.

Umm, oh jeez. Honestly I just want to be myself. I mean, I don't want to try to fit into a, like, a cookie cutter [that] moms are supposed to be, you know, some people think moms are supposed to be, you know, unkempt, or some people think they are supposed to be really nice because they can if they are at home. . . , you know, ummm, I just want to be the best that I can be, which is, you know, if I am not feeling up to getting dressed up, then don't judge me by that, you know, I just, I have a newborn. Today I just didn't feel like putting makeup on or doing my hair or, you know, dressing up.

Jane says there a “cookie cutter” ideal exists but that she cannot match it, and for someone to do that every day would be impossible. Jane referred to two different images of moms – both “unkempt” and “dressing up” but then suggested that she takes it day-by-day and tried “to be the best that she can be.” Some days Jane may get up, dress up, do her hair and makeup, while other times she may remain in her pajamas for the day. She knows that a “dressed up” ideal may not

match the reality of her days with a newborn. She suggests that women toggle between trying to match ideals and deal with their realities, and that this may be a constant negotiation.

Similarly, Lindy believes that women need to feel comfortable with themselves whatever their body may look like. Lindy is a twenty-one-year-old mother with a three-month old daughter. She explained to me:

I just think, the biggest thing is that they should feel comfortable with themselves. I don't think there is really any body image, you know. I think they should just be confident in how they look and, you know, I think it is important that you take off some of the weight or strive to do a little bit of exercising 'cause it just helps your energy. But I don't think there is one specific image, 'cause each woman's body type is so different.

There is some contradiction in Lindy's statements because she believed all women should be comfortable with who they are, but also suggested that new moms should "take off some of the weight or strive to do a little bit of exercising." She related this to energy, not beauty, but there is still a prescription for new mothers in her conversation: new mothers should strive for weight loss. Again, here, then, we see Lindy's acknowledgment that an ideal still exists for postpartum bodies, even if ideals or images are somewhat flexible because "each woman's body is so different." Lindy hints at how women might waver between adhering to an ideal image of new motherhood and knowing the reality of new mothers' bodies.

As shown by the above participants, "real moms" make sure to still look presentable but they do not have to be perfect. Prudence agreed with this assessment. Prudence is a thirty-seven-year-old mother, two months postpartum, with two young children. She currently is a stay-at-home mother who lives in a suburban area.

I think, as long as the mother is healthy, and the mom takes care of herself and her family. I don't think there is no specific image. You know, like the superstars like they have to wear heels and the perfect soccer mom and dress trendy, I mean you can dress nice but you don't have to wear top designer clothes. I mean it, it's nice if you have that kind of money. But, I mean, I feel that it, I mean, as, I mean you

can do a lot instead of dressing like I wear sweatpants, you can wear jeans, nice shoes, nice shirt, wear makeup and do your hair and you still look presentable, I mean, you still look you know, you still look nice. I mean I never used to wear jeans, but since I had my first son I wear jeans all the time. I never wear heels anymore.

Prudence told me there is no specific image; however, she did tell me that mothers can dress “nicely,” by wearing nice shoes, nice shirt, makeup and doing one’s hair. Although she no longer “wears heels” she still feels mothers should look “presentable” Even if they don’t wear “designer clothes.” She does mention the ideal “soccer mom” seen as giving all her time and energy to her children while also dressing “trendy.” She visualizes an ideal mom in both appearance and behavior, but softens this image by talking about what the somewhat more flexible goals of “real” moms should be. With that said, however, Prudence also makes it clear that mothers still need to engage in appearance work and try to look and act certain ways. As much as real mothers know they cannot achieve appearance and mothering ideals, they still understand that they face certain basic prescriptions for behavior: you must still look “presentable.”

Mothers in this sample learn that they can vary their actions and appearance, however, depending on the situation and who they are around. Alicia, age twenty-seven, one month postpartum, with two children, lives in the suburbs. She was on leave from work but in two months’ time will be back to a forty-hour-plus workweek.

I think society thinks mothers should look like desperate housewives. Like all perfect..... I still talk to, like a couple of us are still friends, like, ummmm, like [friend] doesn’t really take care of herself. It, when she, [friend], like when she goes into public, she always wears sweats, like I am fine with it, you got two kid’s man, I am lucky if I get a shower every couple day’s so I could care less, I’m you know, I’m just happy you are out and about. But [another friend] will make comments about her not like, like find some jeans or something, do something with your hair, like not even, you know. It is like you are a mother too, can’t, it is almost like we sabotage ourselves. Like we don’t like you know, give each other, I don’t know the word, you know, give each other slack. And then every time I am around [friend] I feel like I have to like do myself up. You know. But if I go and hang out with [friend] she doesn’t care what I look like, so I can do what I normally do like

slide the hat on and a pair of sweats, do what I do. But for myself I always make sure whoever I am going to see I know kind of what they expect.

Alicia learned how to look or mother differently depending on the situation. When Alicia was around the first friend she discusses, she said she could dress comfortably and not have to worry about looking nice. The second friend is more judgmental of appearance and, therefore, when Alicia goes to see the second friend she makes sure to “do herself up” so that she matches her friend’s expectations. Alicia believed mothers should give one another slack, and that by having such high expectations of fellow mothers we “are sabotaging ourselves.” Yet, she still abides by the standards set by others around her.

Others also felt that mothers should be able to wear whatever they want. Audrina is a twenty-one-year-old mother with one child, seven months postpartum. She does not see herself as an average mother.

I do think of myself as a mother, [but] I don’t look at myself like the average mom short hair or this or that or whatever the case may be. I don’t label like that. Like I am who I am, dress how I dress, you know. This is who I am, I am a mom, you know, but, it doesn’t mean that I can’t wear that nice blouse or I can’t you know wear those tight jeans if they make me feel good or, you know, wear tennis shoes to the grocery store, or high heels to the grocery store, it is just who I am and how I dress. Most of the time it is pajama pants and tee-shirt, it is, so, nothing, nothing has changed. That is who I am. An easy-going person. I don’t care. As long as he is taken care of, he is dressed and he is happy, everything else is there.

Audrina is clear that, if her son is taken care of, it should not matter what she looks like -- that even pajamas are sufficient. However, at the same time, Audrina does articulate the fact that mothering ideals might be stricter: that is, the child must be “taken care of,” “dressed,” and “happy.” Being a good mother is priority number one. Audrina does not see herself as the “average mom” in appearance but knows there are still certain mothering behaviors that are required of her. Real moms, then, might have varied appearances but they still try to be good mothers.

Respondents like Audrina who viewed themselves as “real moms” frequently, and without meaning to, also told me certain ideals that mothers are expected to follow. These ideals included that children should be taken care of and come first, and that it does not matter what you look like but that you should still look like you put some effort into your appearance. Quite a few women were like Audrina (above), however, because they felt that they did not look like mothers. Some of these women specifically noted that they do not want to look like mothers.

I Don't Want to Look Like a Mom

Participants claimed that you can tell when someone is a mother. Women mentioned stereotypes such as “mom jeans,” “mom hair,” and “mom buns.” “Typical mothers” do not make themselves a priority. Thus, women in my sample voiced that their appearances mattered to them and that they wanted to make sure that they made themselves a priority.

Leslie is twenty-eight years old and the mother of an eleven-month old daughter. Leslie claims that you can tell when someone is a mom and she does not want to fit this mold. Leslie suggests that moms have a “certain look about them.”

In general, moms have a certain look about them. . . you usually can tell if they are a mom or not. But, ummmm, I don't know if I just dislike that sort of look, but I don't ever want to wear mom jeans. I still want to wear a bikini, I still want to wear tube tops, be young, look attractive. Maybe I am stuck in my, I don't know, stuck in my high school years, I don't know, but I'm trying. I feel like fashion has evolved with time, I don't feel like I dress the same as I did in high school, but I feel like I am in high school still.

Leslie thought she may be stuck in her young years in terms of her clothing style but seemed to want this, partially because she refused to look like a “mom.” By wanting to wear a bikini and tube tops she suggests that she wants to maintain a “young” and “attractive” body. She mentions “mom jeans” and “that sort of look” in somewhat derogatory terms, as if appearing like a stereotypical mother is below her. Leslie's twin sister, Tiffany, mother of two young boys, feels similarly.

I feel like the typical mom looks very not put together, like she's never a priority in her life. I have that feeling that's how most moms turn out and I don't want me to be that way. I really want to be a good-looking mom or at least trying to be good looking. Trying to make myself a priority as well, I mean my kids will always come first. But I definitely do want to be that mom who still takes care of herself.

Tiffany stereotyped mothers as not being put together and not seeing themselves as a priority in their lives. She does not want to turn out that way. Her "ideal" is represented by mothers who have time to take care of themselves. However, she must be able to mother well enough to create this time for herself. Tiffany is a stay-at-home mother with a husband who works long hours. She claimed that "kids will always come first" but, assuming her motherwork is efficient, she can then take care of herself.

Women may learn from others before them, however, about whether to prioritize appearance work while mothering. While Leslie and Tiffany explicitly said that they did not want to look like typical mothers, Kimberly was taught by her own mother that she should let this go. Kimberly was twenty-four years old with a baby who is barely one month old at time of interview -- thus, not even a full month postpartum. She told me about an experience she had with her mother when her mom disapproved of what she wanted to wear, now that she was a mother.

I did try a dress on and my mom was like, 'You are a mom now, you can't wear that dress.' I was like, 'Why?' I guess, I don't know. I wouldn't want someone to think, "Oh, I can't have a child because I don't want to have to change my wardrobe." . . . I mean, I guess, if you had a really, I don't know, out-there wardrobe, maybe you would have the change it a little bit, but it really shouldn't matter. For the most part I think, I don't know, trying to incorporate motherhood into your normal life is the easiest and best solution or I think it does [cause] problems and cause more stress.

Kimberly's discussion with her mother also shows the constant negotiation between what mothers should look and act like. While Kimberly suggests that she wants to maintain previous appearance standards while mothering, her mother discourages her. Both Leslie and Kimberly struggled with the idea that mothers must look a certain way and just wanted to continue appearing

as they did before. Both also received negative sanctions for doing so, however, which highlights the existence of cultural pressure to wear clothing appropriate to your life stage while, at the same time, look “presentable” and “nice.” Kimberly’s own mother is teaching her an aspect of mothering: that a mother’s appearance should be important but should be secondary to the mothering activity that one engages in.

At first, Avril, who had her first child at age sixteen, now twenty-three, proposed that there is no appearance ideal for mothers. Yet, as she talks further, she waffles about the importance of appearance:

There is no ideal. I see, like, girls that are, like, all, like, wear the, like, black stuff and the, like, dark makeup and then they, like, dress their kids that kind of way. I am just, like, you know, I can only imagine what kind of lifestyle they are going to have. But that is the way they are, everyone is different, so, no, I don’t think there should be a certain way that moms should look.

Although Avril claims that there is no appearance ideal that women should adhere to, she critiques mothers around her who “wear dark makeup” and “black clothing” after having a child, specifically stating that she “can’t imagine what kind of lifestyle they are going to have.” Thus, in comparing to other mothers (whether she thinks she does or not), she establishes appearance ideals. The appearance of a mother makes her question one’s mothering behavior, even if “everyone is different.”

Respondents who “do not want to look like mothers” infer that mothers allow their appearances to suffer. This perspective claims that “typical mothers” do not make themselves a priority. Despite this, women in my sample also discussed the need to put their children first and often judged women first by their mothering behavior. In these conversations, women struggle with the reality of putting motherhood prescriptions into practice and how much weight to put on mothering behavior versus appearance.

Mother-to-Mother Comparisons

Because the question, “Do you compare yourself to other mothers?” followed the question, “What does an ideal mother look like?”, women first primarily compared the appearances of other mothers. In this section I first discuss how rural women in my sample felt a need to “keep up” with other mothers in the community. I also consider answers from suburban women in my sample, and how their answers might differ from rural counterparts.

Respondents from rural areas found it important to “keep up” with their friends and acquaintances, perhaps because of close contact with members of their communities. Louise, the stay-at-home mother introduced earlier, lives in a small city in a northern Midwestern state, where warmth often comes before style. When I asked, “Do you compare yourself to other mothers?” Louise replied that she wants both herself and her child to keep up with others in her community.

I guess I don't really go out to compare myself to others but, like, when, like especially ones that are, like, around her age (pointing to her daughter), when [a friend] posts something [on Facebook] about her daughter, I guess parts of me actually compares her (nodding toward her daughter) [to other babies on Facebook]. And as I see [other mothers'] pictures (on Facebook), I see how they have lost all their baby weight. They had no weight.

Louise compared her child and herself to other children and mothers through the social media outlet of Facebook. Through this venue, she views friends from high school who are her exact age, also with children around the age of her child. She judges herself against visual images of other parents who have lost all their baby weight, and who maybe also gained very little during pregnancy. In comparison, Louise has been diagnosed by her doctor both before, during, and after pregnancy as being obese. Social media pictures, while most likely carefully selected to create a certain online presence, create a kind of ideal against which Louise measures her reality. Friends she knows in her community, those who have lost all their weight, may flaunt their weight loss because they are proud of themselves, and that may be what she is also seeing images on Facebook.

However, viewing these images takes its toll and makes Louise feel as if she is not up to par: “I will never look like that but still I check [photos] every day on Facebook.” She shrugs.

Another woman who tries to “keep up” or “catch up” is Kimberly. From the same small town as Louise, she told me that she, too, compares herself to other moms but tries not to.

I want to do the best that I can, and I hate, I am a perfectionist, I don’t like to screw up, . . . but I know I am going to and so, I mean, I compare what I’m doing to what other people are doing and as long as I feel like I am on track. I feel good about myself. But, if I’m behind them then I want to catch up. Or if I don’t think I am doing something as well as other people, I want to catch up. Or be able to do better, I don’t know.

Kimberly suggests that she does not want to keep comparing, but she continues to do so. Even though she also has an internal sense of what she wants to be like, she still wants to be or do better. Therefore, everyone, individually, regardless of whether they feel good about themselves or not, wants to do better—ideal or no ideal. But at the end of the day it is hard not to compare. Especially when a community is small and new mothers have close contact with others, comparing to ideal mothers in the community might be a natural thing to do.

Living in the same small town, but with a different view, Kathryn will not look at Facebook or other social media sites as she feels it just causes competition and high school foolishness that she does not need to deal with as an adult. This does not mean she does not compare herself to others -- she does, and she even compared herself to teenagers during the interview. Therefore, staying off social media does not protect women from seeing and reifying ideals.

I do compare myself to other mothers. But that makes me feel good. I have always been very small. I am a dancer. I still have weight to lose in places but, when comparing to moms, I am already in better shape than most. Still in the classes, I, [the] teacher, I find myself comparing my body to the body of teenagers. I see where I no longer have a waist and my arms are getting droopy at the bottom when we are in second position. But, how do I get my body to look like a fifteen-year old’s again?! I can’t attain that but still compare myself. When you are in a leotard and tights, how can I not? This is not me comparing myself as a mom. This is me comparing myself as a person.

Even women who feel good when they compare themselves to other mothers are at risk of feeling poorly about their bodies. The bodies of teenagers caused Kathryn to feel “flabby.” She is unable to stop comparing herself to others, partially because her dance business requires her to continually be around younger women. She realized that a teenager’s body is not something she can attain as a thirty-one-year-old mother of four children. Nonetheless comparisons still distress her and cause her some of the same grief as for women who compare themselves to Facebook images.

When answering my question about comparison among mothers, respondents often gave specific examples of what they notice when they see other mothers, illustrating how regular and frequent these comparisons might be in everyday life. For example, Christie, a twenty-eight-year-old pharmacist who is eleven months postpartum, also from the same small town, says that she “guesses she sometimes” compares herself to other mothers and gives specific examples of the types of comparisons she might make.

Based on what they are wearing and how they look and then I will go, “That lady looks really bad, . . .(laughing) . . . wow, that lady looks really good,” you know. I think that when you are walking through the grocery stores and, you know, you meet up with an old friend and you see them, you don’t want to feel like you look like crap, you know what I mean” (laughing). So, yeah. I think as far as that goes, like when you look at other people around you, you want to be like, “Yeah, she looks cute, wow, that’s nice.” I don’t want people to think, “Agghhh, look at her.” You know what I mean? But I always try to make a conscious effort to look half way decent when I go out into public even though I have a kid.

Christie believed that when a mother goes to certain locations, such as a grocery store, they should make “some conscious effort to look half way decent” because comparisons are indeed made. She notices women who do and do not look good. Christie pictures a mother at a grocery store, as many of the other women did. A mother is expected to be in a location that is of some benefit to

her children and, at the same time, they should look like they have made some attempt at appearance work.

For some women, comparing makes them feel better about themselves. For example, another rural area woman, Ashley, a nineteen-year-old with two children, tells me that she too compares herself to other mothers. When I asked her how that made her feel, she explained, “Lately good. Yeah. ‘Cause a lot of them aren’t caring anymore [about their appearance], too busy, and they don’t care since [they had] their babies and they just can’t handle it.” Ashley infers that one’s appearance work signifies not only the extent to which women care about themselves but also how well they can “handle” motherhood. She proposes in subtle ways that a mother should be able to care for both herself and her children. Going places without caring about your appearance shows others that you “just can’t handle it.” Mothers who look “too put together” are judged as well, though. Melissa is twelve months postpartum, and twenty-five years old with two children. She lives in the same small rural town as the above women. She stated that an “ideal mom, I guess, is very active with her children and stays, you know what I mean, keeps herself clean as well as her children clean, you know.” What bothers Melissa, however, is when it is evident that a mother spends more time on her own appearance than caring for her children.

I’m very big about that, it really bothers me to see a mom with her coat on and her baby without a coat or her babies face dirty and her face with makeup. I guess that is my outlook on it. I try to be an ideal mom as a role model, and represents you know trying to raise her children.

Melissa felt that some women spend too much time on themselves and not enough on their children. A mother should keep herself clean and look good, but certainly not if her kids do not come first. A mother cannot have an appearance that is “too good” if her children look neglected.

Leslie is from a suburban town and admits to constantly comparing herself to mothers within her friendship circle. Thus, rural and suburban mothers in my sample may be similar in

some of the ways that they compare themselves to each other. She compares herself in terms of appearance and weight is the crux of her comparison.

Just my friends who are moms, I compare myself to them, because they are all skinny minis and they didn't even have to do anything to lose weight. So, it was frustrating to me, . . . I felt like a big monster compared to them because they are all tiny, little, petite, cutesy girls, and then there's, you know, me, who felt like a big fat pig, so I definitely compared myself. I didn't want to be the big girl in the group. I wanted to be little and petite like them but I'm not a petite person, so I will never be, but I could at least be skinny again, that is all that matters to me.

Leslie felt as though she did not fit in with her friends who are mothers who are "petite, cutesy girls." Leslie has never been petite; she is quite tall at five foot eight. Being unable to make herself petite, she wanted to be skinny.

Also from the suburbs, Amanda is from a wealthy family and is married to a physician.

She is thirty-six years old and has a three-month old baby, as well as a preschool-aged son.

When I take my older son to preschool, I see all the moms, hair done, makeup on, designer clothing. I am lucky to have combed my hair and to have clean leggings on. At least in terms of money I feel ok. I can drive in in a brand-new Mercedes and appear as though I belong. But in terms of how I look, I just don't know. These women have it together. I try to tell myself I am different because I have a second younger child but some of these women do too. But they have nannies. I guess I am not keeping up in that way either. I want to raise my kids but having a nanny definitely brings up your social status.

Amanda compares herself to other mothers both in terms of appearance and socio-economic status.

She knows that she does not want to emulate some of the mothering behavior she sees, but she still compares herself in other ways.

When mothers compare themselves to others they primarily concentrate on appearance, because of the way in which I asked questions in the interview. Yet, women are judged first on appearance in general, so it may be that I would have heard about appearance comparisons first regardless of the exact nature of my questions. However, there were numerous times during their conversations when they compared themselves by assessing mothering activities. Thus, it is clear

in my sample data that appearance and mothering comparisons go hand in hand, even if one comparison takes precedence at times.

Reactions to Mothers in the Media

I asked interviewees what they thought of the current media images of pregnant and postpartum women – for instance, images in print magazines located near the check-out aisles at the grocery store. These magazines often show pregnant celebrities, with a headline or comment on their appearances. Other magazines depict mothers right after having their child, again with comments on appearance. Print magazines critique women’s appearances regardless of how closely they represent appearance ideals: For instance, if the woman lost all her body weight or looks good pregnant, she is negatively sanctioned. Each woman recognized what I was referring to as I asked the question about media images. In most cases, the women I interviewed responded by talking about celebrity mothers’ appearances, and compared themselves in appearance rather than mothering behavior. A few women in my sample spoke of the appearance-related pressure they felt from the media. Some interviewees spoke of feeling “close to” or “in similar situations” as specific celebrities. Other women in the sample judged celebrity women for choosing to do so much work on their appearance and engaging in paid work, instead of spending time with their children.

Some participants in my sample expressed having been impacted by very specific celebrity magazines, such as *People*, *OK!* or *Us Weekly*. Kelly, a twenty-eight-year-old woman from a small rural town, with a six-month old baby girl, expressed pressure to improve her appearance when seeing these types of celebrity magazines. Specifically, she wanted to be able to lose weight as quickly as some celebrities, as she was having difficulty losing that last little bit of her weight. She told me, “Seeing magazines, you know. Whoever, seems like they just lose their weight so

much faster than normal people. I want to be like that.” Kelly recognizes that these images are likely airbrushed or photo-shopped; yet she still compares.

Instead of contrasting the choices made by themselves and celebrities, however, other women in my sample completely identified with celebrity mothers. Heidi, eight months postpartum, felt almost like she knew specific celebrity mothers at the time of her pregnancy and birth. She told me she seeks out certain magazines:

[T]he ones with Kendra (Wilkinson) and Kourtney Kardashian. I am, like, what are they doing? I am interested just because they have babies close to my baby’s age, and then I see their bodies and what they are looking like. I shouldn’t say that, yeah. But, yeah. I, ummm, ‘cause I feel it, especially with Kendra because she had more of an athletic body and stuff like that, like me. And I know she got really big during pregnancy too, so I tend to compare to her. I kind of want to compare myself to her because she looks really good, sooo, yeah. Yeah, that is one [magazine] I would pick up, definitely.

These images did not seem to make Heidi feel bad about herself. Instead, portrayals of Kendra Wilkinson’s pregnancy and postpartum provided her with a seemingly tangible goal, one that she saw as feasible in relation to her own body parameters. If Kendra could lose the weight and get back into her “sporty ways,” Heidi thought she could too.

Throughout both of my pregnancies Nicole Richie was pregnant. I could not leave a store without seeing a photo of her in a bikini pregnant. Never were these magazines purchased but her photo was everywhere. I zeroed in on her for the same reason that Carrie had zeroed in on Kendra. I looked at someone with a similar body type to mine. Five foot two and a small frame (and my age). Even though I dislike admitting it, I felt in a way connected to her. Primarily, Nicole Richie was a public figure whom I could look to as a comrade in a way. At the time of my first pregnancy no friends of mine were pregnant or had children. Nicole Richie was someone else was going through what I was; I was not entirely alone. Another small person being stretched out during pregnancy. To keep her consistent with my situation, I assumed her pregnancy was unplanned (but have no idea if it was. Did she make me feel bad about myself? I wish I could say no, but in some ways, she did. None of her photos showed stretch marks. Beginning that small I would assume some stretch marks would appear. I presumed the pictures had been photo shopped or she had some expensive lotion to keep them away, something I

could not afford. She was often shown in her bikini and I had a love of bikinis. Summers prior to children were spent out on the boat in a comfortable two-piece swim suit—pregnancy was ruining this for me. After pregnancy, I stayed stretched out and “somehow” she regained her pre-pregnancy body that was constantly shown on the beach in a two-piece swim suit. She did something I could not and I did not like this. Unlike Heidi and Kendra, I did not feel like I could attain what Nicole Richie did.

Discussion of images of mothers in the media also came up in answers to the question, “Do you compare yourself to other mothers?” Lindy, introduced earlier in the chapter, went straight to comparing herself with celebrities, and then onto comparing herself with mothers she knows. She put herself in active competition with these women -- over who gained the least weight, who had their baby first, and who lost their weight the fastest. She said,

I am always reading these things (holds up a magazine with Kendra Wilkinson on it), because her (Kendra) and Kourtney Kardashian, who[m] I don't even like, both had babies at the same time as me, so it was such a big thing and I remember reading an article before I had her and I remember saying . . . 'Ha-ha, they gained more weight than me!' So, it was constant, umm, competition and there were women like, Stephanie (a friend), and I were due a day apart, so when she had gained less weight than me I was kind of bummed. But she had told me she had gained a lot with her first and not with her second, so there was a difference. I am definitely very competitive, and even competitive to the point of, like, who had their baby first, because there were so many people who were due the same time as me so, I had mine for the most part, first. I want to lose my weight first.

I would not necessarily say that these women served as ideals for Lindy or as comrades. Rather other mothers (either friends or celebrities) served as a motivating factor, to move forward in her life as a pregnant woman and then as a mother. She looked at the media ideals as actual “competition,” just as she did her close friends.

Others in my sample see celebrities as real people and judge them for the lifestyles they live as well as for the ideals they represent. For example, a respondent, Jane, three months

postpartum, age twenty-six, explained to me her feelings about women in the media, and infers the comparison she makes between her own and their exercise routine.

They have the money to spend on personal trainers or surgery, whichever, you know. I don't know what they necessarily do, but I do find it kind of odd that they can get back to their body, you know, their normal what it was before in, you know, like 2 months. You know, to me that's kind of okay [but] then you are not spending your time with your child. I mean, somebody else obviously has to have them for those hours that you are working out or you are doing something. Personally, to me, I would rather be bonding with my child than at the gym, even though like I said I do want to lose weight, but I would rather be bonding with my newborn, rather than, "Oh, I am going to spend 3-4 hours working out. Maybe a half an hour to an hour wouldn't be bad a couple days a week, but they have to be, I mean, I guess I could be wrong but, to bounce back that fast I would think they have to be working pretty hard or have had some type of medical assistance.

Jane claimed to be able to separate the image she has of herself from celebrities because they live different lives. She places herself above these women because she chooses to be with her child (a more admirable mothering behavior, per Jane), instead of working out and putting her appearance first. Jane felt better about herself by critiquing celebrities for their mothering choices. Another woman interviewed, Christie, eleven months' postpartum age twenty-eight says quite similarly,

(laughing!) Ahhhh! To be honest I know that a lot of those moms have someone doing everything for them. So, [I don't say . . .], you know, 'Look at them,' and be like, 'Dang how do they do it,' because I know that they don't. As far as appearances go, yes they always look great. But do I want to be like them? NO. Do I feel like I need to be like, 'Wow, I need to lose 5 more pounds,' no, I don't feel like that at all. Most of those celebrity moms, they have nannies that take care of every little thing that they need.

Christie refers to nannies taking care of "every little thing" that a mother should be doing. Therefore, she does not compare herself to them because they lead a different life than she does. Melissa, introduced earlier, also compares but "just the weight. But I also try to keep in mind that 90 percent of them have someone staying with their baby while they are away." Melissa would like to lose weight as the celebrities have, but the price is having someone else take care of their

child while they are away working to lose the weight. Melissa is unwilling to spend that much time away from her baby.

Not all women in my sample felt close to or compared to specific media characters, however. Leslie sums it up by answering my probe, “Do you ever compare yourself to the women on magazine covers?”, with a resounding “No, I don’t. I compare myself to reality.” To her, celebrities are not real people. Louise, who claimed to be obese, said of media moms, “Like okay, the average person really doesn’t look like that. Look at society, most don’t even lose the baby weight.” She, along with several other women in my sample, commented that real people do not look like what the media presents. Louise does not put down people for not losing their body weight. She sees it as a part of life. To her the images do make her feel overweight at all. She compares herself to women in life, and she finds herself very like the women she sees around her.

Ashley also suggests, “[I]t is fake. I don’t take it or buy it. Don’t even LOOK.” Asia, another respondent, thirty-six years old and seven and a half months postpartum, told me she thought that “those types of magazines are smut. When I am waiting in line I turn the one in the front backward so people don’t have to look at it.” Asia is advocating for what she feels: that the media misrepresents women in her position and she is not going to look at it or take it, and she will do small tasks so that other women do not have to take it either.

Women interviewed for my study had a variety of responses to my questions about mothers in the media. Some participants compared themselves to these women and wished they could achieve the same appearance, such as weight loss, as the celebrities. Other women found celebrities that they could measure themselves against, and use those celebrities as examples of what they could achieve as a postpartum woman. Quite a few mothers in my sample were quick

to put down celebrity mothers, however, and often critiqued them for prioritizing their appearance over mothering, showing again the relationship between appearance and mothering ideals.

Conclusion

Every mother is faced with dueling prescriptions for behavior, and must answer to both appearance and mothering ideals in some fashion. These prescriptions are negotiated alongside one another because how one mothers are intertwined with how one looks at times. And while women in my sample were often clear that they could not attain ideals, they were also cognizant of the range of appropriate and inappropriate behaviors that women engaged in, and how mothering and appearance work was flexible only to a point. While it is okay at times to wear “comfy clothes” one must look presentable. And while it is important to look good, a mother’s appearance should parallel her life stage and she should never look better than her children do. Thus, even “real” moms should not look like “moms” and must also not look “too good”. There are boundaries on appropriate appearance work, just as there are boundaries on what “good” mothering behavior is. Women in my sample relayed information about what those boundaries on appearance work and mothering work are, and made it very clear that too little or too much of either motherwork or appearancework is not acceptable. Women negotiate and balance ideals versus reality in everyday life, constantly measuring themselves and others in the process. In this way, they police the outer boundaries of good mothering and good appearance work, and reinforce the balance between appearance work and motherwork as well.

CHAPTER 8 CONCLUSION

This project began as a story about women and their lived experiences of their bodies, from pregnancy to birth and into the postpartum stage. While conducting 42 in-depth interviews to learn about the lived experiences of the transition to motherhood, women clearly expressed to me what was important to them and gifted me more data than I thought imaginable. I found that bodies are indeed important to women, but alongside the stories about changing bodies came stories about changing lives. Women allowed me to understand the life one learns to navigate as a new mother. What became apparent in my interviews is that new mothers deal with a vast array of issues as they make the transition from pregnancy and birth to the postpartum stage, and that the postpartum period includes numerous and intertwined negotiations. Issues that became forefront in their conversations with me, without prompting from me, included their experiences of losing and taking control. New mothers in my sample also voiced how they navigated a range of emotions, and the two most important emotions they negotiated seemed to be guilt and pride. A section of questioning from my interview guide also dealt with appearance ideals and what mothers “should” look like. My interviewees answered these questions beyond my initial expectations and reported not only what mothers should look like but also who mothers should be, or how they should mother. I use Chapters Five, Six and Seven to present their conversations and my findings about control, emotions, and social ideals.

To complicate this dissertation, all three of my findings chapters are deeply related. Women’s experiences of navigating issues of control and lack of control, guilt and pride, and the pursuit of dual, and possibly dueling, ideals are related and difficult to separate from one another. Thus, I have found that postpartum women are sometimes located in a very contradictory (or at least confusing and complicated) space as they adjust to changing bodies and changing roles. I

use this concluding chapter to summarize and discuss my primary findings on how women navigate the transition to early motherhood. I attempt to apply my theoretical approaches (i.e., Foucault’s “Docile Bodies,” Medicalization, and “Doing Gender”) throughout the discussion of major findings. Following, I address my use of autoethnography, and finally, I provide a discussion of the limitations of my study, ideas for future research, and policy implication

Control

Similar to Miller (2007: 351), I found that the women within my sample found the journey into motherhood to be a “steep, lonely—and bumpy—learning curve for which, in retrospect, they felt ill prepared. It became evident early on that much of the women I interviewed were not getting the postpartum resources they needed. My data show that women (especially women who are economically stable) need informational and support resources during the postpartum. After almost nine months of heavy monitoring by the medical community (and having their health checked monthly and then weekly), and then twenty-four-hour surveillance during labor and the day or two following birth in the hospital, women are released into an unfamiliar world of motherhood that they still need to figure out how to navigate. Approximately three-quarters of the women in my sample reported being left to their own devices, without adequate information or emotional support. Quite a few of these women felt symptoms of withdrawal, or even anomie. Women were, in practice, the “docile bodies” Foucault (1970) speaks of, in the face of the medicalization of pregnancy and birth and then staggered when finding out that no one was observing them once they left the hospital (except perhaps for other women who potentially notice when their appearance is not “presentable”). Very few women in my sample had information or support resources in the postpartum stage, yet it did seem that the poorest women in my sample were the most likely to have these resources – because they received WIC services. Other women

were lucky if they had supportive social networks including friends and family. Women described needing someone to simply talk to and needing someone to answer their questions, but had nowhere to turn to beyond internet searches and mass produced books. Women who had more than one child were definitely better off in their navigations of the motherhood transition, in that they could rely on their previous experience to negotiate the postpartum stage their second or third time. Still, everyone needed resources in the postpartum, since most women did not receive regular contact from medical professionals or even family members and friends.

While feminist scholars who have studied medicalization of birth have conceptualized issues of control and power during birth, and how women hand over control in hospital settings, this work does not often include issues of control extended through the transition to the postpartum year. Most work on control has been focused on control during pregnancy and birth, and does not include an exploration of women's sense of control during the postpartum stage. My data does do this, but further study is necessary as well. Within the context of women's discussions of the lack of control they feel in the postpartum, after almost complete control over them in a hospital setting, future research and policy needs to look at helping women in the postpartum -- not just the poor, but all. Women who received WIC seemed to appreciate it. However, systematic research on the services that women receive from WIC should be completed, as it is unclear in my data which resources were most important from WIC. It could be that just receiving regular contact from medical professionals through WIC is what made women feel more secure. Women who did not receive these WIC services -- especially those who were first time mothers -- often questioned their mothering, felt a sense of aimlessness in the very early postpartum, and experienced considerable guilt as they negotiated the postpartum stage by themselves. Part of the experience of the postpartum stage is feeling a lack or loss of control, and this alone is worth further exploration.

Services such as a simple visitor to talk to them and answer their questions would be of great help. Women may also need to hear that feeling a lack of control is normal. Future researchers should engage in qualitative research that focuses on how new mothers learn to cope during the postpartum and how they gain back a sense of control over their lives. It is also my hope that future policies could aid women more fully as they embark on their journeys into this difficult time, as the real experience of living in the postpartum (and feeling out of control in the process) has been overlooked for far too long.

Guilt and Pride

Related to the need of postpartum resources and women's feelings of being out of control, women's feelings of guilt are of great importance and should be the subject of additional research. First, I did not even ask women about guilt. Through their stories of becoming mothers, however, their guilt became very apparent. Feeling afraid to do something wrong -- and even afraid of the possibility of doing something wrong -- led women in my sample to feel and report this guilt. New mothers in my sample were controlled by their desire to not do something wrong and, thus, they were always at risk of feeling guilty. Past literature does exist on mother guilt, for instance, focusing on women's guilt about returning to paid work. This existing research suggests that mothers' guilt is frequently reported, as I found too. This dissertation adds to the literature in that it brings forth an understanding of how women talk about guilt as they make the transition to early motherhood, and how guilt might manifest differently in pregnancy, birth and the postpartum. Guilt was easy to find and analyze in my interview data while its opposite, pride, was more difficult to locate. This is partially because women may be socialized to talk much less about feeling "proud"; in "doing gender," then, perhaps women do not showcase their accomplishments. It may also be related to the fact that there are many more ways for women to feel badly than there are

ways to feel good during the transition to early motherhood, because women are faced with so many everyday decisions and so many new responsibilities as they become mothers and they are unsure about these decisions and responsibilities. Future research needs to carefully investigate mothers' guilt, especially in the postpartum stage, and aim to find out why women do not speak of pride in motherhood and why expressions of guilt are so common. Discussions of guilt may highlight instances within which we could intervene to help new mothers, and researchers, policymakers, medical providers, and community health workers might all do well to pay attention to what makes women talk about feeling guilty.

Mothering Ideals

There is a plethora of literature on appearance ideals for women in U.S. society, but there is less literature on how mothers navigate these appearance ideals. (An important exception is literature on how women feel that they should “get their bodies” back but this is limited to analyses of women's attempts at weight loss in the postpartum (e.g., Fox and Neiterman 2015).) In addition, any literature that does exist on new mothers' experience of appearance ideals tends to be found in the motherhood literature and not in literature on beauty ideals; thus, there is some disconnect between the existing literatures that I use to frame this dissertation. My research shows that women's concerns about appearance persist through the transition to motherhood, and that appearance is a major negotiation in the postpartum stage. Specifically, there is a social pressure to lose the weight gained, and there is also pressure to “not look like a mom.” This includes dressing in terms of clothing and looking “presentable” as much as it includes prescriptions for body size and weight. Women are also expected to adhere to mothering ideals throughout the postpartum stage, such as not talking about the “bad” aspects of being a new mother, how their bodies may hurt or not “behave” like they used to, or how sleep deprived they may be. Women

are expected to fall in line, love mothering, love their babies and concentrate on baby only. Women are also supposed to look like they are putting their children first when out in public settings. Women who look like they are unable to accomplish these responsibilities reportedly “look like” they are unable to “handle” mothering and taking care of themselves. Women in my sample sometimes used other mothers’ appearances to deem them “bad” mothers, and thus “presentable” appearances become a key way to measure how good individuals are adhering to mothering ideals as well. Therefore, motherhood is intertwined with appearance, otherwise appearance would not be judged as a part of and related to motherhood. Women in my study were also clear in defining boundaries on appropriate appearance work and mothering work, in that women who appeared to spend excessive amounts of time or money on their appearance (or who might have appearances that looked better than their children’s appearances) were deemed questionable mothers as well. Women also talked about negotiating the ideal that mothers should “look their age” or “look their life stage.” Few feminist scholars have documented the intertwined nature of appearance and mothering ideals and how new mothers face complicated appearance norms that include much more than prescriptions to lose weight. Comparisons to other mothers in their communities and on Facebook, and comparisons to celebrity mothers, sometimes make women’s negotiation of their own appearances even more difficult. This dissertation shows that appearance ideals and mothering ideals are negotiated together in early motherhood, and women must balance the pressures to adhere to each and both norms at the same time. It is hoped that, at the very least, my data show that there is a lot more research that needs to be done on appearance and mothering ideals in the postpartum.

Autoethnography

Using the research method of autoethnography was questioned in relation to my study. Specifically, why would I want to put my personal stories “out there?” At first I was hesitant to put myself “out there.” In the early stages of writing my proposal I met with Dr. Sandy Pensoneau-Conway, where she introduced me to the research method of autoethnography. She felt my prospective data would read as a great story or book by linking my personal experiences with the women that I would interview. I read the literature on the topic and tentatively put it in my proposal, not sure if I would use it or not. As I began my actual interviews the women’s stories brought back memories of my experiences of pregnancy, labor, birth and the postpartum, then my whole experience of learning to navigate motherhood. The stories that the women told me brought out themes I realized were quite salient in my own story. Below I reflect upon my choice to use autoethnography.

After an afternoon spent proofreading my literature review, I drove to pick up my kids from school. During this drive, I was reflecting upon my study and I realized why I may have chosen to use autoethnography.

I can clearly remember telling my mom as I was a child that I would never have children. I remember her replying that yes I would have children—if I were to have no children I would live a lonely life. I dismissed her answer. I did not play with “baby dolls.” I did not have any desire to help care for my younger sisters or to mimic my mother as a caregiver. I never asked to hold or look at someone’s baby. I would call babies “it” or “blobs” that all looked the same. I had no desire to play with younger children or babysit, finding them annoying, loud, immature, and someone else’s problem.

So how did I get where I am now?

For the past six years, I have been pushing aside my own education and putting my children first, as well as my husband’s education first, his two graduate degrees, where I proofread and cared for the children so he could get his work done. Mothering was my priority. I did this unconsciously. Not wanting to become a

mother made me feel as if I was not a “typical” mother who would try to follow the “motherhood mandate” or “intensive mothering” ideal. Despite this, I realized, since my daughter’s birth, and then my son, I have felt the “motherhood mandate” pulling me, without being aware of it. I have always felt the beauty mandate; I have been fully aware of this since being a child. But the motherhood mandate? Why would I care about this when I don’t even like children?

For the past six years when my husband offered to take the kids to the pool or beach to allow me time to write, I would say “oh don’t go without me.” It was like letting him take the children without me was losing control. I did not want to miss out on a part of their experience, a part of their life. And if I were to sometimes work while the three of them went to do something I felt a horrible sense of guilt. It was always all four of us, or the children and I. There had become no “I”. My identity was motherhood first and foremost—and I had not even realized this.

This journey has made me ask the question, “How did I go from the child who hated dolls and domesticity to the mother who cannot bear to leave her children with their own father?” I assume when I became a mother I accepted the ideals of motherhood and conformed, just as I had as a child through adulthood accepted beauty ideals and conformed. As a perfectionist, I internally took the ideal as expectation in all that I did.

Ultimately, using the method of autoethnography at times felt conceited. Why should someone want to read what I felt and experienced? However, writing it down felt like I was validating my own story and seeing the connections I had with other women’s experiences made me realize I am not unique. The “motherhood mandate” or “intensive mothering” ideal has a strong pull on everyone, even those who are not mothers. Although I never wanted to become a mother, when I did become a mother it took a fierce hold of me, and I do not know if it ever will let go.

Only now do I finish my own education with both of my children in school, where yes, I volunteer so I can be a part of their education. I found motherhood changed my entire identity, which is the next theme on my list to look through my data for. All in all, becoming and being a mother leads to feelings of control, guilt, and difficulty adhering to the many ideals, even when we may not be aware of these ideals at all.

As one can see, at times, I felt conceited putting myself into the study and at other times I felt completely vulnerable. If I were to pull out my experiences from this study it would feel empty. My autoethnographic sections give a framework for the other women’s similar stories to

be placed. All three main themes relate as one, and the difficulty learning to navigate the pathway into motherhood is difficult whether it is your first, second, or even third child, as each child is an individual and mothers forget information because it had not been used in such a long time, as it was for me and the mothers I interviewed.

Limitations, Contributions, Avenues for Future Research and Policy Change

No research study is perfect; nor can it explore every aspect of the topic at hand. Most my forty-two respondents were white and lived in the Midwestern United States. A limitation of the study, and a suggestion for future studies, then, would be to explore the transition into early motherhood with a sample including better representation of racial-ethnic groups. My study does hint at potential class and residential differences, but much more substantial analyses of rural versus suburban differences and socio-economic differences need to be undertaken to truly understand how WIC and other services might make a difference in the postpartum stage and why women who have economic stability might feel a lack of resources in this stage. Most women in my study also come from a Christian background, thus limiting the scope of this study further. Finally, I do not do a systematic investigation of whether the number of children or the amount of time one spends in the postpartum stage makes a difference; based on the data I do have, I do think that both make a difference in shaping how women talked about their experiences of control, emotions, and social ideals. Furthermore, I did not use the quantitative data that I collected as much as I could have in this dissertation because I made the choice to prioritize women's voices; expanding the analysis to include more quantified data would add both validity and reliability to my conclusions.

From these women, I learned that the healthcare system in the United States, in a Mideastern state, in both small and large towns, is not adequate. If the health provider is overly

involved in pregnancy, labor and birth, it is not healthy to just “drop” women when they go home with their newborn. From these women, I believe we need a continuing education for mothers in our society. It should begin before the birth of the child, to gain a social network of friends as you gain an education, and it should continue until the children reach kindergarten. “Mommy and Me” programs should be offered in a variety of locations, free of charge, where mothers can meet other mothers and discuss their lives, difficulties, and joy. More than anything the women wanted to tell me about their lives as mothers and many would have spoken for hours upon hours if I had allowed it. Additionally, in the first weeks and months after the baby comes home house visits should be made. Women questioned what they were doing and did not realize how they felt was “normal.” Women who received services, such as WIC, did not question themselves, they had someone to ask questions to, to “normalize” their experiences and make recommendations.

In sum, I used an open-ended, phenomenological approach to enable women to voice what is important to them as they navigate the transition into early motherhood. I also included my own experiences by way of autoethnographic journaling, and hope that readers see how useful this journaling can be – both as a check on bias and a way to be reflexive during data collection as well as a check on how valid one’s own experiences are in relation to others’. In some ways, I learned more about my own experiences of pregnancy, birth and the postpartum by engaging in this study, and I realized the gaps in my own resources more fully as I analyzed other women’s stories. I had not realized the extent of my own issues with control, guilt, and social ideals, until I collected and analyzed my interview data. After analyzing both my own experience and the experiences of 42 other postpartum women, I realize that additional qualitative interview research and quantitative survey research can be developed to further examine issues of control, guilt and pride, and explore how women think about and pursue both appearance ideals and mothering ideals in the postpartum

year. I end this dissertation with one last excerpt from my own journal, to illustrate the true journey that these 42 women and I took to get to this point.

Numerous women experience becoming a mother. For many women, a mother is something they are expected to become. As a younger woman, before becoming a mother, I envisioned the passageway into motherhood as a smooth, clear, paved road, with picturesque scenery and few obstacles. Some of the forty-two women I interviewed for this dissertation envisioned the same thing. Despite our optimistic visions, we found that the route to motherhood is not as simple as presumed.

The pathway to motherhood proves to be rough terrain, and a small forested trail waits for us. This trail is littered with garbage, leaves, sticks, and pebbles. The footpath takes us over boulders, valleys and mountains. There are forks in the road when we least expect it. At some point, we may be given a magical and mythical map containing directions for a "perfect" trip. Unfortunately, most of us do not get that "perfect" excursion so the map does not hold great advantage.

As we take the trail, various creatures come out and tell us what to do. Sometimes we do as we are told by these strangers and sometimes we don't. Whichever decision we choose may lead us to feeling a sense of guilt, or if we happen to be lucky a sense of pride. The creatures pressure us and follow closely the nearer and nearer we get to the end of the path. When we start the long trek up the looming and final mountain, the creatures never quit screeching and at times carry out their recommendations without our consent.

Suddenly, although at first it seemed to take forever, we are at the peak of the mountain standing alone in the wind and rain. Every way we turn is a large void. The mountain no longer has its form. We are on a single stone alone holding an infant whom we just met. Do we jump? Yes, we leap. We leap into the unknown. Although we lack a guide, we close our eyes and hope we can each find our own way. Because, well, there is not much other choice.

APPENDIX A: FLYERS

Do you have a baby who is under 12 months old?

Would you be willing to talk about your postpartum experiences?

A new research study is interested in learning how postpartum women and new mothers feel about their body. Participation in this research includes a one-time interview and the completion of a questionnaire.

Women will be paid \$15.00 for their participation in this research

The interview & questionnaire will take approximately one to two hours.
Women can choose when and where they are interviewed.

**To learn more about this study, please call:
Jody Sauer, PhD student, Wayne State University
(989) 370-1083
as7982@wayne.edu**

Postpartum Interview
Contact: Jody Sauer
(989)370-1083

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Postpartum Interview
Contact: Jody Sauer

Do you have a baby under 1-year-old?
**Would you be willing to talk about your
postpartum experiences?**

A new research study is interested in learning how postpartum women and new mothers feel about their body. Participation in this research includes a one-time interview and the completion of a questionnaire.

Women will be paid \$15.00 for their participation in this research.

Individual interviews take approximately one to two hours.

Women can choose when and where they are interviewed.

**To learn more about this study, please call:
Jody Sauer, PhD student, Wayne State University
(989) 370-1083
as7982@wayne.edu**

Do you have a baby who is under 12 months old?
**Would you be willing to talk about your
postpartum experiences?**

A new research study is interested in learning how postpartum women and new mothers feel about their body. Participation in this research includes a one-time interview and the completion of a questionnaire.

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Individual interviews take approximately one to two hours.

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APPENDIX B: CHECKLIST FOR SCREENING POTENTIAL PARTICIPANTS

Title of Research Study: Women's Postpartum Experiences:

Body Image and the Cultural Ideals of Mothering and Beauty

Principal Investigator: Jody Sauer, Ph.D. Student, Wayne State University

Date: _____ Time: _____
 Name of Potential Participant: _____
 Phone Number of Potential Participant: _____
 Email Address of Potential Participant: _____
 Best way/time to reach: _____

Script:

I am a researcher and would like to talk with you about participating in a Wayne State University study. The study is about postpartum women and body image.

If you are eligible and choose to participate, you will be interviewed and asked to fill out a questionnaire. During the interview, I will ask you questions about your experiences during pre-pregnancy, pregnancy, and postpartum in relation to your body image. If you qualify and choose to participate in the study, you are free to stop participation at any time.

1.) Are you interested in seeing if you qualify for the study?

IF YES: Continue with screening questions listed below.

IF NO: Thank the person for her time.

Screening Questions:

These are questions to see if you qualify for the interview and full study.

2.) Are you 18 or older?

IF YES: Continue with screening questions listed below.

IF NO: The person does not qualify, thank the person for her time.

3.) Are you less than 1 year postpartum?

IF YES: Continue with screening questions listed below.

IF NO: The person does not qualify, thank the person for her time.

4.) Do you know that this research is voluntary (meaning that you do not have to participate if you don't want to)?

IF YES: Continue with screening questions listed below

IF NO: Then explain to them that they do not have to participate and that their participation is voluntary. Read information from the consent form and tell them about informed consent procedures. Once they understand, ask them if they still want to participate. After hearing additional information, if they still want to participate and understand that participation is voluntary, only then go to question #5.)

5.) If eligible for participation, ask the following:

- a. What are the best days and times for you to participate in an individual interview with me?
This interview will last between one and two hours.

Days: _____

Times: _____

- b. What is the best location for you for an interview?

APPENDIX C: RESEARCH INFORMATION SHEET

Title of Study: Women's Postpartum Experiences:
Body Image and the Cultural Ideals of Mothering and Beauty

Principal Investigator (PI): Jody Sauer
Sociology Department
(989) 370-1083

Purpose:

You are being asked to be in a research study on body image during the postpartum period because you are less than 1 year postpartum. This study is being conducted through Wayne State University. Please read this form and ask any questions you may have before agreeing to be in the study.

Study Procedures:

If you take part in the study, you will be asked to take part in an individual interview with the researcher. At the end of the interview, you will also be asked to fill out a questionnaire.

- During the interview, the researcher will ask you questions about your experiences during the postpartum period. The questions will ask about your experiences with pre-pregnancy, pregnancy and postpartum body image, as well as your changing body throughout this time.
- The questionnaire will include demographic questions about your race, income, employment status, educational background, and marital status.
- You have the right to refuse to answer any question you do not wish to answer and remain in the study. You also can withdraw participation from the study at any time. You may also ask questions of the interviewer at any time during the research process.
- Your active participation in this study will take one to two hours for the interview and 10-15 minutes for the questionnaire. The interview will take place over the course of one day. At the end of this initial interview you may be asked to take part in an additional interview or allow the researcher to contact you again for clarification purposes. You are free to refuse any further contact with the researcher.
- The researcher will ask you if they can audio-tape your interview. You are free to refuse to have your interview taped and remain in the study. If your interview is audio-taped, the audio tape will be stored in a locked location in the researcher's office for the duration of the study. Once the study is completed, the audio tapes will be erased or destroyed.

Benefits:

There are no direct benefits for you when participating in this study; however, you may experience an indirect benefit by sharing your experiences with others. Additionally, information from this study may benefit other people now or in the future.

Risks:

There are no known risks at this time to participation in this study.

Costs:

There will be no costs to you for participation in this research study.

Compensation:

When taking part in this research study, you will be paid for your time and inconvenience. Specifically, you will be paid \$10.00 for completion of the interview and another \$5.00 for completion of the questionnaire.

Confidentiality:

All information collected about you during this study will be kept confidential to the extent permitted by law. You will be identified in all research records by a code number, and in written reports about this project you will be assigned a code name or pseudonym. In addition, information that identifies you personally will not be released without your written permission. However, the study sponsor, the Human Investigation Committee (HIC) at Wayne State University, or federal agencies with appropriate regulatory oversight may review your records.

Voluntary Participation/Withdrawal:

Taking part in this study is voluntary. You may choose not to take part in this study or, if you decide to take part, you can change your mind later and withdraw from the study. You are free to refuse to answer any questions or withdraw at any time. Your decision will not change any present or future relationships with Wayne State University or its affiliates or other services you are entitled to receive.

Questions:

If you have any questions about this study now or in the future, you may contact Jody Sauer at (989) 370-1083. If you have questions or concerns about your rights as a research participant, the Chair of the Human Investigation Committee can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call (313) 577-1628 to ask questions or voice concerns or complaints.

Participation:

By completing the interview and questionnaire you are agreeing to participate in this study.

APPENDIX D: INTERVIEW GUIDE

Interview #: _____

Date _____

Interview Guide

Women's Postpartum Experiences:
Body Image and the Cultural Ideals of Mothering and Beauty

I'd like to ask you a few questions about your attitudes experiences involving body image. Feel free to give examples or stories to describe your experiences.

(Bold questions will be asked. Non-bold following questions and words in parentheses are probes to use if necessary)

PREGNANCY

1. **Tell me about your pregnancy experience.** (What did you like about being pregnant? What was the best part? What did you dislike about being pregnant? What was the worst part?)
 - a. Can you describe your pregnant body?
 - i. How would you describe your weight?
 - ii. How would you describe your appearance?
 - iii. How would you describe your shape?
 - iv. How did you feel about specific parts of your body?
 - b. When did you start showing? When did you start wearing maternity clothing? (Did you like wearing these?)
 - c. How did you feel about yourself when you were undressed? Clothed? In a swimsuit?
 - d. What types of things did you do to your body to improve your body or appearance during pregnancy?
 - e. Did others comment on your pregnant body? (What did they say? How did it make you feel?)
 - f. Did you feel any pressure to act or look a certain way throughout pregnancy?

PRE-PREGNANCY

2. **Can you describe your body pre-pregnancy?**
 - a. How would you describe your weight?
 - b. How would you describe your body shape?
 - c. How did you feel about specific parts of your body?
 - d. Your overall appearance?
 - e. How did you feel about yourself when you were undressed? Clothed? In a swimsuit?
 - f. What types of things did you do to improve your appearance pre-pregnancy?
 - g. What kinds of comments did others give you on your body, weight, and appearance?

POSTPARTUM

3. **Tell me about your postpartum period** (define the postpartum period to the woman if necessary).
 - a. How would you describe the postpartum period to other women?
 - b. Tell me about a typical day in your life postpartum right now.

4. **What has changed about your body** (weight, shape, appearance, functionality) **since giving birth?**
 - a. Are these positive or negative changes? How have these changes made you feel?
 - b. Do you accept these changes to your body? Do you want to “undo” or “fix” these changes? If so, how will you do this?
 - c. Do you still wear your maternity clothing, pre-pregnancy clothing, or new clothing?
5. **Compare your pregnant self to your postpartum self. Now compare your pre-pregnant self to your postpartum self.** (Identity)
6. **What are some of the changes in your life since giving birth and becoming a mom?** (exercising, endurance, less time to get ready to look good, sex life, bladder, infant feeding, fashion/clothing, showers, attention to personal or physical health, are you restricted in your daily activities in any way?)
7. **What was the most difficult thing for you to accept postpartum? What was the easiest thing for you to accept?** (if they do not mention outright, probe on beauty and mothering)
8. **How did feel about your body** (probe on weight, shape, appearance, functionality) **directly after giving birth?**
 - a. **When you were still in the hospital?**
 - b. **A couple days after?**
 - c. **Weeks after?**
 - d. **Months after?**
 - e. **Now?**
9. **Tell me about what kinds of comments have you gotten about your body postpartum?** (From whom? How does this make you feel? Can you give me an example? Probe on both beauty and mothering. Has anyone asked you if you are pregnant again or still pregnant?)
10. **Do feel any pressure to lose the weight, and change your shape postpartum?**
 - a. From whom or where does this pressure come from?
 - b. Is it important to you to lose your “baby” weight? Why?
 - c. Have you lost it? Are you trying to lose it?
 - d. How do you plan on it? Or, how did you? (diet, exercise)
11. **Have you changed any aspects of your appearance since the birth of your most recent child?** (new haircut, make-up, lotion, lasers, cosmetic surgery)
 - a. Why or why not?
 - b. What has influenced these ideas?
 - c. Ever fantasize about changing your body or appearance?
 - d. Now that you have had your baby do you have a “beauty routine”? (before leaving the house, of before bed, work days vs. home days) Is this different since the birth of your baby? Would you like to change anything?
12. **As a mother, what do you want to look like?**
 - a. Do you think there is a way that mothers, or their bodies, are supposed to look? Who says they are supposed to look this way?
 - b. Do you compare yourself to other mothers? If so, to whom do you compare yourself to? When you look at other mothers what do you look at? Examples? Celebrity moms?
 - c. Do mothers look differently than non-mothers? Do you compare yourself to non-mothers?

13. Is motherhood as you had imagined it would be?

14. Do you feel feminine during the postpartum/as a mother?

15. What, in your opinion, does an “ideal postpartum woman” look like and act like?

a. Do you think you encompass these?

16. What does an “ideal mother” look like and act like?

a. Do you think you encompass these?

FEEDING

17. How have you fed your baby (from birth until current)?

- a. Bottle only, breast only, breast and bottle, breast supplementing with formula
- b. Why? Where these the methods you planned on using?
- c. Did your choice have anything to do with how you feel about your body?
- d. If breastfeeding, when do you plan on stopping? Have you stopped?
 - i. Do you use a breast pump to express milk? (How does this make you feel? How often do you express milk? What requires you to “pump”? Where do you pump? How comfortable is this?)
 - ii. Have you altered your diet, beauty routine, or exercise, etc. because of breastfeeding?
 - iii. What kind of effects do you think breastfeeding has had or will have on your body? (appearance, shape, weight, positive, negative) (either from what you have heard or what you have experienced.

MATERNAL HEALTH

20. How difficult was your most recent labor?

21. Have you seen or called a physician about your own health since the birth of your baby since leaving the hospital?

- i. What for?
- ii. Check off what they have experienced
 - depression, anxiety, emotion, stress
 - birth complications
 - birth control
 - bleeding
 - bladder
 - breastfeeding problems
 - appearance related issues
 - Other: _____

22. Are you getting the postpartum care you think you need?

- a. Are there any resources you wish you had?
- b. In general, what have you been told to take care of yourself in the postpartum period physically and emotionally? What kinds of information are you getting? (moms and friends vs. doctors/nurses, books, online)

23. What is the one thing you wish you knew about the postpartum that you didn’t know before you experienced it?

- a. What would you tell other women about the postpartum period, what lessons have you learned?

24. Is there anything else you want to tell me about your postpartum experiences that I have not asked about?

RATING QUESTIONS (for me to read to them and write down the number)

I am going to read you several questions. Please look at this card and tell me which number corresponds to the way that you feel

CARD READS:

1=HAPPY

2=SOMEWHAT HAPPY

3=SOMEWHAT UNHAPPY

4= UNHAPPY

How happy are you:

- 25. With your current physical health?**
- 26. With your current mental health?**
- 27. With your current weight?**
- 28. With your overall appearance?**
- 29. With your overall body shape postpartum?**

APPENDIX E: QUESTIONNAIRE

Interview #: _____

Date: _____

Questionnaire

Women's Postpartum Experiences: Body Image and the Cultural Ideals of Mothering and Beauty

Directions: Please choose the best possible answer for each question. Mark the box next to the answer that you choose. For questions requiring a written response, please write your answer on the line provided. Thank you for your participation!

DEMOGRAPHIC INFORMATION

1. What is your age? _____
2. What is your marital status?
 - Single
 - Cohabitation (currently living with a partner)
 - Married
 - Divorced
 - Widowed
 - Separated (legal or informal)
 - Other: Please specify _____
3. What best describes your race and/or ethnicity?
 - White/Caucasian
 - Black/African American
 - Asian
 - American Indian or Alaska Native
 - Native Hawaiian or other Pacific Islander
 - Spanish, Hispanic, or Latino
 - Other: Please specify _____
4. What is your highest level of education?
 - Less than High School
 - High School or GED
 - Some College
 - College Degree
 - Some Graduate School
 - Graduate Degree or above (for example, MD, MA, PhD)
5. What is your average household income?
 - \$0-\$14,999
 - \$15,000-\$19,999
 - \$20,000-\$29,999
 - \$30,000-\$49,999
 - \$50,000-\$74,999
 - \$75,000-\$99,999
 - \$100,000 and above

6. What is your religious denomination?

- Roman Catholic
- Baptist
- Lutheran
- Methodist
- Presbyterian
- Jewish
- Episcopal
- Islam
- Mennonite
- Other (please specify) _____

7. How many children do you have?

- 1
- 2
- 3
- 4
- More than 4, please specify the number of children: _____

8. What are your children's ages?

- Child 1 _____
- Child 2 _____
- Child 3 _____
- Child 4 _____
- Specify any other children's ages: _____

9. How long since the birth of your most recent baby?

- Less than 1 Month
- 1 Month
- 2 Months
- 3 Months
- 4 Months
- 5 Months
- 7 Months
- 8 Months
- 9 Months
- 10 Months
- 11 Months
- 12 Months

LABOR & DELIVERY

10. At what week gestation (how far along were you in the pregnancy) was your most recent baby delivered?

_____ (specific week delivered)

- Less than 34 weeks (premature)
- 34- 35 weeks (premature)
- 36- 38 weeks (pre-term)
- Over 38 weeks

11. How many hours were you in labor during the birth of your most recent baby? _____

12. How many days did you spend in the hospital after the birth of your most recent baby? _____
13. What was the birth weight of your most recent baby? _____
14. With your most recent birthing experience, when you left the hospital did the baby leave with you?
 Yes
 No If no, please explain: _____
15. Does your most recent baby have any current health problems?
 Yes If yes, please explain: _____
 No
16. Was your most recent pregnancy planned?
 Yes
 No
17. Have you experienced any of the following (you may mark more than one box)?
 Infertility
 Gestational diabetes
 Prescribed bedrest during pregnancy
 Miscarriage
 Stillbirth
 Abortion
 High blood pressure
 Toxemia
 Other reproductive illness, please specify: _____
18. What type of childbirth did you experience most recently (if necessary, mark more than one box)?
 Cesarean section
 Planned
 Unplanned
 Vaginal Birth
 Epidural
 Other anesthetic
 Natural (no drugs)
 Induction
 Forceps
 Vacuum Aspiration
 Episiotomy (doctor cuts the perineum)
 Tear
 Other (please specify) _____
19. Was this most recent birthing experience the type of birth experience you expected?
 Yes
 No
 Can you explain: _____

WEIGHT

20. What is your height? _____ feet _____ inches
21. What do you currently weigh? _____
22. What did you weigh BEFORE your most recent pregnancy? _____
23. How much did you weigh at the END of your most recent pregnancy? _____

EMPLOYMENT

24. Where you employed before the birth of your most recent baby?
- Yes
- No

If no, please move to question #34. If yes, please answer the following:

25. What was your job? _____
26. What type of work did you do? _____
27. How many hours per week did you work for pay?
- 0-10 hours
- 11-20 hours
- 21-29 hours
- 30-39 hours
- 40+ hours
28. Are you currently working?
- Yes
- No

If you are currently working, please answer the following questions. If you are NOT currently working, please skip onto questions #32.

29. If you are working, how many hours per week do you currently work?
- 0-10 hours
- 11-20 hours
- 21-29 hours
- 30-39 hours
- 40+ hours
- Flexible work schedule, please specify: _____
30. Where do you physically work at?
- From home
- Work at the work site
- Combination of work from home and at the worksite
- Other, please specify: _____
31. How much time did you take off work after the birth of your most recent baby? _____

If you are NOT currently working please answer the following questions. If you are currently working, please skip to question #34.

32. If you are not yet back at work, when do you plan on going back to work?

- Not going back to work
- 0-1 month
- 2-3 months
- 4-6 months
- 7-9 months
- 10-12 months
- Other (please specify): _____

33. When you go back to work, how many hours do you plan on working?

- Not going back to work
- 0-10 hours
- 11-20 hours
- 21-29 hours
- 30-39 hours
- 40+ hours

EXERCISE AND DIET

34. How often do you exercise (how many days per week and times per day)?

35. What type of exercise do you do?

36. Each time you exercise, for how many minutes to you exercise for? _____

HOW OFTEN DO YOU:

37. Exercise postpartum?

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| All the time | Often | Sometimes | Occasionally | Rarely | Never |

38. Diet postpartum?

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| All the time | Often | Sometimes | Occasionally | Rarely | Never |

DURING THE POSTPARTUM, PLEASE TELL ME HOW IMPORTANT IT IS THAT YOU:

39. Fit into your regular clothes.

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Very important | Somewhat important | Not important | Not important at all |

40. Take off any extra weight that you gained throughout pregnancy.

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Very important | Somewhat important | Not important | Not important at all |

41. Regain your pre-pregnant body.

Very important Somewhat important Not important Not important at all

42. Eat foods that are good for you.

Very important Somewhat important Not important Not important at all

43. Get regular exercise.

Very important Somewhat important Not important Not important at all

PLEASE TELL ME HOW MUCH YOU AGREE WITH EACH OF THESE STATEMENTS:

44. The demands of motherhood make it difficult to get regular exercise.

Strongly agree Agree Disagree Strongly Disagree

45. The demands of motherhood make it difficult to eat food that is good for you.

Strongly agree Agree Disagree Strongly Disagree

46. Having a baby brings a lot of stress into a woman's life.

Strongly agree Agree Disagree Strongly Disagree

47. I am sure that I will be a good mother.

Strongly agree Agree Disagree Strongly Disagree

48. I felt proud when I found out that I was going to have a baby.

Strongly agree Agree Disagree Strongly Disagree

49. I felt scared when I found out I was going to become a mother.

Strongly agree Agree Disagree Strongly Disagree

Thank you so much for taking part in my study! I enjoyed learning about your experiences!

APPENDIX F: WOMEN'S RESOURCES

Postpartum:

- ♥ *Postpartum Support International*
Phone Number: 1-800-944-4PPD
Website: <http://postpartum.net/>
- ♥ *Postpartum Depression Helpline*
Phone Number: 1-800-328-3838
Website: <http://www.hbcprotocols.com/postpartum/index.html>
- ♥ *The Postpartum Stress Center, LLC*
Website: <http://postpartumstress.com/>
- ♥ *MayoClinic.com*
Website: <http://www.mayoclinic.com/health/postpartum-care/PR00142>

New Moms & Baby Care: Message boards, blogs and websites

- ♥ *The New Mom*
<http://www.thenewmom.com/>
- ♥ *New Mom Care: Taking Care of Yourself*
http://parenting.ivillage.com/newborn/nmomcare/topics/0_4rpp.00.html
- ♥ *Advice for New Moms*
http://pediatrics.about.com/od/newmoms/Advice_for_New_Moms.htm
- ♥ *Parents: My Postpartum Body*
http://www.parents.com/pregnancy/mybody/postpartum/?ordersrc=msn3postpartum_cgy&cobrandId=ww5&s_kwid=TC-3024-879000620-e-16296986
- ♥ *BabyCenter.com: Postpartum Exercise, Is Your Body Ready?*
http://www.babycenter.com/0_postpartum-exercise-is-your-body-ready_196.bc
- ♥ *An Easy Guide to Breastfeeding*
<http://www.womenshealth.gov/pub/BF.General.pdf>
- ♥ *Super Baby Food*
<http://superbabyfood.com/>
- ♥ *What to Expect (from the writers of What to Expect When You Are Expecting)*
http://www.whattoexpect.com/funnel/registration.aspx?18=default&xid=MSNLP_REG_BrandFirstYear_Src_h&utm_source=MSN&utm_medium=CPC&s_kwid=TC-9514-3225946690-e-403055147
- ♥ *BabyFit.com*
<http://babyfit.sparkpeople.com/>

Pregnancy:

- ♥ *American Pregnancy Helpline*
Phone Number: 1-866-942-6466
Website: <http://www.thehelpline.org/>
E-mail address: aph@thehelpline.org
- ♥ *List of Michigan's Pregnancy Resource Centers*
Website: <http://ramahinternational.org/michigan.html>

Domestic Violence:

- ♥ *National Domestic Violence Hotline*
Phone Number: 1-800-799-7233
Website: <http://www.ndvh.org/>
- ♥ *Michigan Coalition Against Domestic and Sexual Violence*
Phone Number: (517) 347-7000,
Website: <http://www.mcadsv.org/>
E-mail address: general@mcadsv.org

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ABSTRACT**NAVIGATING THE TRANSITION INTO MOTHERHOOD: WOMEN'S
EXPERIENCES OF CONTROL, EMOTION, AND SOCIAL IDEALS**

by

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In this dissertation, I sought to give postpartum women their own voices so that they could help define the postpartum experience on their own terms. It fills important gaps within the literature on new mothers' experiences. A phenomenological approach was used, emphasizing the lived experiences of the women, with an overlay of autoethnography, where the personal experience of the researcher becomes important primarily in how it illuminates the phenomenon being studied. Thus, my personal experience of pregnancy into early motherhood is interwoven throughout this dissertation. Forty-two women participated in the in-depth, face-to-face interviews, followed by a questionnaire. The qualitative data was analyzed, specific themes became prominent, and were coded for this study. Little of the quantitative data obtained by the questionnaire was used for this study. The following are forefront in this study of understanding how do women learn to navigate the "new world" of motherhood. First, throughout pregnancy, labor, postpartum, and early motherhood women experience control in a variety of ways, specifically a lack of control. Secondly, women are often afraid of doing something wrong, during pregnancy, labor, birth, and motherhood, such as differing from the norms put forward by friends, family, and the medical field, leading to feelings of guilt. When things do go right, they can feel

pride, but were not likely to express this in my study. The third area of study in this dissertation, is that mothers are judged in both appearance and motherwork. In a sense, two ideals, “The Motherhood Mandate” and “Beauty Mandate,” are fighting against one another, that of being an ideal mom in terms of mothering and of being an ideal woman in terms of beauty is intertwined. These three themes are discussed in relation to three sociological theories. Medicalization and Foucault’s “docile bodies” thesis both aid in explaining women’s thoughts and experiences, as well as constraints in the postpartum stage. The social constructionist approach of “doing gender,” in relation to the female expectation to mother, is applicable as well, as a general framework under which women think and act.

AUTOBIOGRAPHICAL STATEMENT

In the Upper Peninsula of Michigan, I attended Lake Superior State University as a student-athlete. There, I dabbled in all disciplines, finding that sociology could fulfill my love of learning but not limit my interests. My senior thesis, under Dr. Leslie Dobbertin, was a quantitative survey on the self-esteem athletes. After graduating LSSU, I attended Eastern Michigan University, again as a student-athlete and now research assistant for Dr. Brad Ensor. Ending at EMU, I completed two final essays: 1) a focus group on long distance runners and body image, 2) on Pitirim Sorokin, comparing his early statistical work to his later altruism work. Finishing at EMU I began my coursework at Wayne State University, as I honed my skills as an instructor under Dr. David Fasenfest and began lecturing.

Life changed after my first years at WSU. I married my “high school sweetheart” and my daughter was born a year later. My love of sociology and the academy never ceased, despite this, I felt drawn toward the intensive mothering ideal, thus unintentionally sliding my dissertation to the side. The women I interviewed deserve their stories to be heard and others deserve to hear them. Thus, I hope to publish findings from this dissertation, as well as other data from collected from the interviews. I have not lost my love of sports and would like to complete research in this area, regarding differences in individual versus team sports, and feminine verses masculine sports. I would also like to conduct an open-ended study on why girls drop out of sports and other physical activities during puberty and other physical activities. Finally, I would like to expand my research on mothers to women of other ethnic, racial and religious groups. Currently, I teach for Central Michigan University and live in Northern Michigan with my family.