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A MOTHERHOOD MYTHOLOGY

A STUDY ON ELEMENTS WITHIN EDUCATION, MEDICINE AND THE MEDIA

BY

ELAINE BERGEN

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF EDUCATION

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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A MOTHERHOOD MYTHOLOGY: A STUDY ON ELEMENTS WITHIN EDUCATION, MEDICINE AND THE MEDIA.

submitted by Elaine Bergen

in partial fulfilment of the requirements for the degree of

MASTER OF EDUCATION

Supervisor

External Examiner

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A MOTHERHOOD MYTHOLOGY: A STUDY ON ELEMENTS WITHIN EDUCATION MEDICINE AND THE MEDIA.

by

Elaine Bergen

A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

Master of Education

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Dedicated to

Pam

whose courage to mother, in full knowledge of the price,

was my inspiration.

ABSTRACT

The purpose of this study was to explore the existence and nature of a Motherhood Mythology and to examine three areas in which this mythology was challenged and/or perpetuated.

A definition and characteristics of a Motherhood Mythology were arrived at through a study of the literature. The Institution of Motherhood, as distinct from the mothering, nurturing relationship between mother and child, was found to be filled with beliefs which were described as oppressive and destructive. The expectations and rules of behaviour appear to cause conflict with the experience of mothering. Selected areas within the eduational system, health care system and media were examined for their challenge or maintenance of the mythologies.

The results of the education study were ambiguous and raised some major questions. The two high school curricula offered information, options and the possibility for non-traditional career choices. A review of studies on occupational sex-typing within the schools, career aspirations of female students and labour force reality for women however, suggested very little movement. A central question concerned the development and meaning of the landmarks of female identity. What does this mean in relation to the standard male developmental models on which much of the educational system is anchored?

Within the health care system there again appeared to be some confusion. The two Childbirth Education programs and the two hospital obstetrical nursing units are in various ways challenging medicine's traditional control of birthing. In doing so they confront the accepted

rules of birth and mothering. What is clear however is that the entire event of giving birth is still very much within Medicine/Patriarchy's domain and power. To whom does birthing belong and who can determine its process became central questions to this study.

Popular magazine stands were perused over an extended period of time to determine how advertisements and illustrations treat mothers. The evidence here was overwhelmingly and blatantly a perpetuation of beautiful dreamlike motherhood. Challenge to this came in the form of humour, in this case Lynn Johnston. Her cartoons bring respect and a human face to mothers.

PREFACE

When I was a little girl, I thought babies were cute and fun to play with--like my dolls. I knew I would love to be a mother some day. I would be a happy and loving mother totally devoted to my children. Obviously it was the pinnacle of healthy womanhood. Even boring and hateful babysitting experiences didn't sway me from the dream of what it could be like. Other choices and alternatives were essentially empty. I could not be a medical doctor because when I had children, I would naturally stay home and care for them. My career and education would be useless. The beginning and the end of my identity would be "Mother". It was essential, innate to womanhood. The maturation of my fantasy was to be "Super Mom" and to know ultimate fulfillment.

My daughter plays with a Cabbage Patch doll all day. She thinks babies are cute and so being a mother would be such fun. She is certain she would be happy being a mother and her children would also be happy. She wants to <u>have</u> another job too, but what she will <u>be</u> is a mother.

The fairyland vision of being perfectly happy and fulfilled, of producing cooperative and perfectly adjusted children, and of living happily ever after seems to be operative today. My experience as a counsellor in the Post Partum Counselling Service of Winnipeg Inc. gives me evidence of an active Motherhood Mythology. In spite of the questions of feminism, women are still largely defining themselves in terms of the realization of their reproductive potential and then predicting the results as ultimate happiness and necessary for feminine fulfillment. The reality of the experience for these women, however, does not begin to match their expectations. For me, as for them, these beliefs are dysfunctional myths.

CHAPTER I

INTRODUCTION

Rich (1976) discusses motherhood as having two distinct yet superimposed meanings: "the potential relationship of any woman to her powers of reproduction and to her children; and the institution, which aims at ensuring that that potential--and all women--shall remain under male control" (p. xv). Brownmiller suggests that enforced motherhood may have originally been the price women paid to the men who protected them from the violence of other men (1976). If so, it is "penal servitude". A woman's "right" as a mother is to have children, stay at home, raise them and be responsible for how they turn out (Hare-Mustin, Broderick, 1979). These beliefs are necessary to maintain the social, political and economic systems of patriarchy (Rich, 1976). This is the Institution of Motherhood.

Bernard (1975) says that women are questioning this institution, not the relationship. The fact of not enjoying everything about parenting is certainly not a reflection on feelings toward the children (Radl, 1979). However, mothers who admit to the burdens and losses of parenting are judged as unconventional, immoral or abnormal. The pressure is high to acknowledge babies only as bundles of joy. Anger and resentment are too frequently denied them. "Though the point is not universally conceded, mothers being human have a right to all human emotions" (Barber & Skaggs, 1977, p. 198). The mother/child relationship is not the institution.

Women receive a conflicting message about mothering. Firstly, it is perceived as natural and feminine fulfillment (Oakley, 1980), secondly, childbirth is treated as pathology (Welburn, 1980) and

childrearing as a task for the experts (Ehrenreich & English, 1979). The normal female life crises are given disease labels and resolution is medical. But, says McPherson, psychoanalysis has crippled women by attempting to "adjust" them to a feminine role unacceptable to free human beings (1981). Evidence suggests that attempts are still made politically, socially and economically to maintain the Institution of Motherhood which in turn wrecks havoc on the job of mothering. Hypothesis: that there exists a Motherhood Mythology which misrepresents the actual experience of mothering and that these myths are being perpetuated today.

Statement of the Problem

This study will examine the contents of a Motherhood Mythology and describe ways in which mothering is still being distorted or how the beliefs are being challenged. Areas of research will include:

1. career development versus motherhood within the education system,
2. medical and prenatal treatment of the childbirth event, and
3. popular magazine picture presentation of mothering.

Mythology

A myth is "both true and false, false fact, but tied to human yearnings and human fears and thus, at all times, a powerful shaping force. Myth is born out of psychological drives. . . . Myth opposes belief to facts in order to change the facts, or at least to obscure them" (Janeway, 1971, p. 26).

Since a myth is not simple fact or falsehood, but incorporates emotions, desires and motivation, straight logic is not sufficient to

break it. Besides its strong emotional element, a myth is closely tied to social, economic and political situations. The myths go beyond the difficulties of the time, frame a future of hope, justify reality and provide a common bond of feeling (Janeway, 1971).

Erik Erikson says "A myth, old or modern, is not a lie, . . . It is useless to show that it has no basis in fact, nor to claim that its fiction is fake and nonsense . . . To study a myth critically . . . means to analyze its images and themes" (cited in Janeway, 1971, p. 28).

Webster (Third International Dictionary, p. 1497) defines myth as: "1. a story that is usually of unknown origin and at least partially traditional . . .

2. a story invented as a veiled explanation of a truth . . .

3. a person or thing existing only in imagination or whose actuality is not verifiable. a) a belief given uncritical acceptance by the members of a group especially in support of existing or traditional practices and institutions . . . b) a belief or concept that embodies a visionary ideal . . .

4. mythical matter: the whole body of myths . . ."

Janeway (1971) challenges a commonly held belief that woman's place is (was) in the home. Historically it is inaccurate. The pre-industrial world saw women in the home and in the place of production, which likely took place in the home. Men were also in the home. The Victorian home saw a sharper division between women at home and men in the places of production. Poor women, however, worked outside the home, almost en masse. The more affluent women were, at the least, quite socially involved. The image of "loving woman's world lies within the four walls of her home; and it is only through her husband that she is in any

electric communication with the world beyond" (Bernard, 1975, p. 12) is quite simply wishful thinking--a myth. In post-industrial post-World War II, this wishful thinking has taken on more reality says Janeway. This may be debatable in fact. Janeway cites evidence that history has been reinvented and reinterpreted in light of a desire to have it a certain way. "There is no data more valuable for thinking about our social problems than the unconscious assumptions we bring to them, for they reveal not only where we are, but where we want to go" (1971, p. 11).

The words myth and mythology will be used in this study to denote a misrepresentation of a reality in order to maintain a social order. A myth, though seemingly functional in this social order, will be viewed as dysfunctional and destructive to women and so ultimately destructive to the broader society.

Although a somewhat artificial distinction, motherhood and mothering will generally be used to mean different things. Motherhood is the institution which includes the act of parenting, the physical process of birth as well as the beliefs, expectations and social norms accompanying it. Mothering is more narrowly defined as the relationship between mother and child and the activity of nurturing.

Presentation of the Study

The literature review in Chapter II will examine both popular and professional material which either reinforces or challenges common beliefs and expectations of mothering. It will make a distinction between the Institution of Motherhood with its accompanying mythology and the actual job of mothering. It is the violence of the institution

(Rich, 1976) that is being challenged, not the involvement and power of the mother/child relationship. The information in this review will serve as the basis for the three areas of study.

Work is of central importance in the lives of nearly all people, suggests Employment and Immigration Canada Employment Counselling material. What is work and what does it mean for career development in female students? Gilligan (1982), though not specifically addressing the work issue, would see relationships as having central importance for women. Given that the educational process is based on the developmental theories of Erikson and Kohlberg, is the Motherhood Mythology perpetuatd for girls examining life goals? Do the programs give adequate options and information? The study in Chapter III will focus on two high school career/lifestyle programs and a selection of education-based studies and articles. The results will be compared to labour force employment and mothering realities of women today.

When birth is routinely treated with high technology intervention, the message could be that childbirth is pathology. Prenatal classes prepare women primarily for the birth event with only some general information about mothering. Two current popular words seem to be "natural" and "joy". Chapter IV will examine two prenatal curricula. It will attempt to build a picture of mothering that is presented in these classes. How do these expectations confirm or question the Motherhood Mythology? A search of two hospital maternity policy manuals will further construct a medical image of this event. Some preliminary information suggests these two elements build conflicting messages and myths. However, they may very likely interact together to create the present mythology.

Chapter V will look at a pictoral representation of mothering. The search will focus on popular magazines which are geared to a female/mothering population. They will be selected from supermarket, drug store and "corner store" magazine stands. Hospitals and prenatal classes will also be approached for magazines. Preliminary evidence suggests that strong visual pictures of mother as serene, peaceful and romantic feed into the desire for mothering to be just that--they reinforce a dream.

Chapter VI will discuss the information gathered, draw conclusions and make recommendations in the three areas of study.

CHAPTER II

REVIEW OF THE LITERATURE

"The oneness of the nursing mother and her baby has always fascinated mankind. Like lovers, their union lacks the ambivalence and tensions of sexuality" (Pryor, 1973, p. 1). Pryor, in both the 1963 and 1973 editions of a book officially recommended by LaLeche League International, speaks about the "nursing couple" as "being two people, yet one" (1973, p. 1). The picture of a perfect and fulfilling relationship is clear--and imperative.

In 1885 Charlotte Perkins Stetson (later Gilman) gave birth to a daughter. "Of all angelic babies, that darling was the best, a heavenly baby." Yet as she nursed the baby, ". . . the tears ran down on my breast . . . I could not read nor write nor paint nor sew nor talk nor listen to talking, nor anything. I lay on the lounge and wept all day. The tears ran down into my ears on either side" (Ehrenreich & English, 1979, p. 1). The relationship between this mother and child was highly ambivalent and filled with tension.

The sharp contradiction between Pryor's "union" and Gilman's "ambivalence" begins to raise the question of whether there exists a conflict between the beliefs and ideals of motherhood and the actual reality of mothering. Pryor sees the experience of breast-feeding as the basis for becoming womanly. "For many American girls, prolonged breast-feeding constitutes their first experience of being truly feminine" (1973, p. 13). Gilman, though not responding directly to breast-feeding concerns, states that "the home is primitive and woman confined to it suffer from arrested development" (Ehrenreich & English, 1979, p. 21).

This literature discussion will focus on the apparent contradiction between certain beliefs of mothering and the actual experiences. The words myth and mythology will be used to describe those beliefs which appear to cause difficulty in the translation to reality. (See Ch. I, Mythology section).

One hundred years ago and as early as the eighteenth century, feminists were raising questions and making statements about motherhood, statements that challenged prevailing belief systems of women's place and role. The writings of Margaret Mead (1930's), Betty Friedan (1950's) and Jessie Bernard (1970's) are still challenging these structures and assumptions. They conclude that there is operative a set of beliefs that in some way betray the women who hold them. There are available conflicting sets of literature which either attempt to demythologize motherhood or reinforce and restate the beliefs.

Historical Development of Motherhood Mythology

Shortly after the American Revolution, Judith Sargent Murray said women needed more knowledge to be able to set new goals and grow in the process of reaching them (Friedan, 1973). In 1848, the first Women's Rights Convention in Seneca Falls, New York produced a public statement of grievances against men. ". . . He has made her, if married, in the eyes of the law, civilly dead. . . .He has endeavored in every way that he could to destroy her confidence in her own powers, to lessen her self-respect, and to make her willing to lead a dependent and abject life" (Friedan, 1973, p. 77). Women were beginning to publically question their non-person status and the passive subservient role they were forced to play.

Nineteenth century feminists said women were being stopped short of becoming fully human and their potential was being wasted in the sex-determined functions of wife, housekeeper and mother (Friedan, 1973; Bernard, 1975; Ehrenreich & English, 1979; Oakley, 1980). The God-given nature of women as wives, mothers and housekeepers was on the other hand passionately supported by the Church, politicians and general public. In 1879, Henrik Ibsen's A Doll House made the simple statement that a woman is a human being. Nora is reminded that woman's "most sacred duties" are to her husband and children. She replies, "I believe that before all else I am a reasonable human being, just as you are--or, at all events, that I must try and become one" (Friedan, 1973, p. 76). The early feminists fought for a self-identity that was not predetermined by biological function. They wanted new rights and freedoms in an expanding industrial world.

The structure of the home originated from the need for protection from external forces. In the fifteenth century the excesses of communal festivals required a place of safety for the children. In the eighteenth century, heavy social demands on behaviour led people to seek a place of refuge (Bernard, 1975). With industrialization the home became a sanctuary from the demands and evils of the new economic world. The Victorian home, described as a Place of Peace, was given over to the mother to maintain and preserve (Friedan, 1973; Janeway, 1974; Bernard, 1975; Ehrenreich & English, 1979). Mother was given the impossible and holy task of making the home a "walled garden" or "school of virtue". George Elliot says, "A loving woman's world lies within the four walls of her own home; and it is only through her husband that she is in any electric communication with the world beyond" (Bernard, 1975, p. 12).

The family home is established and assigned to mother to care for with the powerful assumption that if she is loving she will make the home her exclusive task.

Mothering, crystallizing as motherhood became the ideal social regulator of the mother-child relationship. In the pre-industrial world of agrarian production and cottage industry, women were involved with men, both in reproduction and socialization, and in the production of goods. With industrialization the place of production is removed from the home and the woman is relegated exclusively to the realm of reproduction. She becomes alienated from men and production (Friedan, 1973; Bernard, 1975; Janeway, 1975; Ehrenreich & English, 1979). Isolated from the world of the market, from education and any voice in the shaping of the laws, women were forced to accept full time care of children and sole responsibility for them. Romantic images of lovely Madonnas symbolized woman's place, function and above all her willing acceptance and fulfillment in motherhood.

Through the centuries women have been healers and nurturers, possessing generations of wisdom, experimentation and experience in the art of healing. These ancient healers operated within a network of information sharing and mutual support. During the medieval witch hunts, one group that received particular attention and anger from the church was the midwives. A specific issue was their knowledge and use of drugs. Some of these drugs, still meeting the test of modern science, were painkillers, digestive aids and anti-inflammatory agents. The use of a painkiller in labor was a deliberate heresy against a church which taught that pain in labor was God's punishment for Eve's original sin (Ehrenreich & English, 1979).

The conflict between women's traditional wisdom and male expertise focused on who had the right to heal--or, who could make decisions or have power. The issue was not right over wrong, fact over myth, but men over women. Male power won as thousands and thousands of witches (peasant healers) were burned at the stake. As the "wise women" were silenced, women learned to look to "science" and "experts" for guidance (Ehrenreich & English, 1979). Their knowlege and voices effectively stopped, women had little choice but to accept the roles assigned and elaborately justified to them.

In The Yellow Wallpaper, Charlotte Perkins (Stetson) Gilman (1973) fictionalizes her own descent into madness after the birth of her daughter. Sent to a "nerve specialist" in 1885, Gilman received instructions to devote herself to housework and her daughter, to limit intellectual work to two hours a day and "never touch pen, brush or pencil as long as you live" (Hedges, 1973, p. 47). Before her visit with Dr. W. Mitchell, she prepared a thorough case history of herself. He told her, however, to leave it all to him, the expert. She very nearly lost everything. As the narrator of the story she wonders, "John (husband) is a physician, and perhaps . . . perhaps that is one reason I do not get well faster" (1973, p. 10). Rosenberg (1981) says Gilman's depression was a direct result of her lack of meaningful work. Ehrenreich & English (1979) discuss at great length the whole Victorian era of female invalidism. Women were deprived of intellectual stimulation and given the glorified role of motherhood. Much of the menial work was done my others however, and they were encouraged by the medical experts to be weak and passive.

Chesler further documents women's struggle for control and the almost inevitable "madness" that follows. The madness, she says, is in essence a refusal to accept the docile dependent role of "private social loser, wives and mothers" (1973, p. 10). The four women Chesler describes ". . . share a rather fatal allegiance to their own uniqueness. For years they denied themselves--or were denied--the duties and privileges of talent and conscience. Like many women, they buried their own destinies in romantically extravagant marriages, in motherhood, and in approved female pleasure. However, their repressed energies eventually struggled free, demanding long overdue and therefore heavier prices; marital and maternal 'disloyalty', social ostracism, imprisonment, madness, and death" (1973, p. 5).

Over and over again the struggle against the female role haunted women and drove them "mad". Sylvia Plath's heroine says, ". . . one of the reasons I never wanted to get married (was that) the last thing I wanted was intimate security and to be the place an arrow shoots off from. I wanted change and excitement and to shoot off in all directions myself . . . the trouble was, I hated the idea of serving men in any way. I wanted to dictate my own thrilling letters . . . maybe (marriage and children) was like being brainwashed and afterwards you went about numb as a slave in some private totalitarian state . . ." (1973, p. 6). Women who dared to challenge the degrading way they were treated and were forced to live, were risking everything. They were fiercely and dangerously at odds with their own socialization, family and society as so tragically portrayed in the Francis (Farmer) movie (1983).

Turn of the century feminists (Adams, Gilman, Stanton, Stone) devoted their lives to moving women out of the "twilight life" and into broad daylight to join the living world. With strikes, resistance, lobbying and fighting, the vote was won, and with it increasing rights and freedom for women. With this final freedom, the active organized struggle died--women slowly began to return home. Why after this struggle and victory did women seemingly give up their hard earned rights?

". . .the man-eating myth prevailed. . . . The feminists had destroyed the old image of woman, but they could not erase the hostility, the prejudice, the discrimination that still remained. Nor could they paint the new image of what women might become when they grew up under conditions that no longer made them inferior to men, dependent, passive, incapable of thought or decision" (Friedan 1973, p. 93). Women, not having adequate female role models and bitterly angry at men and the system, added fuel to the man-eating myths as they entered business, professions and schools. Women growing up in these years saw only two choices: "In that corner, the fiery, man-eating feminist, the career women--loveless, alone. In this corner, the gentle wife and mother--loved and protected by her husband, surrounded by her adoring children" (Friedan, 1973, p. 94). Thousands became victims of this mistaken choice!

The "experts" fought to put women back in place and to restore the "natural order". They rallied to tell women that they would be happier at home, that they they would be fulfilled and loved. The choice was virtually a non choice. The wish to be more than wife and mother was twisted by memories of the fighting man-eating feminists.

" . . .Permitted to escape identity altogether in the name of sexual fulfillment, women once again are living with their feet bound in the old image of glorified feminity" (Friedan, 1973, p. 94).

Friedan says the return home in post-war years of countless women was very much a Freudian idea. The old hostilities and prejudices were not removed by feminists, educators, or science. In the 1940's they were simply reinterpreted into Freudian thought. These new (mis)interpretations were even more difficult to question because now educators and social scientists taught them, and because the very nature of Freudian thought makes it virtually invulnerable to question. Freud's work on the unconscious makes it extremely difficult for women to question their roles. Questions and doubts could simply be turned back on them as penis envy, unresolved maternal conflicts, or 'biology is still destiny'. The trap was set. Women were forced once again to submit to centuries-old half-human, half-life--under a new guise--but yet the same. The old patriarchal order of open male supremacy was broken. In its place, women became glorified as saintly mothers--honored, adored, on a pedestal, safe. This bind was even more deadly. Women now 'understood' (in Freudian terms) why early feminists were frustrated and why they must now choose the non-choice.

"Maybe (marriage and children) was like being brainwashed and afterwards you went about numb as a slave in some private totalitarian state (Plath as cited by Chesler, 1972, p. 6).

The Motherhood Mythology

Gilman's heroine in The Yellow Wallpaper states the ambivalence of her mother role. "It is fortunate Mary is so good with the baby. Such a dear baby! And yet I cannot be with him, it makes me so nervous" (1973, p. 14). Plath's heroine in The Bell Jar (1966) struggles against the dictum that she must choose marriage and children to be a mentally and emotionally healthy woman. Both writers' stories are essentially autobiographical. Rich (1976) discusses at length the violence of the Institution of Motherhood. Yet in the 1980's Oakley's research finds three basic beliefs around mothering to be intact: that children need their mothers, that mothers need their children, and that all women need to be mothers. Underlying these beliefs are the assumptions that: biology is destiny, to be normal is to be a mother, and to be a mother is to be properly feminine. In spite of contradicting experience, women are still believing and being taught an "ultimate", "fullfillment"-type of motherhood dream.

Professional Mother

Since the end of the Suffrage Movement women have generally adopted a new vision of motherhood. No longer was having children something that happened alongside of other life happenings but became the focus of their lives. No longer were women's physical services required as they had been in a pioneering frontier world. Technology came with labor-saving devices and supposedly more free time. With this came the advertising industries' new standards of "domestic perfection" and "make-work chores" and more reasons to keep the women at home (Slater,

1976). As women read and listened, they moved consciously from professions of economic productivity to professions of reproductive productivity. Child-rearing became an industry. "We are a product-oriented society and the American mother has been given the opportunity to turn out a really outstanding product" (Slater, 1976, p. 75).

Slater says further that most "Spock-taught mothers believe that if they did their job well enough, all their children would be creative, intelligent, kind, generous, happy, brave, spontaneous, and good" (1976, p. 72). The converse follows that if in some way the child is not given absolute total attention by the mother, the child may well become unhappy, maladjusted and show behaviour problems. "Blame Mom" is a favourite pastime of countless child development experts (Maynard, 1983). Although taken to new heights in the 1950's, the "cult of motherhood" was also developing alongside the Suffrage Movement (Ehrenreich & English, 1979). A conference assembly on motherhood was told in 1908 "With clear eyes we must see the goal of our effort and with unfaltering steps journey towards it. The goal is nothing less than the redemption of the world through the better education of those who are able to shape it and make it. The keeper of the gates to tomorrow is the little child upon a mother's arms. The way of that kingdom which is to come on earth, as in heaven, is placed in the hands of a child, and that child's hands a woman holds (Ehrenreich & English, 1979, p. 190).

There is little room for mothers to move without supposedly devastating results to the child. Everything rests on her, the good and the bad. In the last decade the "super child" phenomena has become a sign of a mother's devotion and ingenuity. Slater (1976) responds to

the overwhelming demands placed on the mother, who in turn places them on the child, by speaking of maternal and child overload. Massive inputs of attention from one person is simply not good for the child. There is no escape for the child and the pressure to be perfect, to fulfill mother and to repay her for her sacrifice, are just too intense. Psychologist Leo Salk seems to disagree: "If parents anticipate not providing enough time for one-to-one contact in the first three years, they should consider not having the child" (Cahill, 1982, p. 104). Richard Nixon in 1971 vetoed extended child care services because it would threaten family life. Although Salk and Nixon are not specific about "enough time" or what constitutes quality family life, the implications are clear. If a woman wants (even if she doesn't) or has a child, she is responsible for the way the child develops and the kind of person it eventually becomes. No other time in written history has the sole responsibility of child care been on the mother and at no other time has the pressure been so high to produce the perfect child (Bernard, 1975).

The experts, usually male and rarely doing any actual child care, become louder and louder. Eventually they are no longer external advice givers but internalized and interiorized into the family. They are the center around which the family moves (Ehrenreich & English, 1979). Spock, though a part of this movement, can also be credited with jumping out of the cycle, attempting to join the "youthful rebellion" and paying attention to feminist concerns of maternal overload and blame. Ehrenreich & English (1979) see the power of the experts breaking down. This may well be but the question of whether the power and control of child care has been returned to the mother (parent) remains. Evidence suggests "Motherhood as Pathology" (Ehrenreich & English, 1979) still

exists and needs to be "treated".

Rosenberg (1981) adds to the discussion of the professional mother, the problem of being caught in the contradiction of a high status role and a low status job. The role itself is full of contradictions, then is further compounded by containing work which is socially of low status. The stresses of the mothering job contain inordinate numbers of recognized job stressors, primarily that of high demand levels combined with low levels of control in decision-making. Other stressors that obviously affect mother work are: working in isolation, lack of immediate feedback, repetitive menial tasks and unpredictability. This job of mothering is accepted by women with the "understanding that the job description would be so vast and so vague as to be undoable, that no assistance would be provided and that any errors would be the new employee's sole responsibility" (Rosenberg, 1981, p. 11). No experience or training precedes the job.

In spite of the increasing number of books, articles and discussions about subjects such as maternal overload or mother work burnout and the realities of the job, many women are still accepting the profession of mothering complete with romantic expectations. The women coming to Post Partum Counselling Service (of Winnipeg) are evidence of this. The dream for them is still alive.

Maternal Infant Bonding

In 1976 Klaus and Kennel wrote: "There is a sensitive period in the first minutes and hours of life during which it is necessary that the mother (and father) have close contact with their neonate for later development to be optimal" (Canadian Nurse 1983, p. 31). Their research

on maternal-infant-bonding reinforced the importance of the mother's total and immediate involvement in order to ensure a positive development. Not only was it crucial for the mother to look after her child but she must "bond", or frequently interpreted as "fall in love", within the first few crucial minutes after birth. Pryor suggests that from the first nursing a few minutes after birth, the love at first sight is spontaneous and "biologically normal" (1973, p. 2). The bonding experts, discovering that a baby's eyesight and awareness are sharpest during the first 20 minutes after birth now limit the time this "falling in love" can occur. The mother, still exhausted from labor and delivery, strapped into stirrups and in pain, is given the child, told to make eye contact, skin contact, breast-feed and "bond". The penalty for an unsuccessful bonding during the "sensitive period" has been perceived as high--increased incidence of child abuse and a disturbed maternal-infant relationship.

This emphasis on early bonding can cause untold difficulty to women having an uncomplicated delivery, to say nothing of those who for one reason or another have a birth complication. For women having a Caesarean section under general anaesthetic, or a premature baby in distress, for those confronted with an uncooperative medical staff, for women who for any reason choose not to hold the baby immediately, the bonding belief presents a real problem. She may be labelled by hospital staff as having bonded poorly and a higher risk mother for child abuse. She may be consumed with guilt for having permanently ruined her chances for a good relationship. Having failed as a mother she can expect her child to have some permanent damage.

Prenatal classes and popular magazine articles fed the "bonding movement". Bonding rooms were built on obstetrical wards in some hospitals. A flood of literature taught this new technique that would prevent later behaviour problems in the child. Nursing staff were taught to observe and note bonding efforts: "good" and "bad" mothers were picked out. New mothers are still encouraged to request no eye drops during this sensitive period. Mothers focus consciously and deliberately on falling in love, believing securely that the love established during those first few post-birth moments will carry them magically and safely through mothering tasks. How much attention is paid to the reality of a relationship that is being formed between two people who have just met, one member of whom will be totally dependent on the other for a great length of time?

Dr. Kerry Callaghan in a 1981 magazine given to all new mothers in a Winnipeg hospital promotes the ultimate importance of first hour maternal-infant bonding. "I'm hopeful that we can find ways of assuring that the bonding process takes place smoothly, so that calm, relaxed infants elicit positive nurturing responses from their parents and achieve secure, primary attachments in a mutually satisfying and enjoyable relationship" (Callaghan, 1981, p. 48). A mother writing (in the same magazine) about her two birth experiences, reaffirms this by blaming her difficulties after the birth of her first child on the separation of mother and child until she reached the recovery room. The post-birth period of the second child was relaxed and positive due to immediate contact, "bonding".

Seven years after their statement on the sensitive period for bonding, Klaus writes, "I wish we'd never written that statement...".

Time and further education have yet to break down the myth, heal the damage it has done and understand the natural process of developing a relationship with one's child.

Motherhood as Feminine Destiny

Friedan cites countless stories of 1940-1950's women's magazines that insist that a woman can know fulfillment only at the moment of giving birth. "In the feminine mystique there is no other way for a woman to dream of creation or of the future" (Friedan, 1973, p. 29). Motherliness is a total way of life. To be a woman means to be a mother, or to be inordinately selfish. "Most women have kids because they don't want to be left out" says a teenager (Prendergast & Proust, 1980, p. 517). Magazines of the 1950's were filled with glamorous housewives, treated like "brainless fluffy kittens" who made endless statements like, "I'm so grateful for my blessings. . . Wonderful husband, handsome sons with dispositions to match, big comfortable house. . . I'm thankful for my good health and faith in God and such material possessions as two cars, two T.V.'s and two fireplaces" (Friedan, 1973, p. 57). This is the reward: the question could be asked, at what cost?

Oakley (1980) claims there is incredible social pressure on young women to be mothers, and to accept motherhood. It is after all what women are about. Her "sentimental model" of motherhood makes three connected assumptions: that children need their mothers, that mothers need their children, and that all women need to be mothers. The implications of these beliefs are: that biology is destiny for a woman, to be normal is to be a mother, and to be a mother is to be properly feminine. This is the package of motherhood that young women are supposed to accept.

Psychoanalysis, Religion, Economics and other social systems seem to affirm this model over and over again. Psychiatry has institutionalized, tortured and harassed women who were at odds with their female role. Zelda Fitzgerald, Ellen West and Sylvia Plath attempted to escape its (their) half-life by "going crazy". There, as "helpless and self-destructive children, they were superficially freed from their female roles as private social losers, as wives and mothers" (Chesler, 1972, p. 15). Psychiatry's goal was to help women adjust to this half-life, "help" coming too frequently in solitary confinement, abandonment, drugs, shock therapy and sexual harassment.

Adjustment to motherhood as the female role is the wrong goal as it signifies submission to violence, madness, isolation and dependency (Chesler, 1972; Bernard, 1975; Rich, 1976; Oakley, 1981). The very role of being a mother is rife with oppressive stereotypes that destroy the woman and uphold the ideal. "Were marriage to contain all the virtues claimed for it, its crimes against motherhood would exclude it forever from the realm of love" (Goldman, cited by Chesler, 1972, p. 21).

The Institution of Motherhood denies women a place in the world. The price for having a child (which is said to be the ultimate moment of creation) is to shut out the rest of the world, to deny any other future and to be forever the servant of child and husband (Friedan, 1973). What is accepted as the normal service of the homemaker to the home is rather "the invisible violence of the institution of motherhood, the guilt, the powerless responsibility for human lives, the judgments and condemnations, the fear of her own power, the guilt, the guilt, the guilt" (Rich, 1976, p. 34). "It is the moment when she becomes a mother that a woman first confronts the full reality of what it means to

be a woman in our society (Oakley, 1980, p. 1). The preparation for this reality is a process of leading people to believe that childbirth is easy and motherhood is sunshine and roses (Oakley, 1980).

A most prominent and powerful image in Christian tradition is the Mother and Child. Through motherhood (Mary) comes salvation (Christ). But doctrinally it's an act of passive submission (Virgin Birth). Women's childbearing is their redeeming act in the world, without it they are inferior and evil. Early church "Fathers" Augustine, Tertullian and Aquinas defined women as misbegotten males who without their reproductive value have no intrinsic worth (Clark & Richardson, 1977).

Women's non-person status was legitimated and reinforced: "The real difficulty in woman's case is that the whole foundation of the Christian religion rests on her temptation and man's fall, hence the necessity of a Redeemer and a plan of salvation. As the chief cause of this dire calamity, woman's degradation and subordination were made a necessity" (Clark and Richardson, 1977, p. 224). Daly (1973) talks of the original sin of sexism as the blame put on Eve for the evils of the world. If God is perceived as male, then the male is God and can justify his actions and values as God-given (Clark & Richardson, 1977).

Martin Luther's reformation rescue of women from the confines of the cloister in effect deprived one segment of women of a source of power and self-identify. Protestant women moved from "nun to Parson's wife" (Clark & Richardson, 1977) relinquishing lives of leadership and sisterhood. They were now only adjuncts of spiritual leadership and keepers of the home. As of 1984, there are still churches in Manitoba which deny voting (person) status to women.

Women, over the centuries, have largely internalized the image given to them by God/males. The home and family given a high profile by the church is given over to the woman/mother to care for while simultaneously declaring her a subordinate and non-entity in religious life. Her link to God is through her role as mother and wife. There has been movement, although Daly questions whether women can ever be more than tokens in the male church. Despite disclaimers, women still tend to be recognized in the church for their biological function rather than leadership abilities and contributions. The Mother's Day awards to mothers with the most children and the sermon glorifications of "motherhood" are evidence to this (Scanzoni and Hardesty, 1974, p. 138).

Generally, recent literature that attempts to discredit long held beliefs about mothering (and women) is more readily available. Fewer articles and books overtly romanticize motherhood. According to Janeway's discussion of mythology, sheer information would, however, not necessarily bring about change. The structures in which they are imbedded are still largely intact and so the beliefs continue. Beliefs not only in the romantic fulfillment of motherhood, but also in the necessity of motherhood for self-identify.

Two recent studies of teenage girls (British and Canadian) reveal surprising evidence of the strength of these beliefs. Landsberg reports that three quarters of 1000 Ontario schools girls "brought up to believe that their heart's delight would be to marry and bear children, have a negatively warped idea of the impact of serious careers on the rose-covered-cottage dream" (Landsberg, 1983, p. 203). These girls believe that a non-traditional occupation will exclude them from a

"rapturous lifelong marriage and cherubic children" (Landsberg, 1983, p. 203).

Given the educational process, it is not surprising that the girls feel this way. Landsberg further describes a Canadian research project that "reveals half of all male teachers are prejudiced against women and a quarter believe in some form of sexist indoctrination for girls" (Landsberg, 1983, p. 204). Girls' career ambitions appear to decrease in high school. A 1982 study explored ways in which female egos are flattened and male egos flattered (at women's expense) in the classroom (Landsberg, 1983). It appears as if some effort is being made in the education system to perpetuate the woman's place system and girls, given little reason to explore other realities, are learning their script.

A study (Prendergast & Proust, 1980) of 15 year old British girls revealed that they had knowledge about mothering that was contrary to Oakley's sentimental model. They used words like "'boring', 'exhausting', 'awful', 'depressing', and 'tiring'" (Prendergast & Proust, 1980, p. 520) to describe their own mother's experience of mothering. However, when given a proposition, "It's a good life for mothers at home with a young child", the girls talked not about their personal knowledge but about mothers in general and were affirmative. They made a dramatic shift from experience and knowledge to beliefs about mothering where they maintained stereotypical knowledge: "Most women have mothering instincts" (Prendergast & Proust, 1980).

It is interesting to note that their own knowledge was not valid. What was important was how mothers were supposed to feel. The girls were showing a definite disjunction between experience/knowledge and the proper model of mothering. Mothering is boring, exhausting and

depressing: Motherhood is romantic, glorious and fulfilling.

If this cognitive dissonance is functioning for teenage girls, it is certainly functioning for women becoming mothers. "Most women said that the whole process--the pregnancy, birth, the relationship of mother and child, work of child care and social position of mother--was different from what they expected. Four out of five said their expectations had been too 'romantic'" (Oakley, 1979, p. 12). Are these women who have personal knowledge of the realities of mothering but clung rather to the "sentimental model"? The question arises why it is necessary for women to choose a "dream" that is in direct contradiction to their experience and leads inevitably into a highly stressful time? The clash between present experience and reality is a blow to self esteem and particularly likely accompanied by depression (Washbourn, 1977; Oakley, 1980; Welburn, 1980). A cherished dream is lost. In the period of birth, Oakley points out that the new mother experiences two major losses: a loss of the dream and the acquisition of a new self. This new self must go back and acknowledge her childhood reality of mothering and realize with new significance her mother's life and her own.

Motherhood as Ultimate Maternal Fulfillment

The notion of maternal fulfillment perhaps speaks in part to the importance of holding on to a cherished dream. If, as Oakley and others have said, the assumptions in society are still that "biology is destiny for a woman; to be normal is to be a mother; to be a mother is to be properly feminine" (Prendergast & Proust, 1980, p. 519), then a woman must receive some rewards from a task she has no choice in performing, if she is to be properly feminine.

McBride said the two notions that cause the most difficulty in the positive development of mothers are the idea that having a baby is a woman's ultimate fulfillment and that women are to function as child carers simply because of their sex. "Fulfillment" of motherhood promises happiness, satisfaction, pleasure and serenity. McBride quotes Dr. Theodore Litz (Psychiatrist): "Particularly for a wife, a sense of fulfillment only comes with the creation of a new life. Her biological purpose seems to require completion through conceiving, bearing and nurturing children. . . Feelings of incompletion and deprivation in being a girl have been compensated by realization of her innate capacities for creativity, but the realization requires actualization" (McBride, 1974, p. 5).

McBride looks at the word fulfillment, defining it as "doing the required, carrying out the expected, bring to an end" (1974, p. 6). After women have given birth, done the required and realized their potential, what is left? Baby as ultimate fulfillment comes to mean that you have very limited possibilities for satisfaction after childbearing. Obviously this makes women expect much more from the experience. "'Fulfillment' seems a poor substitute for a life that is full" (McBride, 1974, p. 6).

Breast-feeding

Over the last few decades, breast-feeding has made a remarkable comeback. Where in the 1940's and 1950's it was primitive and shameful, it is now "the language of love" (LaLeche League Conference, 1983). The emphasis on nutritional and other health factors of breast milk is an obvious one. Promoters of formula will counter with their own set of

standards and nutritional value facts. Here the issue is one set of "facts" versus another set of "facts". What is more difficult to deal with are the emotional, developmental values placed on breast-feeding.

A local hospital discontinued its classes on bottle-feeding formula preparation. The goal was to promote breast-feeding. However a half to a third of the mothers on the ward at any given time were bottlefeeding their babies. The message to them was clear, you're on your own since you made the wrong choice. One mother, after months of careful deliberation, chose to bottlefeed. The nursing staff questioned her and made her feel that "In my first decision as a mother I'd failed" (Post Partum Counselling Service of Winnipeg, 1982).

Pryor is specific about the state of the relationship between a bottle fed baby and mother. "The relation is platonic for her at least . . . Her reponse to the baby cannot be the same" (Pryor, 1973, p. 11). The directive of LaLeche League (Pryor is recommended LaLeche Literature) is then that a breast-feeding mother loves her child more than a bottle-feeding mother.

This message is not only devastating to women who for some reason cannot or choose not to breast-feed. Many nursing mothers are constantly anxious about weaning, or going out without the baby or about expressing milk. Everything calls into question their love and the possibility of psychological damage to baby if deprived of the breast.

It is interesting to note that a hospital that actively promotes breast-feeding gives to each mother a magazine which promotes formula feeding. Spring 1981 magazine contained three full page color ads for formulas and five ads for cereal feeding and no pictures of

breast-feeding. "Every mother can breast-feed and every mother should breast-feed." The converse could be, a mother who can't is a failure as a woman, a mother who chooses not to is a failure as a mother.

Mothering as Instinctual

A prenatal instructor told her class, "You're the mother--you'll know what the baby wants by the cry". The expectant mothers went home and awaited the magical "motherknowledge" to descend on them. A T.V. jingle for Enjoli perfume says:

> I can put the wash on the line, feed the kids
> Get dressed, pass out the kisses,
> And get to work by five of nine--
> 'Cause I'm a woman. (Cahill 1982, p. 102)

Hormone theories on mother instinct are dead says Chodorow (1978). The studies have been largely inconclusive and faulty in execution. If mother instinct was a fact, the question could be asked what happened to it in medieval Europe when babies were sent away to wet nurses (Maynard cites Badinter, 1983). Twenty-one thousand babies were born in Paris in the 1780's. Of these, 19,000 were shipped off to the countryside by the wagonload. Parents rarely bothered to note their babies destination.

In the 1960's, T.V. shows like "Father Knows Best" and "Brady Bunch" implied that motherhood was a lark, easy, fun, fulfilling and natural. Little girls frequently play with dolls, nurture and care for them. This is said to be mother instinct. Plastic inanimate dolls are not live, wriggling, ever-demanding babies, yet women believe they can make that transition because they are women (Welburn). They are shocked when they find they have to learn it all from the beginning.

de Beavoir says children are an obligation--and as such "there is nothing natural in such an obligation: nature can never dictate a moral choice: this implies an engagement, a promise to be carried out (de Beavoir, 1952, p. 62). de Beavoir goes on to say that the only time a woman is a natural mother is in the process of birth. After that she embarks on a solemn responsibility.

Women facing motherhood are in an incredibly difficult situation. In the eighteenth century, Mary Wollstonecraft wrote about the paradox of preparing women for the most demanding of all roles by fostering weakness in them. "To be a good mother, a woman must have sense, and that independence of mind which few women possess who are taught to depend entirely on their husbands. Meek wives are in general foolish mothers (cited by Bernard, 1975, p. 33). Bernard says the price women pay for doing what they are taught to do--be passive/independent and mothers, is enormous. The two are in complete contradiction. de Beavoir adds that the child pays the price of being cared for by a discontented women who does not have her life in a healthy balance.

The status of motherhood itself creates another paradox for women. Victorian literature sings endless praise to the virtuous mother who gives serenity, peace and unconditional love (Bernard 1975). Yet only under patriarchy is it idealized, not per se (Hare-Mustin, Broderick, 1979). An unwed mother does not receive this adoration, nor does a mother who chooses to relinquish her child. The qualification for mothering sainthood is obedience to an institution which essentially excludes you from anything else. "It is outrageously paradoxical to deny women all activity in public affairs, to shut her out of masculine careers, to assert her incapacity in all fields of effort, and then to

entrust to her the most delicate and the most serious undertaking of all: the molding of a human being (de Beavoir, 1952, p. 62). Although de Beavoir wrote this nearly thirty years ago, the question of how much has really changed could be asked. Are the changes superficial or fundamental?

Rosenberg (1981) says that motherhood as an institution has a high status, but as a job, a low status. It is not even recognized enough (as work) to pay for it. Yet the particulars of the work make it a very high stress job. Besides the stresses already discussed (p. 19), mothers contend with work in an unsafe and unhealthy environment, confinement to the work area, and lack of job security.

A woman who does not marry is "on the shelf", a woman who does marry and does not have children (by choice) is selfish. A woman who does marry and has children is to blame for colic, eczema, schizophrenia, alcoholism, drug addiction, suicide, father-daughter incest, murder, and homosexuality (Maynard, 1983). Women live with the unrelenting guilt "that daily, nightly, hourly, am I doing what is right? Am I doing enough? Am I doing too much? The institution of motherhood finds all mothers more or less guilty of having failed their children" (Rich, 1976).

A problem for the '80's career woman is the passive dependency called for in accepting the role of full time mother-housekeeper. This is in sharp contrast to the experience many women have prior to having a child. Many have been engaged in careers in which they have been assertive and independent. They have found satisfaction in this self image. Now they are being asked to step back in time. Friedan says they must then struggle with the notion of growing up--this life seems

immature to them. (But if this is immature, and this job has lower status than their previous career, what does this imply about their ability and maturity: self esteem is called into question.) Yet mothering is still proclaimed as feminine fulfillment. Few social supports are available for those who enter joint careers; mothering and out of home career.

The final insult to these problems is the directive for mothers to be happy. Bernard (1975) cites studies of mothers who have shown a distinct difference between being happy in the job of mothering and loving their children. More and more women are saying yes they love their children and no they do not like their job. This seems to be a new separation. One mother said: "I love my children, but I don't like this role. I'm afraid to say that to anyone because they'd think I was a loony" (Radl, 1979, p. 18). Another mother states: "The day I faced the fact that there really are terrible sides to parenthood was a new beginning for me . . . The motherhood mystique would have you believe every normal mother relishes the motherhood role every minute (Radl, 1979, p. 11).

Friedan talks of the total bliss of the 1950's magazine heroines who loved the job and role of mothering. Women were sold the happiness theme. The price to reject it was too high. If they did not like the only thing they were allowed to do in order to be truly feminine, fulfilled and normal, they were truly lost. From the western cultures' perspective, this was a useful and economically sound idea. If women were not happy in their mother jobs, now that industrialization had so thoroughly disrupted extended family support systems, then there would be a serious disruption to men's task of production. On a practical

level men were quite well set up, having someone available whose total responsibility was caring for them and the children. One could ask, but who mothers the mother?

There is a terrible taboo against a woman sharing her frustration and anger with the job of mother. It is seen as a shameful reflection on her. Other mothers obviously enjoy it and receive adequate rewards from it. "Blame the mom" has been internalized along with the fantasies--and the trap is closed. The myths that are internalized since childhood, "turn into a club that can beat her senseless" (Radl, 1979, p. 18).

Mothering is a crisis of identity. "Becoming a mother is a rite of transition and involves a reordering of all the roles that are integrated into a woman's self-concept" (Sheehan, 1981, p. 19). When fantasies and reality are incompatible, the crisis nature of the identity struggle is increased. The expectations of mothering are being experienced by many women as far removed from actuality-as myths. Because of the all-encompassing and powerful nature of the birth event and the fundamental changes accompanying it, these myths would clearly seem to be destructive and dysfunctional.

CHAPTER III

CAREER DEVELOPMENT VERSUS MOTHERHOOD IN THE EDUCATION SYSTEM

Words such as "cute", "delicate", and "sweet" are used to describe girls. Words such as "sturdy", "tough", and "active" are used for boys. Femininity is equated with weakness, masculinity with strength. "Male dominance is due to the almost uniform and universal ascription of higher status to maleness than to femaleness" (Unger, 1978, p. 135). The social power that accompanies ascribed status is deep rooted, complex and all pervasive. Exceptions occur. For most women however, it has remained virtually impossible to reverse this process. Evidence suggests that the "real" status of women, as compared to small legal and legislative gains, is still that of second sex and inferior (Canadian Advisory Council on the Status of Women: CACSW 1983). The primary role of this sex is to mother.

Underlying this chapter will be the premise that the Institution of Motherhood by its definition and description perpetuates for women an inequality in the world. This occurs not only in her home and family, but in the world outside her home. Girls are taught in various ways what to expect from this life with the assurance that it is the dream of feminine happiness.

This section will examine elements of the educational system in terms of its influence, teaching and perpetuation of this inequality of status. Beginning with the understanding that motherwork is a low status position and that our society systematically restricts women's lives so as to keep them as reproducers and child carers, does the educational system maintain or attempt to equalize male/female status?

These findings will be discussed in light of the present realities of women's work world, both in the home and in the labor force.

Review of Department of Education Career/Lifestyle Materials

A manual prepared by the Manitoba Department of Education in 1981 states its "aim is to guide students in developing the understandings, awareness and specific job-search skills necessary to setting realistic career goals and proceeding toward those goals for the students personal benefit and that of the community at large" (Province of Manitoba Department of Education, 1981, p. 1, Appendix A). The writers begin with the understanding that all students, regardless of sex or academic achievement, will be given the assistance needed to make their career choices.

Units of study are comprehensive, including information about specific jobs, workplace statistics, relationship between courses and careers, and preparation for career training. Two studies cited in the manual give students the message that the majority of women work in the labor force and that in terms of education, wages and career status, there exists an inequality between women and men.

Given the guidelines and information available in the manual, creative teaching possibilities appear almost endless. The material is carefully non-sexist in language and content.

The work of Gilligan (1982) calls into question some of the basic social goals of economic/academic/career success for females. The works of Erikson, Kohlberg and Piaget were formulated primarily on the basis of male samples. Are the approaches based on their theories foreign language to adolescent females who are socialized for relationship and

nurturance. Males and females develop in psychologically different contexts says Gilligan. Given this sex-differentiated socialization, how do girls absorb, understand and prepare their life plans in terms of family and career? What educational methods need to vary to produce the same results in males and females? Or is this not the goal?

Even with these questions, the manual's potential is limited primarily by teacher/school creativity and understanding.

Another curriculum prepared by the Manitoba Department of Education in 1982 provides a structure and adequate information to guide students through a comprehensive look at lifestyles (Appendix B). Topics include personal development, consumer-producer issues and interpersonal relationships. A section of special relevance to this paper deals with family/parenting concerns and an overview of relevant resources. A stated objective of this program "is to encourage students to identify, formulate and discover for themselves instead of simply absorbing facts, opinions and conclusions" (Province of Manitoba, Department of Education, 1982, p. 4). The potentials of this manual are exciting and again limited only by teacher/school creativity and understanding of the issues.

Questions arise about the effect of this manual. Is it utilized? If so, do the teachers using it understand the socialization that has occurred so far? Do they understand their own prejudices and biases? What changes can realistically be introduced to senior high students if lifestyle attitudes and influences are crucial at a much earlier age?

Both manuals address in various forms and emphases economic and social life in the 1980's. They both begin with the stated objectives of giving students the knowledge and skills needed to make choices and with the theoretical starting point of sexual equality. When asked if

this material is generally being used in the schools, Martha Colquhoun of the Manitoba Teachers Society, stated emphatically: "No!".* Research would be necessary to determine both their use and long-term effect. Both items are still too recent to accurately evaluate for effect. When the Director of Curriculum Development of the Manitoba Department of Education was asked for high school materials that counteract sexual stereotypes and provide career and family information, these were the only two manuals selected. That appears significant. Recent materials were requested to discover if changes were underway. Evidence of stereotyping in old materials will be presented later in the chapter.

There are available in Canada numerous career counselling programs/ vocational training systems (Employment and Immigration Canada, 1980, 1981). These cover areas of decision-making, information gathering, counselling for behaviour changes and specific job training preparation. Evaluation of these programs specifically is outside the scope of this paper. However a statement in one book raised some questions: "A fundamental assumption underlying employment counselling is that behaviour is learned and can be changed. It is an optimistic view that change or growth is possible and that realistic goals can be accomplished" (Bezanson, DeCaff, Stewart, 1982, p. 1). On one level that view of human nature creates no difficulty. The conflict with this assumption in terms of women and career goal development is best stated by a Waterloo High School Teacher, "I don't have any trouble persuading them (girls) they should take math and science, but I do have trouble explaining to them that when they get into the world of work they're

*used by permission from an interview on April 18, 1984.

going to be paid less than the men" (Ottawa Citizen, October 1983).

It appears as if some High School career and guidance programs and adult vocational counselling attempt to adequately prepare women for the labor force and family life. The underlying assumption, in theory, is equality.

The following section will explore, through studies and articles, sexual stereotyping in the schools, student and teachers' perception of sex-typed occupations and female preparation for family and/or careers.

Review of Educational Studies

Child development experts have long stressed the importance of early childhood influences. These early influences, beliefs and values will remain with the child as a base line of behaviour--unless very conscious and conscientious efforts are made to change them. Studies point to children's sex-typing of occupations. These tend to increase with age until senior college-age level. Young children (Teglasi, 1981) were asked to select a boys' toy, a girls' toy, and a best toy. Results were in accordance with traditional stereotypes with best toys also being boys' toys. When they were further asked to select female occupations, male occupations and best occupations, the results were in line with the toy selection results. The author suggests that as the children get older, their sex-typing will solidify. "It is not the existence of stereotypes alone that has implications for development of self-concept and career development but the value differentiation associated with them" (Teglasi, 1981, p. 195).

A study (Hageman, Gladding, 1983) of third and sixth graders found that the younger children agreed on three times as many occupations

appropriate for both sexes as the older ones. Girls could accept some non-traditional careers for themselves. Boys were consistently more traditional in their choices both for themselves and for adults. The authors felt that role models of people in non-traditional jobs did increase the children's possibility of exploring these occupations. However, as of 1983, there is a long way to go before most occupations will be considered "sex-free".

If sex-typing of roles and careers increases with age as these two studies suggest, the question arises about cause. Do the girls become more "realistic" in their evaluation of society and their place within it? Does the treatment the girls receive within the school reinforce these notions and decrease their self-confidence to challenge them?

Scheresky says, "In our society a conflict occurs between the ideal the society endorses and the actual practise of the society regarding this equality" (1977, p. 220). Her study again saw 6-8-10 year olds aspiring to sex-typed occupations. Dreams fall away when girls are asked to be realistic. Then they see themselves doing what society sanctions women to do: clean house and raise children. She suggests children learn this early and there is no evidence to suggest that the educational process decreases this trend.

Gettys and Cann's (1981) study of two and a half to eight year olds again confirmed the male/female occupation distinctions with the rigidity increasing by age. The authors say that by the time children enter school they are able to accurately understand and identify adult male/female divisions. The most probable source of information they suggest is television and children's books (Gettys & Cann, 1981, cite Women on Words and Images, 1975a, 1975b). There is evidence that

stereotypical information from these sources is weakening (Gettys & Cann, 1981 cite from Kreidberg, Butcher, White, 1978). But given the bombardment of stimuli children receive from television and books, a few non-sexist ones will hardly alter the present effect. Ashby and Wittmaier (1978) underline the importance of non-sexist literature in broadening girls' information base and subsequently their aspirations.

Studies such as Garrison (1979) found that female high school students' aspirations were slowly increasing. This was particularly true in relation to high-status professions. Perhaps this is a result of public awareness, further education, changing family life patterns and legislative efforts at equality. Garrison is optimistic that the "growing belief in equality is accompanied by plans to act upon that belief" (1979, p. 183).

Success for women has stereotypically been tied in with physical appearance. The early feminist career woman was typed as masculine and unattractive (Friedan, 1973). Lanier and Byrne (1981) cite a study (Lausch and Lanier, 1976) which supports the idea that it is increasingly threatening to adolescent girls to be academically successful because success brings negative consequences--such as not attracting a man. Television (commercials particularly) leaves the impression that female beauty is there in order to attract a man which is necessary for female happiness (and motherhood). Westervelt quotes an undergraduate student, "I am a woman, I have been socialized to want to be desirable to men, to be feminine. Yet to be successful in my chosen field and in school, I must exhibit masculine traits. It is confusing and disrupting to me" (Harmon, Birk, Fitzgerald & Tanney, 1978, p. 7).

Bell (and others, 1980) found in their study that teachers rated those children high in self-esteem who were perceived as assertive, athletic and active, typically masculine traits. Masculine personality typed women were found to be most likely to choose non-traditional careers (Wolfe, Betz, 1981). Lanier and Byrne (1981) on the other hand, found attractiveness correlated positively with success and that teachers perceived attractive children to be brighter.

The findings are not clear. Explanations for apparent contradictions could possibly be conjectured. However, the meaning and ownership of female attractiveness is certainly an element of feminist discussion and undergoing changes. This issue is relevant to the topic because if attracting a man (for marriage and family) is a major female goal, and if you are attractive you will "get one", then beauty is important in meeting feminine fulfillment. The confusion arises when attractiveness is also associated with ability and career success. The dilemmas and questions are significant but need clarification.

Teacher bias and teacher as role model are factors that influence children's developing self-concept. Wirtenberg (1980) found in her study that teachers interacted more with boys than with girls and displayed obvious sex-role stereotypes. Block (1981) also found that teachers responded more frequently to boys than to girls, both positively and negatively. Girls in high achievement groups received the least amount of support and positive feedback. One message that girls seem to receive is that academics are really not their concern.

In a 1983 study (Moore and Johnson), teachers were found to have a direct influence upon student educational decisions. These teachers grouped around traditional male/female occupation categories and in turn

perpetuated existing systems of stratification. They also have definitely lowered expectations of their female students. Educational and occupational possibilities for these students decreased through the educational process, say Moore and Johnson.

An important area of teacher influence is through role-models. Males generally hold more prestigious positions in the school and females are seen as less professionally committed (Block, 1981). Flora McDonald says, "In the past ten years, the number of women principals has dropped by about four per cent in a profession dominated by women" (Gall, 1984). The fact that women work primarily with elementary school children perpetuates the stereotype of women belonging with small children (Long, 1982). It is associated with childrearing, which is supposedly "natural" rather than an academically professional career. The Long (1982) study supported the hypothesis that "psychologically androgynous persons "choose elementary or secondary teaching on the basis of personal preference, whereas "feminine" females and "masculine" males choose stereotypically. This would appear to have incredible role model implications.

Teacher bias has been particularly studied as it related to maths and sciences. Girls, says Fennema (1980) are receiving inadequate instruction and support in maths and the message is that it is for boys. "Without adequate mathematical training, women will never achieve equity with men in the world of work. . . Mathematics is truly the critical filter that keeps women, as well as some men, from many desirable professions and vocations" (p. 169).

A study at John Hopkins in 1980 speaks to the issue of sex differences in mathematical ability (Zakariya, 1981). There is in fact,

says the study, a large sex difference. Restak reports, "It was the conclusion of these researchers that this difference results from the males' superior ability in spatial adaptation . . . they found that the most highly capable mathematicians are all men" (Zakariya, 1981, p. 47). Although not a statement of female inability, it again puts pressure on girls in their study of math. A member of the Toronto Board of Education said, "Math is perceived as a male domain, even though it is essential in many of the careers which offer the greatest financial rewards" (The Winnipeg Free Press, May 17, 1983). Socialization is the problem say some, not ability. A journalist from the Western Producer says to adolescent girls, "There is no difference between the brains of men and women. You think they're (math and science) difficult because a society which tries to keep you in your place has led you to believe that" (Ford, 1984).

The fact is that girls are not enrolling in math and sciences in the same numbers as boys. In Toronto in 1984, 35% of Grade 13 girls compared to 65% of boys are enrolled in math (Bullock, Toronto Star, March 1984). A recommendation made by the Science Council of Canada was to have sex-segregated science classes (Delahey, 1983). Evidence suggests that in all girls' schools, greater numbers of girls take science (Delahey, 1983). Muir (1982) believes that when there is not the pressure of competition from males and the fear of behaving inappropriately in a male field, girls do well in sciences.

The school studies examined suggest rather powerfully that stereotyping in the educational system is far from breaking down. It is still exerting its particular influence on its students, and will need considerably more time and effort to effect major change.

Marriage/Career Expectations

A 1979 study (Bullock, 1984) found that 80% of high school girls thought getting a university degree would lessen their chances of marriage and also that children of working mothers become juvenile delinquents. Two assumptions implicit in this finding are that if you are married you will have children and that you will not need to or want to work outside the home and will devote yourself totally to your children.

Two studies of college women also revealed a very high percentage of them choosing to marry (Blaska 1978, Greenglass & Devins, 1983). Greenglass and Devins reported 88.4% of the women planned a career, 67% indicated it was "very important"; 85% expected to have a career and a family. But of these, only 10% planned to pursue a career with preschool children at home. The priority was obviously family. Since women who want to succeed in a profession must often prove to be super competent (in a career and as a mother), a woman with joint careers is under an incredible burden.

It seems as if younger females still place themselves in either/or situations in terms of career planning and choice--you can't be married, have children and have a career. College women appear to have a much stronger commitment to combining career and family. (This has not taken into account the women who don't continue their education after high school--how many of the 80% of high school girls who wanted only family continue on to college?) However the information, limited as it is, has some significant value.

Various problems arise from these expectations. High school course choice is significant in determining future educational and occupational

possibilities. However, if at this stage it is perceived as unnecessary, decisions having long-reaching effects are made. Ford says it well, "It seems unfair to have to make lifetime decisions when you're only 14 years old and the most important thing is to have a date for the Grade 9 dance. But it's even more unfair to condemn youself to always being treated as a 14 year old, which is about the level of treatment that uneducated, unskilled women workers are afforded" (1984). If marriage is the goal of so many high school students and a working mother is the cause of juvenile delinquency, the shock of reality creates quite a conflict.

Marriage/Career Reality

The National Council of Welfare (1979) reports that only 26% of women remain married until they die. Marriage does not guarantee economic security. Only 9% of married women as compared to 54% of formerly married and 44% of single mothers are poor. Three out of every five poor adults are women. Sixty-two per cent of working women work in traditional female clerical, sales and service. Only 5% of working women are in top level wage jobs. In Ontario, 56% of women are in the labor force; of these, 80% will remain there for over 30 years.

The College women who were planning to interrupt their careers to raise children at least to school age will lose skills, experience and economic benefits. A woman is still penalized for having a baby and staying home (CACSW). During the time she is at home she is particularly vulnerable to the stresses of motherwork, social ambivalence about her status and her own expectations (Literature Review). Altman and Grossman (1977) found that daughters of "working

mothers" seem to have a less traditional career orientation. An interesting dilemma appears--if a mother "works" her children can be neglected (inadequate child care, CACSW, 1982) or delinquent (female adolescent fears, Bullock, 1984); if she stays home she is a "good" mother, but reinforces sex-role stereotyping, increasing her daughter's chance of staying in low paying dead-end jobs.

The 10% of the college women who were planning uninterrupted careers, and of course all other mothers in the labor force will be confronted by grossly inadequate child care facilities (CACSW, 1982). In 1980 there were only about one sixth of the required licensed day care spaces available. In a 1984 CACSW report, this figure had dropped to a little better than one tenth. This stress is further accented by inhibitive costs. Although subsidy is available (varying from province to province) for some and not as economically necessary for others, for a large group who are just above the "turning point", the cost is high. For these low income families who have to pay the full cost, the questions are: does the second income cover the cost? is it worth it? who will stay home? Usually mother stays home.

Summary and Conclusion

A 1978 study (National Council of Welfare, 1979) found over half of the high school girls believed that their main role in life was to be a wife and mother and expected to stay home while their children grew up. Another study found college age women with an increasing family and career interest, although the priority was overwhelmingly family. Yet statistics say (National Council of Welfare, 1979) that only 1 out of 4 women remain married and 3 out of 5 poor adults are women. Why? A

likely explanation is "that one-half of the population of this country is brought up on the assumption that it will always be financially taken care of by the other half" (National Council of Welfare, 1979, p. 2). It is still assumed according to the studies cited, that women will take primary responsibility for children and house. When their male provider does not turn up, leaves or dies, the women are inadequately educated, trained and equipped. "In most cases, women are poor because poverty is the natural consequence of the role they are expected to play in our society (National Council of Welfare, 1979, p. 51).

The status of "housewife" which is the work of the motherdream, is low. Occupation housework was ranked 52 out of 93 when a female was doing it and 8 out of 93 when a male was doing it. Secretary (which accounts for the greatest percentage of the female labor force) was only 1 up from housework. Does this suggest that it is acceptable for females to do low status jobs, but not males? When the husband's status is low, his wife's status decreases (CACSW, 1978). Five Million Women: A Study of the Canadian Housewife examines housework as a job, realizing that for many women in the labor force this job remains theirs also. A poster on a University of Manitoba Education professor's door reads, "A woman's place is in the home and she should go there immediately after work".

The CACSW quote Warrior (1975), "Housework (like other slave labor) . . . is a function that certain people are slated for from birth, because they possess certain physical characteristics. This is one of the factors that has made it easier to oppress both women and blacks (National Council of Welfare, 1979, p. 12). This statement is a rather far cry from the "rose covered cottage" dream of Pampers' commercials

(see Chapter 5). John Kenneth Galbraith in Economics and the Public Purpose (CACSW, 1978) coined the phrase "convenient social virtue" to describe the attitudes that the industrial world used to glorify menial tasks so that one group of people will perform them for another group. "The ultimate success of the convenient social virtue has been in converting women to menial personal service (p. 12). Although the practice has been discontinued, a British judge in 1973, sentenced a man to a specified time of cleaning someone's apartment (p. 13). This form of "deterrence" is many women's daily lot--for what offence?

Both the National Council of Welfare in its Women and Poverty (1979) and the CACSW in its As Things Stand (1983) agree that it is a myth that the situation of women has greatly improved in the last ten years. "Ten years ago, the majority of Canadian wives were full-time housewives. Today the majority of wives are in the paid labor force (CACSW, 1984, p. 5). Positive changes have occurred in the legal status of women, but effects have yet to be tested (e.g., sex and equality in the Charter of Rights). In health areas such as birth planning and abortion, there is a definite deterioration.

The wage gap has not diminished. "Ontario Labor Minister Russell Ramsey says he is afraid that a law requiring equal pay for work of equal value could close businesses and put some people out of work . . . the straw that breaks the economy's back" (Stead, 1982). Federal NDP Member of Parliament Margaret Mitchell told a Winnipeg news conference, "the recession has widened the wage gap between men and women in the federal public service to 12%, with pay cheques over $7000 more for men than women" (Free Press, Winnipeg, March 8, 1984). Deputy Premier of Ontario, Robert Welch, said about equal opportunity and wages, "there's

no point pretending legal battles are instant remedies. Even if we could speed up the wheels of justice, we can't legislate social attitudes" (Ottawa Citizen, 1983). This asks rather clearly then, how are attitudes changed? For this paper, the question arises--what role does the educational system have in this process?

The questions that prompted this study concerned the perpetuation--or challenging of the Motherhood Mythology in the Educational system, combined with an overview of the home/work reality facing women. Few answers were arrived at. Further research would be necessary to clarify this area. Interviews of teachers and principals as to utilization of relevant materials, attitudes toward stereotyping and examination of Board policies would be useful. A study of children's perceptions of social attitudes in their school systems and of their curriculum could be done.

The two study guides examined in this chapter revealed one major significant factor--that in the educational system there are educators who have "official" goals of sexual equality. Obviously what it cannot reveal is to what extent the specific material is utilized and whether the attitudes inherent in the material are common. Since both curricula are very recent (1981 and 1982) the effects cannot be evaluated for some time.

The studies of sexual-stereotyping in the schools revealed a rather overwhelming result in the direction of student sex-typing of occupations and teacher sex-differentiated instruction, perception and attitudes. Girls place family as a high priority although evidence suggests careers are gaining more commitment as well.

The reality of the work world for women places them in quite a difficult situation. As education broadens its scope to actually include women, and career aspirations do increase, women are faced with stark facts of underemployment, unequal pay, poverty and inadequate child care facilities. They find they can't achieve what they expected--either with their families or in the labor force.

More questions than answers again arise out of this--Does education and knowledge break down the myths of female happiness and security only as wife and mother? If myths are emotional needs and desires, what role does education have in the realistic preparation of male and female students for their life plans. The notion of males and females growing up in different psychological contexts and thus developing in very different ways (Gilligan, 1982) must have an impact on the educational process. Would differential treatment, and acknowledgement of these different worlds perpetuate the system or begin to bring equal value standards to each system. Does uniform treatment perpetuate the system by speaking male language to females who don't speak that language at this stage?

This paper cannot explore these questions to any length but emphasizes the need to see these discussed. Gilligan suggests that women socialized to relationship/nurturance as their primary development need, cannot focus on separation/achievement until this has reached a resolution. This significantly occurs at/after the biological time of mothering.

From this study it would be inaccurate to conclude outright that the Educational process perpetuates the Motherhood Mythology. It is obvious, however, that the Institution of Motherhood with its dreams, misrepresentations and sexual stereotyping, is very much alive within the Educational System. There is some evidence that suggests challenges to this Mythology are occurring and will continue. The wonder is that in 1984, so little has changed.

CHAPTER IV

MEDICAL MESSAGE OF MOTHERHOOD

"It is an offense, according to the Medical Act, to practice medicine (which is defined as including the practice of midwifery) except in emergency situations, unless one is registered with the College of Physicians and Surgeons of Manitoba" (Community Task Force on Maternal and Child Health, 1981, p. 4). Since most physicians are still male and/or male trained, birthing is a male dominated process. Welburn (1980) says, "It is men who decide how, where and increasingly when, women will give birth" (p. 46). A psychoanalyst repeats this, "The doctor and the gynaecologist are the authorities who, in the main, prescribe the circumstances of the birth which takes place in their building and under their guidance and control" (Lomas, 1978, p. 175). Besides the enforced hospital births women are subjected to an increasing number of elective inductions and caesarean sections. Under this system most women begin such an important event in their lives; "a situation which inevitably creates alienation" (Welburn 1980, p. 46).

In this chapter, the writer will explore the birthing preparation and experience as determined by childbirth preparation classes and hospital obstetrical nursing manuals. Although other factors affect this experience, this paper will need to be limited to these two areas. The study is prefaced by an historical overview of birthing and a brief discussion of present childbirth concerns. The questions underlying this study will be how this pre-natal information and nursing philosophy and procedures affect a woman's expectations and reality of birth. How do they relate and contribute to her development as a Mother? If, as

Burst (1983) suggests, the control of birth is a highly political issue of patriarchy and women experience this as a fundamentally alienating process (Welburn, 1980), what are the implications for mothering and the Institution of Motherhood?

Review of Birthing History

Traditionally birth was women's business. The knowledge of birthing and of attending at birth was passed on from woman to woman and from generation to generation. Birth was likely neither the ecstacy of strong natural childbirth advocates nor the horror of contemporary medical design (Lomas, 1978). It was treated as the natural process of human reproduction. It was also a crisis which called out culture-specific rituals and customs. These, for whatever reasons, served to mark the physical and social rite of passage of the woman to Motherhood (Stern and Kruckman, 1983).

In the Middle Ages, the Church embarked on a deliberate and well documented persecution of women. The midwives/healers received particular attention (as discussed in the Literature Review, Historical Development of Motherhood Mythology). The tenders of birth came through this period tainted with suspicion and superstition. Often proclaimed as the victory of science over magic, it has been reinterpreted by Ehrenreich and English (1979) as the victory of male power. Men had won this battle over control of birth and slowly began to replace the women as experts. In the 1600's Louis XIV, a layman, invented the birth table or modern delivery table. In the 1700's specific obstetrical knowledge and teaching developed. In the 1800's the conquest of the dreaded puerperal fever (ironically caused by the obstetricians), the

development of obstetrical anesthesia, use and refinement of forceps, development of the isolette and growth of modern nursing moved birthing deeper and deeper into the realm of medicine. In the 1900's the evolution of the male midwife and obstetrician reached its present state. Some of the social factors that contributed to this were the low status of women, influx of poor immigrants and the opportunity to practice their skills on cooperative willing victims.

Burst (1983) and Lovell (1981) emphasize that economic competition and political power were key elements in developing modern obstetrical medicine. "Historical inquiry into the development of the medical profession as a business discloses that the focus on control is important in the maintenance of social inequality and in the persistence of health problems in women . . . The development of medical dominance would have been severely impeded if women had not been commodities to be used" (Lovell, 1981, p. 26).

The midwife, who was the keeper of centuries of birth knowledge and likely knew the sensations and meaning of birth through her own body, was relegated to the sphere of the ignorant, primitive and illegal. Midwives as "specialists of the physiology of human reproduction" (Community Task Force on Maternal and Child Health, 1981, p. 1) were replaced by obstetricians who are "specialists of the pathology of human reproduction" (p. 1). Since they lack first hand knowledge of a woman's body and are trained to perceive the female body as deficient (Freud, 1933), they must rely on the medical procedures they have been taught (Community Task Force on Maternal and Child Health, 1981).

In Canada we have legalized this control of birth and made a clear statement about female birth wisdom. "Of the two hundred and ten

countries in the W.H.O., only eight, including Canada, are without systematic provision for support by a midwife during normal childbirth" (Community Task Force on Maternal and Child Health, 1981, p. 2).

"In such an atmosphere of paternal domination of home and society, feminine passivity was encouraged and the childbearing function moved from the control of women with female midwives in the home to the control of male physicians determining the child bearing experience of women in the hospital" (Burst, 1983, p. 44).

After women were eliminated from healing, medicine/man was free to define female health and disease. Lovell explores how this was done in ways that kept women subservient, silent and grateful, and physicians powerful and rich (refer to Literature Review, Historical Development of Motherhood Mythology). Women were kept as perpetual patients. Nurses and wives were also useful tools in order to keep women in place. Using Freire's oppression theory, Lovell describes how these women modelled themselves after the men they worked for, gained their satisfaction from imitating their masters, and received "token material pacifiers" (1981). Left out of the decision-making process, they were expected to obey and leave everything in His capable hands.

In 1975 Arms published an angry and radical account of birthing in North America. The history of childbirth, she says, is a "chronicle of interferences in the natural process" (p. 26). Anesthesia, physical confinement in an unnatural position and surgical procedures "just in case" are just naming a few. Through the last decades, women have begun to organize, protest and reclaim birth as their own. They have become informed and assertive. "The conflict is intense and severe between women and physicians who disagree over who has control over the

woman's body and who will dictate what the childbearing experience will be" (Burst, 1983, p. 48). The struggle is far from resolved as medicine moves further and further into high technology birth. Birth is pathology and Man/Machine is still the expert. The reward is a baby--what is the price?

Present Childbirth Concerns

Welburn quotes one doctor as saying, "Medicine is initially a technical operation which involves doing the bare technical necessities and when it comes to childbirth the technical operation is getting the baby out alive and keeping the mother alive and getting them home, and that's it" (1980, p. 51). An easy next step is to redefine the woman as a mere functioning uterus with all the alienation that implies. Sheer physical emptying of the uterus as the sum of childbirth totally ignores the impact of emotional and social factors. "It (birth) is one of the most profound and important experiences in a woman's life" (1980, p. 47), in her life, not the doctor's.

What are the current issues of conflict between medicine and women? If, as Welburn contends, medical science is the domain of men and childbirth is their property, what is happening to women in the process of birth and becoming mothers?

When a woman first confirms her pregnancy, she begins a one year process of close medical supervision. She is advised on and strongly encouraged to follow specific regimens on diet and physical fitness. Her blood pressure, fundal heights, fetal heart rate, blood and urine are monitored and recorded. She is most likely registered for a 6-7 week session of prenatal classes late in pregnancy--often adding a 1-2

week Early Bird session in the first trimester. Quickly subjected to ultrasound and frequently to amniosentesis, she is categorized and recategorized according to parity (number of births), age and medical risk factors.

There appears to be a tension between the knowledge and information a pregnant woman is expected to have and the still prevalent attitude of "Daddy knows best" (Welburn, 1980, p. 48). Technical details of prenatal classes combined with endless medical monitoring collide with, "You are going to have to answer a lot of questions and be the subject of a lot of examinations. Never worry your head about any of these" (Welburn, 1980, p. 52). The childbirth preparation is obviously meant to include the woman as a "participant" in the birth, to give her knowledge which will reduce her fear and from which she can make choices. Perhaps unwittingly these too have contributed to the medical image of birth as pathology. "Society in general makes every possible effort to prevent the pregnant woman from accepting pregnancy and labor as a natural physiologic function. The same amount of attention to eating would make most of us have nervous indigestion" (Arms, 1975, p. 71).

Childbirth preparation in Great Britain is simpler says Chris Robinson* (Labor and Delivery Education Director at St. Boniface Hospital--former nurse midwife in England). Implicit in this method is the assumption that birth is physiologically natural therefore less is made of the process itself. The emphasis is preparation for the child rather than childbirth preparation. The naturalness of having a baby is reinforced by a society which is prepared for chldren, e.g., department

*with permission from an interview on May 28, 1984.

stores and train stations have rest areas for breast-feeding, strollers are available everywhere. Babies are visible and integrated into public life. Babies are normal. The transition to parenthood will not be as fraught with opposition and tension as in North America. Perhaps in their zealousness to claim birth for women, our childbirth educators have not adequately examined the long term effects, implications and assumptions of their belabored process.

The debate around analgesia/anesthesia is critical to the control issue. Welburn says there is still a "strong cultural undercurrent that women should suffer during labour, a hangover from the 'pregnancy as punishment' attitudes towards sex" (1980, p. 51). Biblical references reinforce the "should" of women in painful labour as punishment for the seduction of Adam. The medieval church regarded any pain relief in childbirth as blasphemy.

There is some evidence that the midwives had developed concoctions of analgesic herbs which they gave to their laboring women (Ehrenreich and English, 1979). However, they also understood pain as a part of birth. Rich (1976) makes a distinction between suffering as pain which can be faced as a challenge, and affliction, as pain which is the lot of the powerless and the oppressed. The task of the midwife was to face and challenge the suffering/pain of childbirth--to work with it, to guard the process, to be assuring and present, to assist. The loss of ownership of birth has turned childbirth into affliction/pain to be denied, or feared and removed. But, warns Rich, though suffering is not to be sought, rather used as an opportunity for growth, "the avoidance of pain--psychic or physical--is a dangerous mechanism, which can cause us to lose touch, not just with our painful sensations, but with

ourselves" (Rich, 1976, p. 152).

The 1940's saw total anesthesia as the popular birth pain relief. Mothers could release their entire birthing process to the physician who presented them with a baby after they awoke. Arms (1975), Rich (1976), and others suggest that it is the male fear and misunderstanding of pain and their need to be in control that led to the extensive use of anesthesia. "A doctor anesthetizes himself through anesthetizing a woman, in order to avoid his own fear about pain" (Arms, 1975, p. 158 cites Hermein Watkins). Women in their natural life cycles touch pain (and death) regularly and before the interference of medical science understood or accepted these sensations (Welburn, 1980; Landsberg, 1983). Without this inherent knowledge the doctor sees (him)self as heroic when during a difficult time in the labour a woman turns to him with "help me". He takes over and medicates. "I wonder if any of you realize what is the <u>hardest</u> thing to do in midwifery? It is to do nothing? Further, I wonder if you realize what is the <u>most important</u> thing to do in midwifery? It is to do nothing?" (Welburn, 1980, p. 68) says Dr. Matthew Duncan. Who is present during a hospital childbirth process who can know the woman's needs and can know the complexities of the birth experience?

Louis XIV's invention of the birth table is still in use today after 300 years and despite its proven medical/physical disadvantages for the woman. This King enjoyed watching birth and could do so more comfortably if the woman was on her back with her feet/legs tied up. Traditionally women have used positions of their choice any of which followed the laws of gravity--standing, sitting, squatting, etc. As the man midwife took control, the women were forced into the most

uncomfortable position (for them) and the one that causes the most difficulty for woman and baby medically. Dr. Caldeyro Barcia, president of the International Federation of Gynaecologists and Obstetricians is quoted as saying, "Except for being hung by the feet, the supine position is the worst conceivable position for labour and delivery" (Welburn, 1980, p. 58). Aside from the iatrogenic complications of hypotension, fetal hypoxia, prolonged second stage of labour, forceps and episiotomies, the issue is again, who has control of an experience that is fundamentally female.

"Bonding" as proposed by researchers Klaus and Kennel is interestingly also a "man-made concept". A midwife attending birth would traditionally place the baby on the abdomen, providing immediate physical contact and serving to increase uterine contractions to release the placenta and stop blood flow. After the cord was tied, the baby was placed at the breast. This was again physical and eye contact which also served to increase uterine contractions to stop blood flow. It was the medical intervention of high technology which removed this natural contact. Lost were its essential physical benefits and its emotional relational elements.

The bonding concept gets its support from two sources; studies of imprinting behaviours in animals, and studies related to maternal deprivation and separation (Elliott, 1984). A problem with the first source is one of transferring animal behaviour directly to human behaviour. A problem with the second source is that the maternal deprivation studies which showed severe infant difficulties were done primarily with institutionalized babies. Later studies of infant/maternal bonding for a "sensitive period" (a definite time during

which this contact must be made) were inconclusive. Klaus and Kennel's research and conclusions were zealously and literally applied now to all mother/child situations as the answer for mother/child relationship problems (e.g., post partum depression, child abuse).

Preventive medicine is a key phrase for much of modern obstetrical care. "Prevention can be worse than the cure. . . To live is to risk. Without risk we are all living in that padded cell. Prevention has a break-even point. Up to that point it is helpful, beyond that point it can be harmful. Obstetrics has now passed its break-even point" (Welburn, 1980, p. 60). Routine episiotomies "just in case", perineal shaves, enemas, intravenouses, fetal monitoring "just in case" are all invasive procedures. All contain a degree of risk. More and more doctors are saving babies and mothers who might have died without medical help. More and more women and children are experiencing alienation, depression and loss with medical intervention (Arms 1975, Rich 1976, Welburn 1980). Cohen and Estner (1983) quote Diony Young as saying that a "positive childbirth experience appears to create in the mother an increased self-esteem and self-confidence. A negative birth experience, where fear and pain predominate, may adversely affect a mother's feelings toward her child" (p. 37). Women are caught--if they obey and submit they are promised a live baby--if they refuse they are legally liable for child abuse (Community Task Force on Maternal and Child Health, 1981) and emotionally and socially ostracized as irresponsible. The price is their integrity. Dr. Frederick Leboyer, a French obstetrician, says the price is also on the child. Of modern hospital births, he says: "Such is birth. The torture of the innocent. One would have to be naive indeed to believe that so great a cataclysm

would not leave its mark. Its traces are everywhere; on the skin, in the bones, in the stomach, in the back, in all our human folly, in our madness, our prisons, in legends, epics and in myths" (Welburn, 1980, p. 83).

An argument put out by medicine and the recent trends to regionalize all perinatal care is essentially "every woman deserves a live baby (and the advantages of high risk technology) and we're going to see that she gets one." It's an emotional argument and difficult to disagree with. There are two immediately apparent problems in it. The first being the one of control--who decides what for whom? The second one is that in this system little "real" provision is made for normal uncomplicated childbirth care (Shearer, 1977).

"The basic belief that childbirth is a high risk ailment underlies obstetric intensive care and calls for routine use of the latest tests and technology" (Shearer, 1977, p. 145). A Winnipeg physician questioned said, "Childbirth is perceived and treated as pathology". As evidence also is the fact of home births being so vehemently resisted--even with medical back-up units (Appendix F). There is a very deep conflict within the philosophy and management of birth. The philosophy may be that of normal physiological process, but treatment continues to be contrary to that. With the routine use of technology, a snowball effect is put into motion. For example, a woman is placed on her back and external fetal monitoring electrodes are placed on the abdomen. This increases the risk of maternal hypotension and fetal hypoxia--fetal stress--internal fetal monitoring (with its possibility of scalp abscess). The extended time in the supine position prolongs labour--augmentation of labour--increased pain--(analgesic or) epidural--prolonged second stage--fetal stress--

forceps--episiotomy and fetal depression--loss of control! A potentially uncomplicated birth becomes a crisis and a medical-surgical event.

Doctors are trained to do something. Says Robinson* "they are bored doing nothing so they start the process rolling and it's difficult to stop".

Doctors are overtrained to deal with normal birth. Medical socialization is in doing so doctors don't have the skills to support the woman psychologically and to wait for the process of birth to run its course, continues Robinson. For example, in the second stage of labour, the doctor is scrubbed and sterile (can't sit down and do anything else comfortably). Frequently the doctor and woman are strangers to each other, so comfortable small talk and reassurance is difficult. The women is then the object of the doctor's impatience. She is checked internally, over and over and over again. This can be excrutiatingly painful at this stage and offers no new information. Although there are many medical contraindications for such a procedure, it is acceptable practice. The effect of this is pain, humiliation and violation! Women coming to the Post Partum Counselling Service of Winnipeg have frequently used the word rape to describe this event. In a standard high risk birthing center the woman is repeatedly exposed and violated. Countless different people come in to check her internally. In order not to feel ashamed and to be able to live with themselves, women must distance themselves psychologically from the experience says Robinson. (Similar is the psychological distancing of men/husbands involved in the process.) They become "pathological", that is, in order

*quoted with permission from a conversation with Chris Robinson.

to justify what is happening to them and to save themselves, they must perceive themselves as sick--and submit! Robinson stresses it is not one person(s) responsible but an entire system which dictates medical control of birthing. She says also in the issue of episiotomies research has not borne out its necessity. Yet medical students, through the impatience of their teachers, are not taught slow controlled births, only surgery. They don't have the necessary knowledge and the system is perpetuated.

Until recently childbirth educators and medicine have acted as if when birth is completed the process is over. When the baby has been discharged, the mother takes over immediately. Throughout the event of birth she has been dependent, passive and excluded from the decision-making process. Then she is given the difficult and demanding task of mothering. She was treated as "sick", is now well and ready to get on with life. Even though some "bonding" may have occurred, the mother is not prepared for mothering. Stern and Kruckman (1983) suggest that the lack of respect and attention our culture gives to the post partum period results in further alienation, isolation and depression. Few support systems and the failure to recognize the tremendous social changes involved, contribute to post partum depression.

Pregnancy and birth are obvious major events prior to mothering. Preparation for birth and the birth experience itself are critical factors in the mother's self-confidence and self-esteem post partum. The following sections will explore and describe two prenatal programs and two hospital obstetrical units. What are the philosophies and protocol? What messages do they give about birth and mothering and what

implications do they have? In what ways do these institutions perpetuate or challenge the myths as portrayed in Chapter II?

Review of Childbirth Education Materials

"Freedom of choice through knowledge of alternatives" is the motto of the International Childbirth Education Association (ICEA). The childbirth education program of Manitoba Association for Childbirth and Family Education (MACFE) supports this motto (Appendix C). They elaborate this with, "we believe that there is a range of acceptable alternatives and that in providing access to credible information on choices available to them, we free parents to make the best decisions for their own families" (MACFE Childbirth Education Proposal, p. 4). The material stresses the respect for individual preference and that no one, including the instructor, has "right" answers. Rather, an aim is to teach the consumer (of the childbirth system) to examine it, understand the rationale for certain procedures and then make appropriate choices. The concept of shared learning appears to be used throughout--that is, couples learn from each other, from the instructor, and the instructor from the class members.

They "provide information and opportunities for discussion at the time of greatest need and concern" (MACFE Childbirth Education Proposal, p. 4). This seems to include an attitude of non-protection. Parents will not be shielded from potentially unpleasant information. This, in theory at least, creates the possibility for parents to raise their fears and concerns and to begin to build the bridge from dream to reality. There is a tension here that seems to need some attention. Needs and concerns are frequently created by given situations, social

values/systems and/or media presentation. Do these then accurately represent what is the greatest need at the time or are they socially induced needs which may later prove to have been inadequate? In this case the question could be asked whether the heavy emphasis on the childbirth process creates anxiety and of course tremendous expectations. This is reinforced by further elaboration and discussion. The trap is set for possible failure and disillusionment. The other side of this concern--is it useful to address a concern that is not consciously present? What is the responsibility of the educator--to raise new concerns and needs, then speak to them?

Do childbirth education classes adequately prepare prospective parents for birth? Is this their sole task or is it also to prepare them for parenting? Norma Buchan, Education Coordinator at Women's Hospital in Winnipeg, says that we have substituted prenatal classes for postnatal care. This emphasis on the birth puts too heavy an expectation on this event and then leaves the mother 72 hours after birth to virtually fend for herself. Chris Robinson states that in Great Britain the postnatal care is more extensive than is the prenatal birth preparation.

A unique feature of the MACFE program is its postnatal series. It acknowledges that "the childbirth experience (is) continuous in nature from preconception through pregnancy, birth and parenting, and requires tangible support, service and assistance throughout these stages? (MACFE Childbirth Education Proposal, p. 4). Although presently not as fully developed as its prenatal program, it recognizes the "fourth trimester". These postnatal classes include lectures by professionals in the areas of child development and health, child nutrition and development of

teeth. The emphasis appears to be somewhat "how to". The question this raises is whether the child centeredness fails to acknowledge the nature of the transition crises. Does it pay enough attention to the mother's (parent) changes--to emotional and social realities? The immediate concern of a mother (parent) is usually the child--do these reinforced concerns add pressure and guilt at a vulnerable time? An objective is however, to also "provide an excellent opportunity for participants to share their birth experiences, parenting concerns and establish contacts with other new parents" (MACFE, Outline of Courses). If specific professionals are brought in to discuss, do these sharing sessions actually occur? Is there permission to focus on the mother as well as the child?

In the preparation of this course, careful attention has been paid to physiological and emotional changes of pregnancy, labour and delivery. The primary focus is the process of labour and delivery--what is happening, what one can expect, and how to prepare. There is little evidence in the outline, philosophy and objectives of the romantic notions of "natural" childbirth--the aim is prepared childbirth. True to stated objectives, they present alternatives and make class members aware of the realities of a hospital birth. Mothers are encouraged to discuss a birth plan with their physician. They are the consumers and must take responsibility for what they want. This seems obvious. However the question could be asked whether the consumer of childbirth health care has in actual fact much control over what happens. It may present a difficult bind--yes the consumer is responsible to change a "system" that is not useful, however the consumer at this point is very vulnerable and under the control of the powerful medical system. When

women are told they have choices but on entering hospital find they have few, is the sense of violation and frustration even higher? The MACFE childbirth educators feel strongly that the consumer, given the knowledge, can begin to effect change. The issue of advocacy resurfaces.

One class session focuses on the post partum period stating objectives of identifying emotional and social changes in the self-image and role of the new parents. Reference is made to the possibilities of post partum adjustment difficulties and resources and options are suggested. The class outline suggests that a fairly comprehensive and positive discussion on the "post partum family" is possible.

A question could be asked about the balance between six classes on pregnancy, labour and delivery and one class on postpartum concerns. Does it overemphasize birth as the crucial event? If it is responding to public request for all this specific information, is it truly responding to need or who determines this? They state that "Birth is not simply a medical event but a 'life-crisis'--a time of change and growth that affects many aspects of one's life" (MACFE Childbirth Education Proposal, p. 3). This statement seems to send a confused message. Birth is a medical event--suggesting pathology. Birth is also a life crisis--suggesting a naturally occurring life event which constitutes a crisis for the woman (family). Which is it? What is the <u>starting</u> point? By merely informing class members about birth routines and procedures do they reinforce the recent trends to further medicalize birth? Do the endless details in medical language present an unconscious picture of birth as illness?

One statement in an overview on infant feeding appears somewhat more biased than the objectives would suggest. Both breast-feeding and bottle-feeding options are discussed. However, they conclude with quoting Dr. Richard Goldbloom, professor of pediatrics at Dalhousie, who says that there are two things formula doesn't have--immunization and love. The implication of course is that a bottle-feeding mother isn't able to give as much love. Is the love in the milk (bottle or breast) or in the delivery?

A second Childbirth Education program was examined (Gajdosik, 1984). The material obtained was of a very different nature and comparisons will be difficult. Parallel issues will not be raised. Whereas the MACFE program is only in its second year of operation, this program has been presented since 1974. The earlier program is still focusing on assessing needs and developing philosophy and objectives, the second one is more established in the personality of one instructor, rather than in written objectives. The course outline and labour guide however (based on Lamaze Childbirth classes) have been revised six times and are in revision again.

The course is divided into seven sessions. The first one is an "Early Bird" class usually done in the first trimester of pregnancy. This is an introduction with a focus on physiological changes and nutrition. The next six are done during the last trimester. The first four deal with preparation for labour and delivery, the last two on physical and emotional changes after birth and an introduction to parenting. A feature of the last evening is a visit and discussion by two "Lamaze families" who have "graduated".

The emphasis throughout is on knowledge of the birth process and practice of psychoprophylaxis techniques. "A mother cannot control the working of her uterus in labor but she can learn to control her reactions" is a caption on a labour practice sheet for mothers and their coaches (Gajdosik, 1984). Ferdinand Lamaze says, "a woman must be imbued with the thought that she is essentially responsible for the success or failure of her own childbirth" (Arms, 1975, p. 188). With this fear and guilt thoroughly in place, the fervour of its adherents is understandable. Childbirth is a natural female process--does it follow then that she can fail or succeed? If birth is an involuntary physiological act, are these words/concepts anything but value judgments and ultimately destructive? Is control of "birthing" synonymous with control of the passage of the baby from uterus to "world"? Margaret Mead says, "It should be pointed out that natural childbirth, the very inappropriate name for norms of delivery in which women undergo extensive training so that they can cooperate consciously with the delivery of the child, is a male invention meant to counteract practices of complete anesthesia, which were also male inventions" (Arms, 1975, p. 179). Besides, if there is medical intervention, how responsible is the woman for the delivery?

The place of men as central is very crucial to Lamaze birth. Although the original intention was to have a family centered birth experience, the word "coach" has for some people the connotation of "expert", "taskmaster" and "winning". It's interesting that the new term used for women who assist women in labour is "companion". "There are . . . forces at work today tending to bring men back to their time honored role as birth attendants" (Gajdosik, 1984 cites Chabon). This

seems to be sheer fantasy. Historically, men were hardly present during birth. This was "women's business", except of course as obstetricians for complicated births! The introduction of men is relatively new.

The packet of handouts for class members appears attractive, extensive, and comprehensive. It included nutrition pamphlets (even recipes) for mother and later baby, breast-feeding information, three copies of Canadian Society for the Prevention of Cruelty to Children (CSPCC) magazine, exercise/fitness booklets, information on development of the fetus and physiological changes of the mother, a booklet on Bonding, one on Birth Companion, Sex after the Baby, Caesarean Birth, and a Birth Plan Outline. A 50 page colorful book entitled Delivery and Beyond dealt with topics such as last trimester, getting back into shape, feeding baby, general baby care tips, baby-proofing your home and helping baby learn. The book seemed to be full of useful information, clearly and interestingly presented. A number of questions arise. Although the book is positive and very pleasant, there is little recognition of the ambivalence and anxieties as presented by Rich (1976), Washbourn (1979), Welburn (1980), and others. Physical discomforts are smoothly dismissed--"Perhaps the most comforting thought of all is that the soreness will go away soon" (p. 10), not mentioning how long it might take. The pictures are all beautiful, showing exquisitely gowned, made-up women, and smiling contented babies. There is no evidence of maternal fatigue or baby with "cone shaped" head! The information, though not inaccurate, is overwhelmingly and decidedly glamorous and romantic--The Mother Mythology par excellence! It seems to overshadow the rest of the packet.

In all fairness there is a little paragraph about "Love" (p. 34) together with sections on illness and clothing. "Yet there'll be many times in the first months of your baby's life when you don't think your little one is so lovable. Times when your baby wakes you in the middle of the night, then takes much too long to feed. At times like this you can hear your maternal instinct slamming the door on its way out" (Prentice Women's Hospital and Maternity Center, Northwestern Memorial Hospital, Hoffman, Gerbie, Edoff, Vitt, p. 34). On the opposite page is a full size color photo of a disarmingly beautiful, exquisitely dressed one year old. The disclaiming effect is powerful.

Is this message intended? Is this reality for some people or the dream? What effect does this have on a couple preparing for a first child? When their reality of birth and parenting do not match the happy affluent life of the families portrayed, do they read "failure"?

The article in the packet on "Bonding" by Diony Young stresses the importance of family-centered medical care. Mothers and babies belong together. It is important for the emotional well being of all concerned. In this she includes father and siblings. Her approach is multi-dimensional and seems realistic. Many factors affect bonding, she says, and mothers separated from their babies at birth as well as adoptive mothers do "develop a close, loving maternal bond with their babies in the early weeks and months" (Young, 1978, p. 1). She speaks of nurturing, which has connotations of an ongoing process, rather than bonding which suggests a time limited event.

A new feature of the program is its use of Dialogue Questions at the end of each session. The instructor gives a few open ended statements--asks the couples to write their answers separately. This is

done as homework. Questions about their expectations of the birth experience, about each other, about recovery and about parenting are just a few of the questions asked. Couples are encouraged to share their answers and discuss them throughout the week. The objective is to get couples to formulate and share their expectations of themselves and each other, their fears, anxieties and feelings about what is and will be happening. It would be difficult to monitor the effectiveness of this, but it holds creative possibilities. The statements can be useful in merely giving the couples words like "fear" and "expectations" to deal with in relation to this experience.

In a discussion with the instructor and writer of this program, the question was asked whether an attempt is made to bridge the gap between the ideal and the reality of a hospital birth. The technology of high risk centers is certainly far removed from the ideals of the Lamaze birth. She replied that information is given about routine hospital procedures and the different possibilities that could occur. She also said that she encourages the couples to discuss and prepare a Birth Plan. This is agreed on with the physician who hopefully can implement this in the hospital. It is the responsibility of the couple to find a physician who will work within their request. It would be interesting to find out how closely these plans are adhered to in the hospital. How do hospital staff respond to them. What is the effect of broken plans on the couple?

This program is a strong attempt to make birth and parenting a joyful experience. The sense of excitement and anticipation literally glows from every article. This is one side of parenting and a very obvious strength. There is a glaring lack however, of any mention of

the daily struggle and confusion of mothering a new baby. Is this discussed in class? Is there permission to acknowledge this side? On the other hand, is there a price for being too realistic? Does it, as some suggest, substract from the excitement of the new birth?

Review of Hospital Obstetrical Materials

Material examined at the Women's Hospital, Health Sciences Center, included Philosophy and Objectives of Maternity/Newborn Nursing, (Appendix D) Integrated Post Partum Care as well as standard nursing procedure manuals. A conversation with the Director of Special Education projects helped elaborate and clarify the positions and goals of nursing care at the Women's Centre.

Article #1 of the Philosophy of Maternity/Newborn Nursing (1983) states: "We believe that the Maternal/Newborn Nursing Service at Women's Hospital has the unique responsibility of caring for women at one of the most critical periods of their lives, of including their family and of fostering interaction between the parents and their newborn child. We recognize that not all pregnancies have happy outcomes and we acknowledge our responsibility to support and comfort the grieving family". This statement recognizes the crisis nature of childbirth for the woman and her family. It also acknowledges the reality of death and/or other unhappy outcomes.

Article #4 of the same philosophy sheet states: "We believe that we are the patient's advocates and are responsible to coordinate the efforts of other professionals in the hospital and community on the patient's behalf". A 1982 Philosophy of the general Department of Nursing, Women's Hospital, raises the advocacy concern by saying: "We

believe that nurses have a responsibility to be advocates for patients in promoting and maintaining their human rights and dignity".

When a woman is admitted to maternity at the Women's Centre, she becomes a patient in a hospital that is 60% high risk. That is, 60% of the women have been diagnosed as being at above average risk for the delivery of their babies. It would seem advocacy would be a concern. Because the hospital is a high risk referral center as well as a teaching hospital, it would be easy to assume that procedures would be high technology with an eye to research and practice. How are patient rights maintained in such an atmosphere? "The parents will be involved in making decisions regarding care of mother and baby" states an objective. What does this actually mean in light of the high risk label the majority of the patients have? What happens to the 40% who are not high risk? Are they protected from these routines?

A Nursing Procedure manual includes as a standard procedure a 20 minute fetal monitoring for every patient. It would be safe to assume that the route of choice for monitoring would be external. (This involves a belt and electrodes secured around the abdomen and connected to a monitor.) However, the possibility of internal monitoring is not removed. Should doubts remain, this quickly becomes established. "Monitoring carries inherent risks to the mother and fetus. Maternal risks include infection and unnecessary operative delivery for 'fetal distress'. Fetal risks include scalp abscess, infection, haemorhage, and trauma. Therefore only fetuses considered to be at risk for intrapartum asphyxia should be monitored" (Fetal Heart Rate Monitoring: Indications, Methods and Interpretations).

A 1977 article (given along with the material at the hospital) states that, "although most academic hospitals require routine fetal monitoring, the only controlled studies have shown that there was no difference in any measurable parameter between electronically monitored high-risk newborns and matched groups of high-risk newborns who were monitored during labor by a nurse with a stethescope". The implications and questions are interesting. Is technology used because it is available? Is is more cost-efficient? Is it more interesting for the technicians supervising the birth? What are the psychological implications of replacing a nurse with a belt, electrodes and machine?

Perhaps this tension is best explained in a statement made by the Women's Center Director of Education that every women deserves to deliver in a high risk hospital, and that with the 1.7 children women are having, they can't afford to take any chances. The assumption is that given proper understanding of the procedures and process, every woman who wants a live baby will gratefully accept them. But if every woman deserves the security of a high risk center, would every birth ultimately become high risk? Would birth as pathology be evermore reinforced and women accept that they are not in control of birthing? The question remains whether the incredible advances and "miracles" of modern medicine always serve the woman and her child or the cause of medical glory. Who can make this decision? Can the nurses truly advocate for the patient or for medicine when these two appear to clash.

Generally the philosophy and objectives were comprehensive and thought through. They seemed to pay careful attention to the learning of mothering skills and the process of social transition to mothering.

Several safeguards have been established to counter the effects of high risk maternity care. One such plan is the Birthing Room. The low risk woman in labour is allowed to labour, deliver and recover in one room without having to move from labour room to the "surgical" delivery table to the recovery room and finally to the post partum hospital room. Five birthing rooms, though incredibly tiny and equipment-dominated, are testimony to the effort to humanize and demedicalize the process. Women admitted here are permitted somewhat more freedom in the birth process (within the parameters of routine procedures).

Another feature which promises exciting possibilities is an integrated Post Partum Care Unit. In this system one nurse looks after the mother-baby dyad. This allows for more individualized and flexible care and treats the mother and baby as a family. The father is actively encouraged to particpate when present. Continuity of teaching is also fostered. Presently operating with only 12 beds, it will expand rapidly in the near future. Family-centered care is not a new concept. It is traditional home care now reinvented to counter the "illness" frame of reference for hospital maternity care and to pay special attention to the social and emotional elements of birth.

It appears as if maternity nursing has come round from "family centered" home delivery to "family centered" hospital delivery. Is this the best of all worlds? The message appears confusing. To whom does birth belong? Is it sickness? The care is intensive, the experts are definitely in charge. Then 72 hours after delivery, the woman and baby are discharged and the lack of adequate post partum supports (as outlined by the Task Force on Maternal Child Health) seems to say--it's natural--do it yourself.

The material studied at St. Boniface Hospital was similar in many ways (Appendix E). The fundamental philosophy of maternal/child nursing is that "All patients have a right to optimal care. . . In regard to women we believe that they need to be informed of their alternatives regarding health care and to participate in the decision-making process. Nursing practice in the care of women necessitates a non-judgmental role of patient advocacy. Women are holistic beings who should not be treated as a set of organs but as unique individuals. . . Child bearing is a normal physiological process which impacts upon the whole family" (Department of Maternal/Child Nursing Philosophy).

Again the basics for maternity care are information, choice, advocacy, individual rights and childbirth as normal physiology. The difficulty here again is the tension between these goals and the reality of life in a high risk maternity centre. How does one resolve the conflict between these goals and the routine procedure of fetal monitoring, intravenouses and episiotomies? High risk obstetrics creates risk! What message do women receive about birth at St. Boniface? If the Lamaze classes teach that every woman is responsible for the success or failure of her childbirth, what happens to her when medical intervention is the norm?

Some of the nursing objectives speak to bonding/relationship concerns. One statement seems to carry two messages: "Teach parents the importance of bonding but stress that bonding times are flexible and if not possible immediately after delivery, the hospital will provide bonding time as soon as it becomes feasible" (St. Boniface Hospital Department of Obstetrical Nursing). If this relationship is not cemented immediately, all hope is not lost. However, the hospital which

is in charge of the baby will give the mother time(s) to "bond"!

The nurse is given guideline questions for her to keep in mind as she observes the mother/child relationship. "Is there evidence of bonding? Does she maintain eye contact? Does she hold the baby closely? . . ." The concern is for positive development to occur. Does the mother, in hospital for only 48-72 hours, develop these "bonds"? Or, what does this mean? What stresses is she under to perform?

A concept not seen in any of the other hospital or prenatal materials addresses the fantasy child/mothering versus the reality child/mothering conflict. It recognizes that these two will likely be different and that a loss and grief process is expected and normal. "Parental love grows with time. Parents need to know that ambivalence toward the newborn occurs occasionally" and "The post partum period and adjustment to the parental role is stressful" (St. Boniface Hospital Department of Obstetrical Nursing). This understanding if translated into actual nursing care would seem to hold tremendous possibility for a less painful parental transition.

St. Boniface Hospital has available to the childbirth consumer two large and homelike birthing rooms. No equipment for medical/surgical birth is visible to the woman in labour. An attempt is made to emphasize the normal. In the past year they have also instituted a 12 bed Family Centered Care Unit. Philosophy and management appear to be similar to Women's Hospital. Here too the effort is made to counter the effects of giving birth in a high risk centre and the traditional practice of separating mother and child. Plans are to expand this unit.

The introduction of birthing rooms and combined (mother-child) care are tremendous steps away from the sterility and control of birthing

a decade ago. The philosophy and objectives present an acute awareness of the emotional and social impact of birth and mothering. The reality and impression of the hospital material and physical layout is confusing, however. Birth is still primarily a medical event and the woman still seems ultimately to be a passive and dependent "participant" in the process.

Loss of control usually means the loss of some expectation and dream. In childbirth this could translate to a questioning of self. Am I inadequate, as a woman, as a learner in the childbirth classes? If I must depend on medicine (tender of the sick) what is this event? Birth receives critical crisis-like attention throughout prenatal classes and in the hospitals. Is the alternative to return to premedical horrors and mortality rates? Hardly. Yet births in North America are frightening affairs says a British trained midwife*. Then interestingly, after birth the tasks and life changes that occur are socially non-events--e.g., "I'm just a mother", "She'll know what to do, she's a mother". The message is confusing. Post partum depression, say Stern and Kruckman (1983) is caused by the lack of 1. social structuring of post partum events, 2. instrumental support and aid for the new mother, and 3. social recognition of the transition for the new mother.

Rich's (1976) discussion of the violence of the Institution of Motherhood focuses on the violation of women throughout their entire reproductive process. From the Biblical (pre)scription of women in childbirth agony to Grantly Dick Read's ecstatic and exhilarating experience of natural childbirth, the question persists. Whose experience is birth? In an attempt to make sense of this bewildering

*with permission from a conversation with Chris Robinson.

problem is it any wonder that women must numbly submit to the present situation as "normal" or become frighteningly depressed?

Summary and Conclusions

The movement of midwifery from the hands of women to the domain of men is well documented. One immediate result of this was two centuries of puerperal fever and death as the physicians moved from cases of disease to childbirth. Slowly, perhaps as asceptic techniques proved to be an answer to the fever, childbirth became a part of medicine and associated with sickness. Medicine was big business and women important commodities. Their health was defined politically and economically.

There has been a very definite move in the past decade to redefine and normalize birth. Inherent in this comes the restructuring and rethinking of motherhood. Writers suggest that its present form is a man-made invention. The changes in birthing and the mythologies around mothering then go hand in hand. As North American childbirth is a culturally produced event, so is motherhood (Rich, 1976).

This process will not be smooth. Technology has invaded the birth room and claimed to be the salvation of women and babies. There is no real questioning of its life-saving attributes and possibilities. But what must women (and children) sacrifice for this gift? Can it be refused? The forcep could be a symbol of the obstetrician--a symbol of invasion and violation. It's difficult sometimes to see that as a gift.

The study of the childbirth education material reveals that in at least two sets of classes the possibilities exist that Motherhood Mythologies are perpetuated. Obviously the results are limited. (Further extensive work could be done to obtain a broader picture.)

Although many disclaimers are presented, the overall effect of the second one is that birth and mothering is glamorous, fulfillment and dreamlike. The first program, though presenting both positive and negative aspects, is nevertheless birth-child centered. This again tends to define motherhood as Everything. Research would certainly be useful to determine the effects of these emphases. The Motherhood Mythology has been powerfully woven. It supports a social system which demands of women to be happy and fulfilled in that role. A need is present and begs response. The first program particularly does make an effort to respond with questions of the system. It invites women to reclaim the experience.

The hospital studies show definite concerted attempts, on the part of nursing personnel, to humanize birth and return control to the mother. The Birthing Rooms, the Integrated Care Units, the theoretical recognition of "transition to Mother crisis" are perhaps the most critical ones. Nurses, as well as many doctors, remain caught and limited within the grip of "Medicine". However, the theory and much of the practice seem to be in conflict. The haunting question throughout is: can the power of a centuries-old patriarchal institution backed by the inpenetrable logic of modern technology be broken to truly release birthing and mothering from its bonds?

"What we bring to childbirth is nothing less than our entire socialization as women. As long as birth--metaphorically or literally--remains an experience of passively handing over our minds and our bodies to male authority and technology, other kinds of social change can only minimally change our relationship to ourselves, to power and to the world outside our bodies" (Rich, 1976, p. 182).

CHAPTER V

PICTORAL PRESENTATION OF MOTHERHOOD

"Magazine ads and television commercials portray the supermom, who presides over an immaculate home, dresses like a fashion model, sings to a sweet, joyous Gerber baby, and who has all the time and energy in the world to devote to the needs of her spouse and baby." (Jones, 1983, p. 201). This is of course the "perfect mother". Women whose lives are this way are a "success" and women whose lives are not this way are "failures". Reality obviously puts most women into the failure category.

If pictures speak a thousand words, one could speculate whether the reinforcing effect of magazine ads and pictures is more powerful than the verbal disclaimers of the myth. Popular magazines found in stores and new parent magazines given out in hospitals and prenatal classes were overwhelmingly myth promoting in their visual presentation.

Magazine stands in a number of supermarkets, drug stores and "corner stores" were selected. Magazines were picked up and checked frequently throughout a ten month period. Magazines were also collected from hospitals, prenatal programs and a number of mothers. The pictures selected for this chapter seem to be representative. There was virtually no evidence in the popular magazines reviewed that portray the "other" reality of the mother experience--confusion, exhaustion, endless menial tasks, anxiety, and stretch marks. There was also no sign of the vast number of mothers who live in poverty, or those above the poverty line who cannot afford luxurious nurseries and designer layettes. There was no evidence of babies with Downs Syndrome or a physical disability.

Before Michael left the hospital, his parents had a lesson on dryness.

Now a lot of parents learn how to change a Pampers before Mommy and baby leave the hospital. Because more and more hospitals use Pampers. They stay twice as dry as cloth diapers, because their quilted lining stays twice as dry. It keeps wetness down in the padding, away from baby's tender skin. A drier baby's more comfortable and happier. Keep your baby nice 'n dry in Pampers. Just like more and more hospitals do.

Quilted Pampers stay nice'n dry. Twice as dry as cloth.

1. The new mother, fresh from delivery, is beautifully gowned and freshly made up. As most women remain in hospital only 48-72 hours, this woman will still be stiff and sore from delivery positioning, a surgical perineal incision and will be physically and emotionally exhausted. The relaxed, perfect couple, though not "unreal" is likely not "reality".

Cradle Club Magazine. Toronto: Girling Wade Marketing Inc. 11(4).

Daddy built her crib and Luvs® shaped her diaper to keep Lisa comfortable.

Lisa's crib is designed to cradle her in comfort. But what about her diaper?

If it's Luvs, it's a diaper designed for her comfort.

If it's like the elastic diaper on the left, hold it and a Luvs up to a bright light, as we did.

See the difference?

Diapers Fully Extended.

Luvs hourglass-shaped padding curves to fit comfortably between a baby's legs. The other elastic diaper's padding is wide and rectangular, and can bunch up between her legs.

That diaper may cost less, but it won't fit like Luvs.

So put your little one in a diaper as comfortable as Luvs, and you can all sleep like babies.

© 1983 Procter & Gamble

Luvs

Your baby's comfort begins with Luvs.

2. Although the advertisement is for diapers, the item that is being sold is a beautiful happy family. Daddy builds the crib, Mommy smiles contentedly, baby lies sweetly comfortable and behind it all Daddy and Mommy hold hands in perfect union. Everyone is relaxed, clean and perfect.

Best Wishes. Toronto: Donald G. Swinburne. 1983, 35(3).

3
FEEDING YOUR BABY

3. This mother of twins had the time, before dressing and feeding these two beautiful babies, to put on make-up, do her hair (complete with fresh ribbon) and put on a lovely clean gown. The amazing feat is keeping two infants awake and contented long enough for her to manage that angelically peaceful face. Soft light filtering through exquisite white curtains envelopes this happy group in near ethereal bliss.

Prentice Women's Hospital and Maternity Center, Northwestern Memorial Hospital. Delivery and Beyond. Chicago Illinois.

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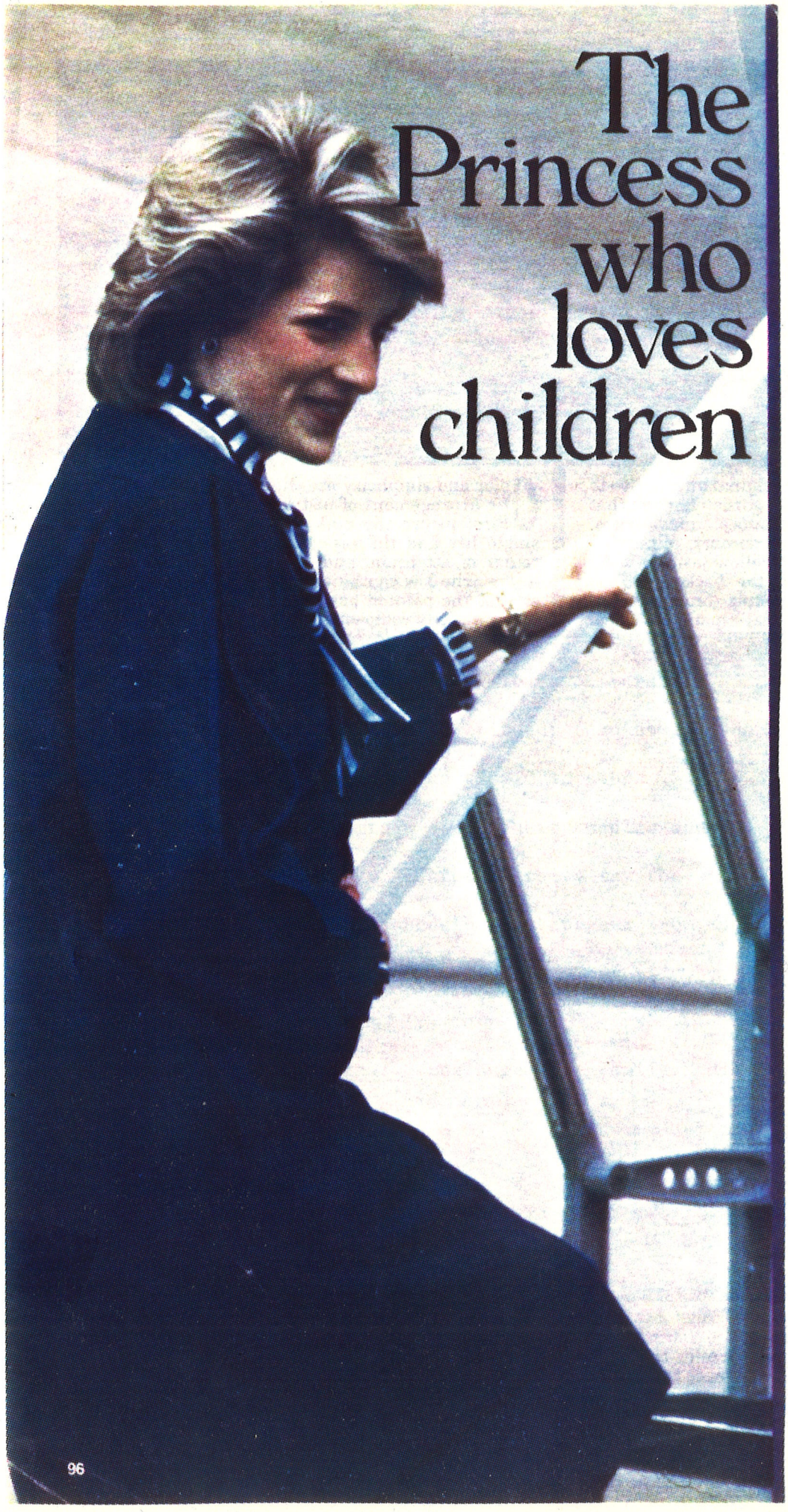
4. This haloed child-madonna and baby dressed in virginal whites exchange a glance of holy love. The hazy greenery, soft light of Paradise and the blessing of Mother Mary enshrine Motherhood.

Best Wishes. Toronto: J. L. Hunt Publications Ltd. Summer 1981, 33(1).


The Princess who loves children

5. This expectant mother who is daughter-in-law to one of the world's richest women and a celebrity in her own right "loves children". "Diana's special glow is brighter than usual, and both she and Charles can't seem to stop talking--and beaming--about their toddler son and the expected baby." Unfortunately, say the authors, her busy schedule has kept her from much actual child care.

Ladies Home Journal. Los Angeles: Family Media, Inc. July 1984.

BUSTED STARS: WHAT REALLY HAPPENS WHEN THEY BREAK THE LAW

US

WPS 34190

New baldness drug

16 Candles' flame

21st Century Diet

Pompeii's phobic Olivia Hussey

MAY 21, 1984/$1.25

OH, BABY

Happy Mother's Day! Celeb moms & their diapered darlings

A Tilton tot to Cherish

A li'l Osmond for Marie

Teri Copley's got it made

Margaret Ladd's lad & lass

Karla De Vito's sweet Lyric

0 21
70989 34190

6. Happy Mother's Day! to all mothers from five famous beautiful mothers. Their lives hardly mirror the lives of most mothers. Can viewers see the perfect face, manicured hands and exquisite clothes as a picture?

Us. New York: Peters Publishing Co. May 1984, *8*(11).


Psychic ma
Madame Red reads between the lines—pay
February 1984
$2.00
The supermoms
With quiet determination they're revolutionizing the family

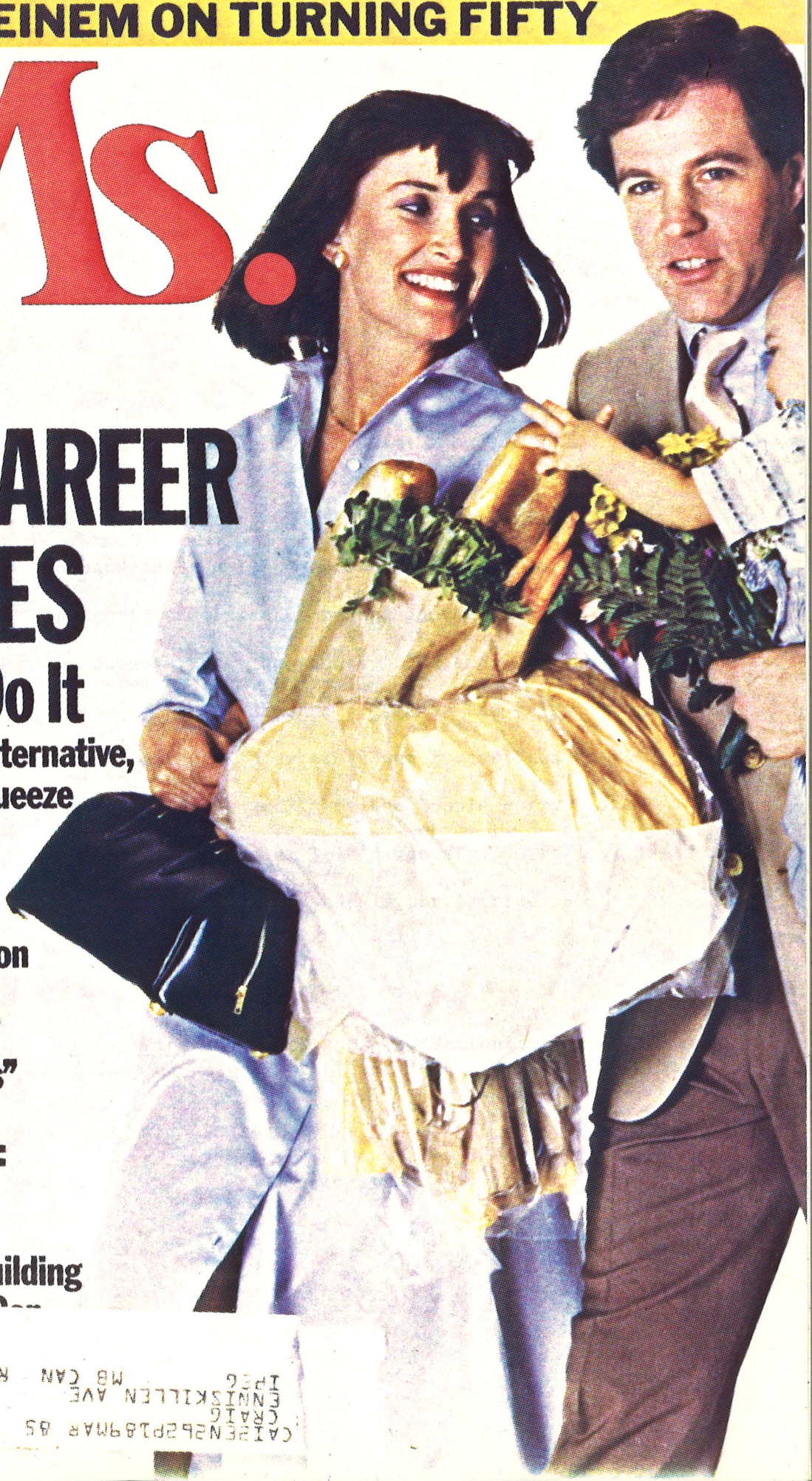
7. Four professional women and their children smile with supermom pride. By the type of professions represented, it would be safe to assume there would be an intense conflict of time and energy. There is obviously a "song of triumph" in this picture. Will "supermoms" revolutionize the family or merely build a new myth? Where are the husbands/fathers who share this revolution? Where are the majority of working mothers represented?

Winnipeg Magazine. Winnipeg: The Winnipeg Sun. February 1984.

GLORIA STEINEM ON TURNING FIFTY

Ms.®

JUNE 1984
$1.75



TWO-CAREER COUPLES

How They Do It

The Commuting Alternative, The Social Life Squeeze & Other Trade-offs

- Fiction by Barbara G. Harrison
- Money: "Yours," "Mine," and "Ours"
- Vietnam Nurses: The Unsung Vets
- Politics '84—Building From the Ge

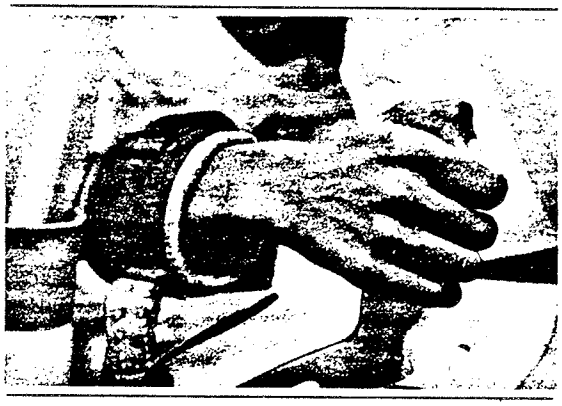
CAIZEN25P189MAR 85
CRAIG
ENNIS KILLEN AVE
IPEC MB CAN R2V 0H8

8. This happy doctor/mother with her handsome husband and son is on her way home from work, having first picked up things at the cleaners and the supermarket. He had the time and forethought to buy flowers. Someone picked up the baby. Reality appears somewhat skewed by the freshness, make-up, clothes and items the couple carry. The picture belies the article's honesty! Mythology as the desire for all of what is partly true is evident again.

"Ms Magazine" New York: Ms Foundation for Education and Communication, Inc. June 1984, 12(12).

5

The New, Improved, Quick-and-Easy, All-American Hospital Birth



9. Gripped in the throes of childbirth, this woman is given an iron "hand" to hold and a leather strap to keep her there.

Arms, Suzanne. Immaculate Deceptions. Boston: Houghton Mifflin Company, 1975.


Do they ever grow up?
Lynn


No. It's true... I've GOT to admit.... ours is the most beautiful child in the world.
LYNN

10a. Presenting the ludicrous, the picture evokes feelings of exhaustion, hopelessness and frustration--the familiar.

10b. Without fanfare or glamour, the mother simply states her love for her child.

Johnston, Lynn. Will They Ever Grow Up? Don Mills, Ont.: Nusson Book Company, 1981. pp. 16, 106.

Summary and Conclusions

Pictures 1-6 are fairly representative of the way mothering is presented in magazines. Although many of the pictures could appear in a family album they are essentially still life--a moment in time. Yet put altogether they give an impression of ongoing life, of reality, of the "if only. . .". They embody the Motherhood Mythology. And this is also truth! Perhaps there are few ways that pictures can effectively communicate the "other side of mothering". However the imbalance gives a loud clear message. This beautiful mother, lovely baby and the total serenity are possible if only . . . Advertisements are trying to sell something. The goal is not to present an accurate picture of contemporary family life. But what they are in effect selling is a dream and so become engaged in a devastating and disrespectful treatment of mothers. Pictures 5 and 6 portray mothering in its most exotic form. The "Princess who loves children" (Ladies Home Journal, July 1984) hardly knows the daily endless exhaustion of caring for the baby and house in virtual isolation. Neither do the "Celeb Moms" (U.S., May 1984) in their lovely clothes represent the vast majority of women's lives. Can these really be seen and accepted as still life, fantasy or as the final success?

Pictures 7 and 8 appear to be myth breakers. They represent the "new woman" who is choosing family and career. Both the articles behind the pictures speak of the conflict and struggles of this lifestyle. They include rewards and sacrifices. Perhaps in a real sense they are "revolutionizing the family" (Winnipeg, February 1984) and building a new synthesis of women's lives. A difficulty in picture 7 is the "Supermoms" and the apparent ease and joy with which they manage to be doctors and

mothers or lawyers and mothers. Is it that easy? Where are the majority of working women who mother and work in the labor force in clerical-minimum wage jobs? Where is their recognition? In picture 9, the two career couple is obviously wealthy, professional and beautiful. The question could be asked whether these two are not simply "new myth" promoters?

Picture 9 is a picture rarely seen by the public. Its message is not told from magazine stands. The hands are tied to an iron rod. It is easy to "see" the rest--the feet strapped up into stirrups, the woman exposed, vulnerable, helpless and available to any observer to insert his fingers into her vagina. The straps are slowly being taken out of the delivery rooms, but they are yet not far removed from "pornographic bondage" scenes and bear mute testimony to the horrors of birthing practices. One could question whether the beautiful serenity on the faces of the "picture" mothers is their salvation from this reality.

Picture 9 is one reality that contrasts sharply with the magazine stand messages. The starting hypothesis of this paper is "that there exists a Motherhood Mythology which misrepresents the actual experience of mothering and that these myths are being perpetuated today." The evidence gathered showed that within popular magazines the Motherhood Mythology is loudly and unequivocably proclaimed and promoted. Some challenge and balance however, comes through cartoons. In comparison to the research in the education and medical studies, the magazine media form most blatantly perpetuates the myths around mothering.

Pictures 10a and b represent two of a host of pictures on the market that use humour to look at mothering and child care. They appear to be a visual media form that can portray at once the utter ambivalence of mothering-the daily, hourly times of anger, love, mistakes and joy.

CHAPTER VI

SUMMARY, DISCUSSION RECOMMENDATIONS AND CONCLUSION

Personal and professional experiences and a general knowledge of the literature began to raise the questions about the expectations and realities of being a mother. Where does the dream come from? What purpose does it serve? What do the seemingly conflicting messages mean and how are they reinforced or confronted?

The study began with the hypothesis that there exists a Motherhood Mythology which misrepresents the actual experience of mothering and that these myths are being perpetuated today. Three areas were explored. These included: 1. women's career development, aspirations and reality versus motherhood within the education system, 2. medical and prenatal treatment of the childbirth event, and 3. pictoral magazine representation of mothering. They were described and discussed in relation to their influence on mothering.

Summary

A Mythology of Motherhood does exist. As reviewed in the literature in Chapter II, it certainly is "both true and false, false in fact but tied to human yearnings and human fears and thus, at all times, a powerful shaping force. Myth is born out of psychological drives . . . Myth opposes belief to facts in order to change the facts, or at least to obscure them" (Janeway 1971, p. 26).

This Mythology would appear to be the belief system which undergirds the Institution of Motherhood as outlined by Rich (1976). Although its articles deal with the mother/child relationship, it is essentially a method and rationale for keeping women confined and controlled. The

medieval struggle between the church and the women healers is perhaps a significant introduction to the development of the Mythology. Though time has changed the focus many times, a central theme remains. What is the meaning, structure and ownership of every woman's reproductive potential?

Motherhood has passed through seemingly diametrically opposed periods. The mass abandonment of babies in 18th century France and the 24 hour a day devotion required of today's "good" mothers seem light years apart. Eighteenth century women did not have adequate knowledge about their reproductive powers. They just kept on having babies. This physiological mothering did not guarantee emotional mothering, or nurturing. Contemporary women choose to give birth but learn to mother within the realm of the expert, essentially removed from their own experiences. Perhaps the 18th century experience was in part a response to the destruction of traditional female knowledge as the dedication of super mom is again in part a response to women's alienation from self and the sources of power.

Certain questions remained at the foundation of each study. In 1984 are the myths being maintained or are they being challenged? If myths are tied to human yearning and fears, what are the processes at work in our society? Emotional needs, says Janeway (1971) are translated into belief whether objectively true or false. Where and how are the beliefs about women's place and mothering being examined?

The materials examined for the study of the educational system (Chapter III) revealed few surprises but profound ambiguities. Sexual stereotyping is active within the schools. This is true for both students and teachers. Change, however, is evident, e.g., increasing

numbers of female high school students aspiring to non-traditional jobs. At least two curricula which aim at sexual equality are available. The reality of the work world, however, places women in a very difficult position regardless of personal philosophy and educational preparation. Unequal pay, difficulty obtaining leadership positions, inadequate child care, unequal pension benefits if she stays home with the children, the dilemmas of career vs mothering, and the statistics of female poverty are just some of the problems women face. It appears to be a no-win situation all around. The Motherhood Mythology is both alive and being maintained as well as being challenged within the educational system.

The question remains, is the challenge to the Mythology "real", that is, can it effect fundamental change? If it is, why is there so little progress? Or is this simply a natural delay in the cause and effect relay? Does education adequately prepare women for career reality? Can it do the job, given its orientation in male developmental theories?

Chapter IV again identified conflicting messages. There is evidence in the hospitals of strong leadership committed to bringing about changes in birthing practice. Increased choice, Birthing Rooms and Family Centered Care are the major items. In routine practice however, the guidelines appear to be derived from medical technology and an "intervention mentality". Childbirth education programs are neither uniform nor consistent in their positions. One program presents alternatives and rationales for birth procedures and encourages parents to choose according to their needs. Its focus is primarily birth and child. Objectives convey the importance and impact of the transition to mother and the social reality of parenting. There is some question as to how much this is being

stressed by the instructors. The second program is glowingly positive and "trains" women to succeed at birth!

If birthing is a political issue of patriarchy (Burst, 1983) as is the Institution of Motherhood with its reinforcing mythologies, how can this be challenged within the medical system? As long as childbirth is treated as pathology and motherhood is seen as ultimate fulfillment, women would seen to be tied to a system that rules them. Obvious changes are occurring--yet the basic message and control remain the same. Birthing is the unique female experience, and its question is fundamental to female identity. Is control of this then the key to breaking into the system?

Response to Chapter III

In Chapter I (p. 3), it was suggested "that attempts are still made politically, socially and economically to maintain the institution of motherhood which in turn wreaks havoc on the job of mothering". Within the educational system, evidence points to the ongoing maintenance of the foundations of the Motherhood Mythology. That is, the sexism on which the mythologies are built is alive in the schools. At the same time there are strong challenges to this system and concrete attempts are made to counter its effects.

Adolescent females are caught in a difficult situation. On the one hand they are drawn by the promises and messages of the Motherhood Mythologies. To be adequate, womanly and happy you must be a "total mother". If you do it "right" that is how it will be. On the other hand is the pull of early feminist mythology which promises freedom and "you can be whatever you want to be as long as that is not mothering". In the middle is a confusion of experiences, facts and knowledge.

Oakley's studies show that girls know from first hand experience the realities of mothering. They also believe that they can improve on that experience to fulfill the dream. Life then confronts them with economic difficulties and the low social status of the "coveted" housewife role. If they choose career and mothering, they face job discrimination, lower pay than men and inadequate child care. If they choose career only they forego mothering. To top this they realize that they have female bodies and wonder what it means in their life. For many it is hardly a choice, but rather a natural consequence of their lifestyle and the way they perceive the world. The options are hardly choices at all. That they deal primarily in either/or categories is not surprising at all. In light of the dilemmas, a dream as a hope for future happiness is most understandably welcome.

It is interesting to note that recent studies as cited by Friedan (1981) show that the mental health of women has improved sharply in the last two decades. Bernard (1975) said that marriage is driving women crazy. Now women who are combining careers and mothering seem to be healthier and happier, in spite of the apparent conflicts (Ms. June 1984). Statistics Canada recently published a report that simply said that women who are working outside the home enjoy better physical and mental health than housewives (Free Press, May 1984). This information, though not yet too comprehensive, could have significant impact on the development of school programs.

Perhaps there is a reference here to Friedan's major theme of a synthesis. School programs that react to sexism by only encouraging career development are not presenting a holistic perspective. In the 1960's the unisex clothes symbolized an effort to abolish sexism and

promote equality. In the school this might translate to a general (and primarily positive) integration of boys and girls. "Let them play ball together, let them compete and work together." The 60's experience however, revealed this to be another version of "husband and wife are one and that one is the husband". Without an understanding of the issues and objectives and a consideration of "psychologically differentiated socialization" this problem could simply be repeated.

This caution is not to suggest a shutdown in any of the equality efforts that are being made, but simply to acknowledge the tension. Women are not totally defined by their reproductive potential. (Even Freud graciously concedes that, "an individual woman may be a human being apart from this" (1933, p. 185). However women have for so long been denied much valuable knowledge and experience from which genuine life choices are possible. An assumption of this paper has been that men and women should have equal opportunities and information. What is not always clear is what that truly means for women. Much more careful research of women's history and experience is needed to fill in the blanks.

Evidence of inadequate role models for girls (and boys!), teacher perception of male intelligence needing more nurturing and the maths and science issue are strong counters against women developing an early career consciousness. At this point the struggles and questions of the women's movement to equality must confront the movement of men in this regard. Early feminism broke women's symbiotic ties with men and became independent. Men obviously had to respond to this and their own growth is an integral part of the synthesizing process. Friedan says this movement is well underway. It is almost frightening though to suggest

that some of the resolution of the career/mother conflict will hinge on men being able to join women as equals, not rulers.

Theory, policy and curricula remain just that without accompanying action. In the schools this could become crucial in the role model concerns. Administrators as primarily men counter the message that girls are as "smart" as boys and that equal opportunity is a reality. Primary school teachers as primarily female continue to reinforce the mother/child link and lessens the professional status of these teachers. It also removes men from the public arena of nurturing.

The results of the studies on sex-typing occupations and career aspirations are confusing. At what point in the system can it be most effectively challenged? Why is there not more movement? Is the key role modelling? Or perhaps the system is broken, and what the results indicate is a floundering--a struggle to anchor somewhere.

Response to Chapter IV

Chapter I presented the expectation that having a baby would be the most fantastic, totally joyous experience imaginable. Chapter IV revealed birthing and mothering as being rather, in part, a loss of a dream, alienation and the loss of self control to a powerful male system. Is the Motherhood Mythology an enticement to bring women back again and again to childbirth? That is an interesting thought. Do men, and the women who accept this system, really believe that if women were given the truth about birth and mothering they would stop having babies? On the contrary, perhaps if women were allowed to experience their own truth in this event there would be no need for the Mythology to draw them and trap them. Whatever the reason, the price is high that women pay to fully

respond to their reproductive potential. It is fairly obvious in the study that there is much within the Medical/Prenatal systems which perpetuate the Mythology. The fantasy, the child focus and the childbirth as pathology themes run throughout. It is a puzzlement why it is necessary for a women run Prenatal series to focus on the glamour and the "ultimates". Is there still the fear that "if I don't do this properly (succeed) I am a failure as a women"?

The other focus on the technical details of childbirth reinforces the illness aspects in spite of verbal disclaimers. Birth is a very important crisis event for a woman. It is an event whose "graceful resolution" is integral to positive development and growth. Yet it is one event. It is not the sum total of mothering. It is not an end in itself. This would be Washbourn's "demonic resolution". When birth is the ultimate, there is little choice but to experience crushing losses and confusion. If the initial intention was to be honest, to <u>allow</u> women back into their own birth process (incredible double talk!) it has served its purpose only in creating the <u>effect</u> that women are a part of it. That is, they know what is happening but can't do anything about it.

For whom is this knowledge important? Buchan suggests that prenatal preparation was man's invention in exchange for birthing control and postnatal supports. It is noteworthy that traditionally when women healers/midwives were responsible, the detailed knowledge of birthing was not that critical for the mother. After all she was "safe" with her midwife. What was more important was nurturing and support after the baby arrived--and female ownership. The Mythology seems necessary then to fill in the emptiness left by the alienation of female self from birthing.

The hospital material presents a conflict. Theory is again in one direction and practice in another. It is in part an understandable cause and effect delay as it is always easier to write theory than to live/model it. But that is too simple. The question is far from resolved about who controls the birth event and what it means. It is true that more babies and mothers are surviving. Is that the crux of the argument for medical control? First of all it is not all that clear whether technology or the improved living conditions are accountable--probably both. Secondly it does not pay attention to questions of ethical concerns such as physical survival at any cost, what is the price and who pays. It does not give a woman the respect of recognizing that it is her body, her life--and that she will likely not choose destruction!

The medical high technology birth and the other extreme of exhilerating natural childbirth are both profoundly anti-woman! The mythologies outlined in this study are nothing short of insulting. The "fluffiness" of glamorous motherhood is a statement about the prevailing attitude of female "fluffiness". The attempt to reinterpret childbirth in the manner of Grantly Dick-Read and Ferdinand Lamaze (though including useful sections) is a male vision. It lacks understanding of natural female physiology, pain and birthing. Routine medical intervention is also a disrespect and violation of this process. It reinforces female dependency and a negative self image.

The anti-woman theme goes further. Breast-feeding as one of the romanticized elements of mothering is to be carried out under blankets or in the isolation of the home. The breast as an erotic-sexual symbol is flaunted everywhere and is acceptable. As a mothering symbol it is treated as obscene. A good mother breast-feeds her baby--on demand. A

good (discreet) mother does not do this in restaurants, shopping centers or airplanes--for fear of disapproval, or arrest. She hides in washrooms to feed her baby, or goes home. The double talk is astounding.

The tension of medical advances and woman-owned birth is not easily answered. It is and, perhaps because it involves ethical issues, will remain a tension. The fear is that the changes occurring are not really addressing the basic problem but merely presenting another trade-off.

The discussion seems to come around again to the issue of female identity and the place of mothering within that. It is an old question that has been dealt with by the experts over and over again. It is also a new question in that it is being asked now from within female experience. In the past the answers have been oppressive and destructive. There is obviously another route to pursue, another question to ask because self-definition in terms of reproductive potential does not equal the Motherhood Mythology. The answer must include choice and wholeness.

Response to Chapter V

The pictoral message of popular magazines in both illustrations and advertisements is clearly and loudly myth enforcing. This media form is a blatant and deliberate perpetuation of glamorous, perfect, happy motherhood. The articles accompanying may often speak to the contrary, but the impact of the visual is that of a powerful disclaimer. A commonly used definition of pornography is that (pictures in this instance) which degrades and violates the personhood of someone. It is not difficult to place most magazine pictures in the category of pornographic.

The pictures found in the magazines studied were overwhelmingly ones of perfect female beauty, as defined by Hollywood, and beautiful perfect babies, as defined by Gerber foods. These mothers and babies inevitably lived in expensive, professionally decorated nurseries and homes and promoted the distinct impression of absolute happiness, absolute fulfillment and absolute perfection. They are but "fluffy brainless kittens" (Freidan, 1973) given no self-respect or dignity. Where is the colic, the fatigue, the dirty diapers--not to mention the guilt? There was no evidence in these pictures of a balance, of an attempt to portray mothering as anything less than Perfect.

The Lynn Johnston cartoons on the other hand offered respect and humanity to mothers and mothering. In their caricaturing of parental dilemmas, the cartoons identified a whole spectrum of feelings and experiences. Permission is granted for mothers to be angry, confused and loving. All pretenses are gone and the utter rawness is liberating. Although gaining popularity, it is questionable whether these cartoons prevent the development of the Perfect Mother image. Magazines are more available and accessible, particularly to a younger female population. Also, their pictures hold out the promise of happiness, if only . . .

Discussion

Female identity concerns

Throughout the previous four chapters one could trace a common theme, that is, the nature of female identity. For so long this identity has been defined in male terms. Studies have used male samples. Male understandings, interpretations and experiences have led to conclusions which have invariably placed women into categories of lower development.

A common phrase, "a healthy adult is a healthy male" is more than humour. The landmarks of female growth have been superimposed on male ones. There are now new questions being asked about these landmarks. What are they? What is uniquely female? What is generations of socialization under male tutelage?

Washbourn (1977) explores the development of female identity through significant life-crises. These center around the physical crises of having a female body. The psychological and spiritual resolution of these events, says Washbourn, allow her the choices about who she will become and what the structure of her life will mean. "To perceive female sexuality gracefully involves seeing it within the process of becoming more fully human and with an understanding of the purpose of life. To interpret female sexuality demonically means to find a false sense of identity in the female role--to romanticize it, to manipulate it, or to see it as an end in itself" (1977, p. 3).

This would suggest that the potential of every women to choose to have a child is basic to female identity. Challenges arise from numerous directions. Two of these are psychoanalysis and feminism. Freudian thought placed on mothers the awesome responsibility of raising emotionally healthy children; early feminism tried to liberate women from the "imprisoning" mothering role (Heffner 1980). Neither position gave her the tools to deal with the issue adequately. The first one created untold guilt and feelings of inadequacy. The second one added irrelevancy by making mothering an unimportant element of being a woman. Feminism responded to Freud's belief that women's bodies are deficient and that at 30 years of age, "there are no paths open to her for further development" (1933). In part he is referring to his notion that when a woman has given

birth, particularly to a son, she comes round to her completion. This value still appears to have a hold on the social values that are placed on female experience and growth. Early feminism's response, though appropriate and welcome, did not go far enough in understanding the complexity of female identity. They focused on her individual independence and her relationship to male power structures. Fortunately, the Freud/Feminist polarities are slowly giving way to a new synthesis.

Gilligan (1983) discusses female development as distinct and unique. It is not clear whether these differences (such as, women are "affiliation" oriented in adolescence and early adulthood and men at this stage are "achievement" oriented), are biological or socialized. It is clear that the physiological potential of female reproduction is at least one central factor in their development. Is Gilligan's finding of affiliation/relationship as the primary need in the adolescent-young adult female the result of Washbourn's life-crises resolution process? If this is so then is the question of motherhood an issue that must be the focus before career possibilities can be explored? Labor force statistics seem to bear this out. Has this been conveniently used to keep women at home and passive, or is this sheer habit?

Throughout the heyday of the feminine mystique, women followed this natural calling at the sacrifice of other developments. This may not have become such a concern if the value judgements of female deficiency had not accompanied this task and if the myths surrounding it had not dictated such absolutes. That is, mothers within this system are supposed to be totally devoted to the child and totally happy--resulting in total seclusion and alienation from world affairs, self and others.

This would seem to be a good example of Washbourn's "demonic resolution of female sexuality".

Feminism, particularly in its 1960's reawakening, made harsh (and 'total') statements about the slavery of motherhood--and justifiably so. The oppression of the institution was blatant and obvious. The struggle was intense to gain even a footing and then some measure of equality in a world so long denied them. What feminism did not, and possibly could not at that stage attend to, was the need and desire to mother--to nurture. This would have been betrayal to the cause, to the movement out of the feminine mystique.

Friedan writes in 1981, "Instead of the polarization of two kinds of women--or feminism versus the family--which has plagued the women's movement in the last years, and prevented the very possibility of political solutions, new research shows that *virtually all women today share a basic core of commitment to the family and to their own equality within and beyond it, as long as family and equality are not seen to be in conflict*" (p. 219). Although this does not address physiological mothering exclusively it does speak to the nurturing/affiliation needs as being crucial, but not for the price of self-sacrifice!

Friedan's 1981 analysis and critique of feminism appears somewhat reactionary at times. When she denounces the extremists and the resulting polarization, she does not fully acknowledge the necessary process of growth--from dependence to independence to interdependence. The passionate withdrawal from male dominance was an integral step in the progression from submission/passivity to new understandings of strength, love and self-identity. However, she does throw out a new challenge, "There is a reconciling of seeming opposites that has to take

place now, a dialectical progression from thesis-antithesis (feminine mystique-feminism) to synthesis: a new turn in the cycle that brings us back to a familiar place, from a different vantage. In the second stage, the path that Ibsen's Nora walked to find herself in the world after she slammed that door takes her back full circle--but it's no longer a Doll's House (p. 81).

Gilligan (1983), in her discussion on female development, does not pay specific attention to biological potential or process. Yet she focusses on relationships and interdependence as the "path to maturity", both in love and work. The question is where does the focus come from? Given the present male reality system (Schaef, 1981), does this focus not lead naturally to vulnerability and the continuing likelihood of being controlled?

Here again, Friedan's synthesis appears to be a little too neat. Questions of female identity and landmarks are not likely resolved that smoothly. These concerns are significant, their understanding fundamental to female wholeness. But what does this look like in reality? Generally there has been a "this" or "that" division. What could a new synthesis look like and how do we arrive there? There is a definite tension. Some of it stems from not knowing whether women develop as Gilligan outlines <u>because</u> they are women. If they are "integrated", are we back to square one in terms of power balance. How can we move from the nurturing emphasis as primary to equality in the work world? What and where is the link?

A key area in the female identity question is the mothering/ nurturing issue. Traditionally this has led to dependence. What will resolution of this crisis look like from the vantage point of

independence and interdependence? What meaning and structure will female identity have in this stage? There is new hope and excitement in the fact that the issues are now being seriously considered from within women's experiences and life crises.

Motherhood Mythology as a Counselling Issue

Women have internalized society's belief and expectations of themselves as wives and mothers. If, as discussed earlier, these beliefs and expectations are oppressive--then women have internalized oppression. Traditional therapy has been a form of social control of women in that it was usually done by men who were obviously trained in and influenced by the prevailing expectations of women and whose goal was to help women adjust to the system. These therapists were "experts" and had "answers" for women's experiences. Women had to sacrifice their personal growth and development in order to meet these expectations.

Feminist counselling is essentially women helping women, validating the experience of being female in our society. "By combining a healing, educational and political process, women can help themselves with their own power and knowledge to become all that they can" (Emberly, 1984, p. 23). Feminist counselling begins with the premise that women are the experts of their own lives. The counsellors share in this life and offer support and information. They focus on the individual's strengths. They believe that the personal is political (birth?) and that "problems have social as well as personal causes and remedies" (Emberly, 1984, p. 25).

After decades of listening to male experts who know how a mother thinks, feels or acts, and what birth should be like, it is easy to see the place of feminist counselling for women who are mothering. Within this kindred relationship they can better explore their own beliefs, feelings and needs. It is a milestone says Emberly "when a woman can focus on her own needs and feelings. . ." (p. 23). Although it is certainly possible for a sensitive male counsellor to help her through this process, he can never bring to it the fundamental understanding and meaning of being a woman. Women who are questioning the Motherhood Mythology or experiencing a difficulty within it are questioning not only a specific event but the entire social system and their own socialization. More and more women appear to be asking these questions, more and more women will need to find their own solutions, their own meanings and make suitable choices.

Mythology, Dreams and Fantasies

What is the saving value of a Mythology? Is this the dream that keeps people moving and gives them hope? Do we need a Princess Diana fantasy?

There is little question about the importance of dreams, goals and hopes. Without them life would be rather dull and stagnant. The mythologies in question seem to fall under a different category, however. Though somewhat artificial, a distinction is made here between dreams, myths and fantasy. Dreams are discussed as being within the realm of the attainable. The process and achievement of these dreams are life-opening and positive in effect. A fantasy, on the other hand, is understandably outside of reality. It is the imagination's free rein, it is mind play.

With this clear, fantasy can be a safe place of enjoyment, creativity and practice. A mythology seems to lie somewhere in between. Arising out of truth and combined with human needs and fears it gives the impression that it is attainable. Given the Janeway discussion that, "myth opposes belief to facts in order to change the facts, or at least to obscure them" (1971, p. 26), it is easy to draw out its destructive possibilities. Janeway continues to say that myths go beyond the difficulties of the time, frame a future of hope, justify reality and provide a common bond of feeling. This certainly sounds constructive.

There are definitely some difficulties in this system. The theological concept of heaven has frequently been offered as a reward for suffering and silence. It is the future of hope for the poor and oppressed and justifies their reality. But if it keeps the poor poor, does it make the suffering desirable? Is it a substitute for a life that is free?

The Mythology of Motherhood has been described as oppressive and destructive. It derives its tenets from fact, as well as from psychological drives and fears. However it has served to keep women in a closed place and has grossly limited their movement. Do the oppressed need a "heaven"? Do women need a Motherhood Mythology to give substance and hope for something better? Does our social order need it to keep women where they are?

The Motherhood Mythology is supposed to be true. That is, if you live right, believe right and work hard, the rewards will pour in. You will succeed. If you do not meet the goals, if motherhood is less than perfect, you have failed. You have not lived right, believed right or

worked hard enough. In the "Knight Rider" (TV) fantasy, a car can "fly" over buildings, haystacks and rivers. Few people will feel they have failed if in reality their car doesn't fly.

An argument could be made that pregnant women need a dream (or have unknowingly accepted a dream). Perhaps during this period they cannot hear or comprehend anything less. Their dream is the energy that moves them through the fear of the unknown. This should not be confused however, with a set of beliefs that cannot move you forward, only imprison. The Motherhood Mythology does not appear to open up life options, rather closes them. It does not permit choice. Protection of reality only serves to reinforce the Mythology, not the dream.

The question could be asked of the educational system and the maternity health care systems. Do the schools open up the world for the female student or do they keep her in her place? Do the hospitals and childbirth educators promote growth and new life or confine the woman through control and violation? Dreams are tailor made for the individual (even recognizing the impact of social norms and values). The Mythology is imposed on all women from an external source. The only choice has seemed to be its polar opposite.

Perhaps the "Princess who loves children" (Ladies Home Journal, July 1984, p. 96) is a car that flies. It is for most people a flight of imaginings. In light of the myths discussed, the pictures of "common" women are nothing short of portrayals of confinement for women. Where in all this is the permission for individual dreaming, the freedom to hope and build goals which are positive and life giving? The mythologies are needed. They are needed by a social system that cannot yet accept women as equal, as whole. They are not needed by women.

The recommendations will speak to the challenging of this mythology. They will range from the specific to the visionary. Hopefully they could lead to a broadening of human experience.

Recommendations

General Social and Political

Political power and influence in the realm of social attitudes and treatment of women is both crucial and simple. Steps have been taken to rectify past injustices, but overall the process has kept pace with the whims of those who rule and enforce rather than with needs and justice. *Measures are long overdue which would equalize wages and job opportunities.* This is possible, costly and essential.

Women still suffer economically when they have a baby. Short maternity leaves force many women to return to the work force early facing grossly inadequate infant care. In staying home for longer periods they lose benefits, salary or job. Men are granted only token paternity leaves. Child care is touted as all important, yet given minimal support. *Extended maternity or paternity leaves with benefits and job security, on the job child care, flexible work hours including job sharing and part-time work are just a few primary needs.* Blockage of these requests are primarily philosophical, not based on feasibility. These are not just concerns of women. They are concerns about the family and about relationships.

North American mothers receive a double message. Babies are important, keep them at home. Acknowledgment of the first part of the message would involve many structural changes (besides attitudinal). *"Baby areas" should be included in all major public facilities such as*

shopping centers, parks, airports, and restaurants. These would provide a rest space to breast-feed or change the baby. *Strollers could be made more readily available in these places. Stroller access to and within buildings and high chairs in restaurants are inadequate.* There is a distinct overall impression of childlessness, particularly in the cities. At every turn the message is babies are not allowed--except in playgrounds, at home, or in pictures.

Friedan goes back to the 1890's writings of Charlotte Perkins Gilman for a partial solution. In response to the incredible isolation of nuclear family life and the endless drudgery of perfection housekeeping, she reconstructs Gilman's vision of changing architecture to match changing needs for women. The house is the symbol of the oppression of mothers. It is the foundation of the dream--the end. It is the prison from which the Mythology drama is enacted. Major social change cannot come about without concrete structural change. Gilman proposes housing units with kitchenless apartments--common dining facilities, common housekeeping/gardening help, common child care. For many women, mothers particularly, entering the labor force means adding one job on top of another. Some couples are sharing more equally the house and child care. Whichever way, the fact is that another heavy burden is placed on the family. If the woman stays home with the children and the man goes out to work, there are two jobs. If she also goes out to work there are three jobs to be done. We are still socially structured for an unpaid full-time housekeeper (mother?) to be present in each house. Friedan suggests that without some major external change the oppression/mythology will remain. Women are looking for new growth and new challenges--but do they have to throw out mothering because they hate confinement and housekeeping?

The suggestion is radical, provocative and old. Variations of the extended family, communal living and cooperative housing ventures have been tried in the past few decades. Few have survived--but the need for alternatives keeps cropping up. Says Friedan--it's the house that keeps us from transcending the sex roles which have locked us in. The new equality, she believes, will be lived in new surroundings. The opposition to this in government is the refusal to accept that only 7% of Americans live the God-given "American" family dream: mom, dad, 2 children, dog, cat and house! (Friedan, 1981). Zoning laws against extended family living make this kind of living arrangement difficult. It threatens the dream family.

Friedan's proposal suggests fascinating implications and possibilities. Perhaps it would be possible to be a career woman and a mother without sacrificing absolutely everything else. Perhaps the choice to have children and parent full time for a while would be less lonely. *Experimentation and further research in extended family/multi-family living should be supported legally and socially.*

"It is a myth useful to the Right--and folly for feminists to acquisce in--that equal rights for women threaten the values of the family. In the second stage, with all those separate little houses and their appliances now requiring two incomes to purchase and support--and no housing of any kind available to meet the human needs and economic capabilities of most young and old, single or non-parenting families today, in cities or suburbs--the grand domestic revolution may be joined, by practical necessity, by men and women who never thought of themselves as feminists and never went near a commune" (1981, p. 300).

Education

It would be quite safe to conclude that curricula are patterned according to male system reality. This would obviously make it easier for boys to succeed in traditionally male areas such as maths and sciences. The myth that females can't do as well in these subjects combined with programs written for males puts females at a definite disadvantage.

Curricula that keep in mind not only non-sexism, but psychologically differentiated socialization will pay attention to the needs and ways of learning of males and females. Studies have suggested that role models and stories about men and women doing non-traditional jobs do have a positive effect. *The education system will need to be more conscious and deliberate in the role models it selects and be conscious and deliberate about its reading materials.* A few good stories in Kindergarten and one female principal are hardly enough to change a system.

If it is true that boys' early play with trucks and blocks prepares them for physics and girls' early play with dolls prepares them for mothering, *then conscious and extensive "hands on" experiences are crucial for boys and girls in both the trucks and dolls categories.* The goal is not sameness, but increased options. Girls can learn the skills necessary to also choose physics and competitiveness and boys can learn the skills necessary to choose relationship and softness.

More questions than answers grew out of this study. *Further research is needed to study the landmarks of female development. What do they mean, where do they come from and what effects do they have on her? Further research is needed into the effects of the present educational structures on female identity and development. Studies could be done to*

assess the meaning and reason for apparent solidifying of traditional values and ideas as children pass through the schools. It is an area which holds much possibility for change. Gilligan's polemic of female development applied to the educational system could provide for some exciting new discoveries.

Childbirth Preparation and Postnatal Follow-up

The natural childbirth movement (Grantly Dick-Read) increased the attention that was paid to the physical process of labour. The intention of course was to allay fears so as to increase the positive aspects of the birth. Ironically it has increased expectations out of proportion and added the anxiety about failure to an already stressed situation. *Prenatal teaching regarding the details of labour and delivery including medical terminology could be simplified.* This is not suggesting a withholding of information but rather a shifting of priorities and the accompanying message that childbirth is normal, not pathology.

The midwifery model of maternity is essentially woman to woman care. Canada is one of eight countries in WHO who do not accept this model. They remain with primarily medical, primarily male intervention in childbirth. Until such a model is accepted in Canada, progress in the direction of woman-owned birthing will be slow. The Medical Act forbids midwives to deliver and places birth in the category of pathology. *This Act must be challenged.*

Within this model a midwife would make contact with a pregnant woman at a first prenatal visit. This same person would follow her through prenatal preparation, labour, delivery and recovery at home. This becomes a person the pregnant woman can establish trust in and develop a

relationship with. During the vulnerable process of labour and delivery, procedures that must be carried out are not done by a stranger (or a man), but another woman who is trusted. In the postnatal period they have access to the home and continue nurturing the new mother. In Great Britain this midwife visits every day for 10 days. In Holland a para-professional health aide comes in to help with housework for a few days. A complete discussion on midwifery cannot be carried out here, nor is it the answer to every birthing problem. It could, however, be a key element in producing positive change within maternal health care in Canada.

The Prenatal period would be a logical time to begin building a network of support. The birth will end after a number of hours, but the aftermath is a life commitment. Presently an expectant mother will see her Prenatal Instructor and Obstetrician. In the hospital she sees nurses and doctors--perhaps her own. After discharge she sees a public health nurse once or twice, her obstetrician once and then a pediatrician. After six weeks she's on her own except for her pediatrician. She has seen an array of professionals. There is little continuity and little possibility of developing much trust and confidence in one person. If she's lucky she will have family and/or friends who can offer support. If she has a great deal of energy she can search for other support systems.

New mothers today likely have less experience and less "real" information about child care and mothering plus are weakened by medications and invasive observation techniques (Newton 1982). They need extra help and care in order to feel good about themselves and their new jobs and to be able to pass it on to the baby. Support systems are

perhaps a primary prevention of post partum emotional problems.

"Cradle Roll" for example, is a program used in some churches which provides support for every new mother. When a new baby is born, a support mother is assigned to the new mother and baby. A two year commitment is made. Visits, calls and special care and attention are the primary tasks. Although the program has some uniquely religious objectives, it becomes in fact an important support system. Programs such as these have unlimited potential.

A greater emphasis on the postnatal period could be made during the childbirth education programs. The transition to and reality of parenting seems to be a much more crucial and long term event than is presently attented to.

Hospital

If the house is the symbol of the oppression of traditional motherhood, is the hospital the symbol of the violation of women in childbirth? Probably yes. The question is whether it can be redeemed to adequately serve the needs of the uncomplicated births and humanize the truly high risk births. There are concerted efforts being made. *Physical restructuring of wards to more closely resemble home situations and reorientating nursing staff to a "non-illness nurturing" reference could be future objectives.* There is operative within hospitals the maxims--if you're in a hospital you must be sick. If you are not sick you don't need care. The appropriate theory appears to be present, the implementing of the practice is possible.

Birthing centres are opening in various American cities. The latest Canadian bid to open such a centre has been vetoed by the College of Physicians and Surgeons. *Lobbying must continue in order to provide adequate alternatives for women.* Safe home births, with special medical back-ups are also possible in some countries-why not in Canada?

The midwifery model would carry over into the hospital. *Midwives need to take charge of normal deliveries.* They need to teach medical personnel about the process of birth. The doctor, trained for pathology, needs to move in only when actual pathology is evident. Traditional female knowledge is getting lost in the maze of technology and power. There is no choice but to salvage it and build on it if women are to reclaim birth.

Media

The impact of the visual in advertising and illustrations is undoubtedly more powerful than verbal descriptions or disclaimers. It is highly unlikely that challenges to the 'media' will quickly change their profitable approach. There are, however, other ways of breaking the power they hold over the viewers. *Learning to 'read' the pictures and understanding the messages should be an early educational objective in the schools. Prenatal classes also need to give some deliberate time to the discussion of advertisements and pictures relating to pregnancy and children.* Awareness and understanding can go a long way to reducing the negative impact of the visual media.

Conclusion

The argument could be made that this study and its responses are too pessimistic. Pessimism, however, implies the awareness of destruction and injustice occurring and the accompanying resignation that that is how it will remain. This paper is not pessimistic. It is a description of a social situation which has in the past proven to have devastating effects on women and children; a situation which is still very much in evidence today.

The optimism lies primarily in the courage of women to choose to give birth and to mother--not once, but again (and again) in full knowledge of the price. This courage is the hope of newness of life. This courage is the hope for the mobilization of energies to effect real change. As women are accepting their rights to their own birth process and its uniquely female knowledge they are becoming free to release the Motherhood Mythology.

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APPENDICES

APPENDIX A

Career Development

A Resource Guide

excerpts

RATIONALE FOR CAREER DEVELOPMENT EDUCATION

Research studies and surveys conducted by the Department of Education in 1978[1] 1979[2], and 1980[3] and by the St. Vital School Division in 1977[4] have confirmed the growing interest and the need of students at the junior high and high school levels in Manitoba for additional school-based opportunities for career education and guidance. These findings have been corroborated by educators, employers, and community representatives[5], and by government specialists working in the field of youth employment[6], who have pointed to the high levels of youth unemployment and under-employment, and have looked to the school system to help in alleviating these problems by providing programs and services to assist students in making a successfu transition from school to the world of work.

This document has been prepared to provide assistance to teachers and counsello concerned with addressing those needs. The information and activities in the following pages have been designed both for group and individual counselling situations, whether in the career guidance program or integrated within other curriculum areas. The aim is to guide students in developing the understandings, awareness, and specific job-search skills necessary to setting realistic career goals and proceeding toward those goals for the student's personal benefit and that of the commun at large.

GOALS AND OBJECTIVES FOR CAREER DEVELOPMENT — GRADES 7 - 12

Included within the mandate of the Task Force on Career Development was the responsibility to "identify and describe the major concepts and goals which should guide career development programs" and to "recommend to the Department of Education" appropriate action to meet those goals. The following list encompasses the goals and their component objectives, as accepted or revised by the Department.

UNIT ONE: CAREER PLANNING AND PREPARATION — GRADES 7 - 9

1. THE INDIVIDUAL WILL EXPLORE AND DEMONSTRATE INCREASING MASTERY OF A RATIONAL DECISION-MAKING PROCESS IN CONSIDERING VARIOUS LIFE GOALS AND IN MAKING TENTATIVE CHOICES CONCERNING LONG-RANGE CAREER INTERESTS BY:
   - 1.1 understanding the steps involved in decision-making as related to all phases of career planning.
   - 1.2 understanding concepts related to decision-making such as:
     - a) the acceptance of responsibility for the outcome of decisions; coping with consequences;
     - b) the need to change decisions in accordance with new information;
     - c) the risk which attaches to decision-making;
     - d) the fact that, while others contribute information, they do not control our decisions;
     - e) the idea that failure on a particular task is not equivalent to failure in life;
     - f) the responsibility to take an active rather than passive role in planning and in decision-making with regard to one's future.
2. THE INDIVIDUAL WILL EXPLORE PERSONAL GOALS AND THEIR SIGNIFICANCE FOR CAREER PLANNING BY:
   - 2.1 identifying how personal goals are a part of making career decisions.
   - 2.2 understanding that planning helps to preserve freedom of choice and expand available options.

2.3 establishing goals for self-development and assessing where one is now in relation to the achievement of those goals.

2.4 explaining relationships between educational and occupational decisions.

2.5 selecting high school courses with respect to occupational goals.

3. THE INDIVIDUAL WILL LEARN BASIC JOB APPLICATION AND JOB-HUNTING TECHNIQUES BY:

3.1 having experiences in which to observe people at work (work exposure).

3.2 completing job application forms citing personal interests, aptitudes, and qualifications.

3.3 preparing letters, applications, resumes, and references related to career placement.

3.4 preparing for an employment interview.

4. THE STUDENT WILL ACQUIRE KNOWLEDGE ABOUT THE WORLD OF OCCUPATIONS BY:

4.1 preparing a self-inventory of personal interests, abilities, values, needs, aspirations to be used as the basis for systematic exploration of the world of occupations.

4.2 acquiring a range of occupational information about those career clusters which relate most directly to the student's self-inventory.

4.3 matching personal data with occupational data in the formulation of tentative short- and long-term plans.

4.4 acquiring understanding of career-related concepts such as "career clusters", "career ladders" (the logical progression from lower- to higher-level jobs in the same field), "employability skills", "entry options", etc.

4.5 acquiring an understanding of the factors influencing the changing world of work (e.g., changes in the production of goods and services, changing roles of men and women, etc.).

4.6 increasing occupational and self-knowledge through the use of outside resources and experiences in the community (e.g., work exposure through observation of work sites, conducting interviews relative to job skills, observing workers in non-traditional jobs, etc.).

4.7 becoming aware of the interdependency of jobs in the community.

4.8 understanding how geographical mobility may be related to certain occupational opportunities (e.g., relocation when two careers in a family are involved).

4.9 identifying factors affecting job success (responsibility, inter-personal relations, appearance, etc.).

4.10 acquiring some understanding of how to collect and evaluate data about conditions affecting employment opportunities (e.g., economics, demographic trends, etc.).

5. ON THE COMPLETION OF SECONDARY SCHOOLING, EACH INDIVIDUAL SHOULD HAVE DEVELOPED DECISION-MAKING SKILLS TO THE POINT OF BEING CAPABLE OF MAKING REALISTIC CHOICES, FROM SHORT TERM TO LONGER TERM BY:

5.1 assuming responsibility for one's own career planning.

5.2 assessing one's aspirations, values, interests, and aptitudes as factors in making career decisions and plans.

5.3 identifying, collecting and evaluating information for use in formulating post-secondary plans.

5.4 generating realistic alternatives in terms of post-secondary plans.

5.5 demonstrating capacity for decision making in ambiguous circumstances.

5.6 being able to define career investigations that help determine his/her suitability for a particular post-secondary program or job.

6. THE INDIVIDUAL WILL DEMONSTRATE JOB-APPLICATION TECHNIQUES BY:

6.1 preparing a more detailed job resume.

6.2 filling out application forms.

6.3 participating effectively in a job interview.

6.4 preparing introductory letters such as letter of application.

6.5 being aware of one's own responsibilities related to the job search.

6.6 being aware of strategies that can be employed in an effective job search.

6.7 being aware of how to prepare a budget in the support of short- and long-term career goals.

6.8 being aware that career directions are continuously open to chance.

6.9 applying all previous knowledge in preparing a comprehensive career plan.

UNIT FOUR: WORK AND WORKING -- GRADES 10 - 12

7. THE INDIVIDUAL WILL ACQUIRE KNOWLEDGE OF THE WORLD OF WORK ADEQUATE FOR CONTINUING HIS/HER PLANNING BY:

7.1 understanding the concepts of intrinsic and extrinsic satisfaction in work.

7.2 acquiring the resources and information necessary for making occupational and educational decisions (descriptions of occupations, working conditions, environmental conditions, prerequisites, availability, mobility, promotion, training, facilities, wages, abilities, interests, projected trends, etc.).

7.3 gaining an understanding of local places of employment (and the limitations of local employment).

7.4 understanding the routes for advancement in selected occupations of personal interest.

7.5 knowing the expectations and needs of the employer.

7.6 understanding occupational classifications in the world of work (for example, the CCDO).

7.7 having some practical work experience.

7.8 being able to utilize the resources and information available in the divisional, community or school career centre.

7.9 understanding typical on-the-job conflicts and methods to resolve conflicts (e.g., absenteeism, harrassment, hazing and failure to communicate).

7.10 being aware of the importance of appropriate work habits.

NOTES FOR THE LEADER

One way to develop a definition for the term 'lifestyle' is to investigate ways in which careers influence individuals involved in them. Another way is to reflect on the way an individual prefers to live. You have only to compare the typical lifestyles involved with such occupations as actor, banker, farmer, ecologist, soldier, politician, and rock musician to realize the elements in those occupations that affect lifestyle.

Related to the notion of lifestyle are a number of concepts. They can be briefly summarized as follows:

1. Every indivdual develops a personal "style" which he/she can fulfill in a career which has a similar "style".

2. People pursue careers for many reasons. A person may be suited for several different careers.

3. The choice of a career usually involves a compromise between greater and lesser needs.

4. People change, and change careers, as they go through life.

5. A worker must understand not only his/her job, but also his/her employer's policies and procedures.

The family has a tremendous influence on lifestyle. In Ready, Aim . . . Aspire!, the authors see a number of issues related to these influences from parents and relatives:[25]

1. Early childhood fascination with such career models as firefighter, teacher, policeman, flight attendant, doctor, lawyer and astronaut;

2. Approving or disapproving commentary about certain careers heard over the years;

3. Discussions in the areas of social status and work;

4. Events or influences that brought students into contact with their first jobs;

5. Personal skills and talents versus family connections and expectations which may have affected job pursuits.

ACTIVITY A: YOUR LIFESTYLE

PERFORMANCE OBJECTIVE:

The student will analyze case studies in order to gain an understanding of "lifestyle".

SUGGESTED GRADE LEVEL: Grades 10 - 11 - 12

TIME REQUIRED: 40 - 80 minutes.

PREPARATION: Ensure adequate supply of student materials.

PROCEDURE:

1. The leader should introduce this unit by informing students of the following facts.

   Some facts:[26]

   a) Most Canadians spend two-thirds of their waking lives working in a chosen career. Choose carefully!

   b) Nearly 60% of Canadians are not satisfied with the work they are doing.

   c) The majority of girls between grades 9 and 11 have lowered their career ambitions. Many have settled on 'female jobs' requiring little further training (health semi-professions, child care, secretarial, clerk, and other office work).

   d) Many girls' greatest fear for the future is that they might not marry.

   e) Today, most women are employed for five to ten years before having a child, spend a maximum of ten years at home with pre-schoolers, then go back on the job for another 30 years or so until retirement age.

   f) Unfortunately, for the young girls who give little or no thought to preparing for their 35-40 years on the work force, one of the most important factors in determining what jobs they will hold during most of their lives is their level of education.

   g) Almost half of all women workers are concentrated in only ten occupations. By contrast, the 20 leading occupations for men account for fewer than 40% of their number.

   h) In 1976, there were 28 divorces for every 100 marriages in Canada. As a result, in that year alone 30,500 new single parent mothers had to fend for themselves. 44% of them or 13,420, are now living in poverty.

   i) Most Canadian women are bound to become widows and when they do, they will become members of the poorest group in Canada. In 1975, 45% of widows aged 55 to 64 were poor, as were 66% of those over the age of 65.

j) School counsellors tend to have stereotyped ideas about women, work and the family which they use in counselling girls on their future plans.

k) Women feel that the amenities associated with work are more important than do men and are more willing to accept lower salaries.

l) The Job Satisfaction Survey found that women are less concerned than men with the availability of promotional opportunities and the chance to get ahead.

The leader should conclude by emphasizing that we need greater equality in education, equality in the labour market, and equality in marriage.

2. Distribute the Six Young Women handout. Students should read the cases and complete the questions at the end.

3. The leader should generate a discussion based on the student answers. Since all 'six young women' will probably not be chosen, the leader should also discuss those who weren't.

NOTES:

SIX YOUNG WOMEN

LINDA

Linda is a good student. She likes typing, history and math, and enjoys reading historical novels. Linda is shy, but warm and friendly if people speak to her first. She spends some of her time in class gazing out of the window, daydreaming.

Linda is an only child and has a "fair" relationship with her parents. She does not feel close to either one.

In grade 10, Linda meets a boy in one of her classes and they become very serious about each other. This is the most meaningful relationship Linda has every had with anybody. They fall in love with each other.

When Linda is in grade 11 and her boyfriend is in grade 12, she finds she is pregnant . . .

GENILLE

Genille is an average student and likes sports and music. She plays drums in the school band and is in the Girls' Athletic Association. She is also a school social leader — a good dancer and dates a lot.

Her parents are divorced. Her mother doesn't approve of boys that are of a different religion, race or ethnic background. She wants Genille to date what she thinks is the "right kind" of boy. Genille's father is a very suspicious person and doesn't want her to date at all. Her mother and father talk about boys in one way or another much of the time. The mother frequently talks against the father to Genille. The father spoils Genille by always wanting to buy her something . . . clothes or whatever she wants.

Genille is continually thinking about dating and falling in love. She is a very energetic person — aggressive, friendly and always eager to find out what is going on.

CONNIE

Connie just doesn't seem to fit anywhere. She is not a good student, not popular and not athletic. She just can't wait to get out of school. She is rather cute, but when she talks with a boy, she feels like a dunce and her words come out all mixed up — if any come out at all.

Since Connie was a small child she has loved to take clocks (and other gadgets she could get her hands on) apart and put them back together again. She is very good at this.

Connie's parents are dead. She has changed schools many times because of being placed in various foster homes, which is one reason she is discontented in school. She is now in a foster home where she is relatively happy.

She ran away from the foster home previous to the current one because the young people that took her in were involved with drugs. She took some and had a bum trip. The young couple got scared and left her unconscious in the park. She was found by the police and placed in juvenile hall. This was her only experience with drugs. She felt "they just weren't for her."

In her present foster home it is understood that as soon as she gets out of school she should get a job and be independent. The only classes she enjoys in high school are typing and business machines. She loves to take the machines apart and fix them . . .

PHYLLIS

Phyllis is going steady with Bruce. They have lots of friends and go out more in a group rather than just by themselves. Phyllis has started thinking how she would like to get married as soon as she graduates from high school. She is not interested in working or being a career girl — she wants to be a wife and mother only.

Phyllis has some interest in her Art Design and Home Ec classes and is working on a design for a long white satin wedding gown for herself. In some of her classes the teachers think she is diligently working on assignments, but when they walk by her desk they see many drawings of wedding dresses.

Phyllis never knew her father. He just evaporated when she was about two. Phyllis is rather close to her mother. Her mother says she is glad the father is gone . . . "All he did was drink, gamble, and run around with other women anyway." Phyllis' mother also feels that men get most of the breaks . . . "But that's just the way it is. . ."

MARIA

Maria is very tall and thin. The kids tease her and call her "Giraffe". She feels very self-conscious and that she is different from other girls. Being taller than many of the boys in her class makes her feel awkward and unsure of herself around all boys.

Maria loves the water and likes to swim. She would like to go to the pool, but doesn't cut classes because her sister would probably tell on her. Her sister, short and petite, two years older and two grades above Maria, is very popular and a great student. Maria's parents and teachers always compare her unfavourably with her sister. Maria is jealous of her sister's freedom and can't wait until she is older. Nothing much interests Maria at school except swimming, sewing and a merchandising class she will take in grade 12.

Maria's parents are both professional people who have high expectations for their daughter . . .

MARCIE

Marcie doesn't like to do things for "show"; however, if she has a real interest in something, she'll spend hours on it. She is very interested in animal: nature, biology, botany . . . and people. Her favourite subjects at school are biology, art, and world geography.

She likes to sketch and draws pictures for and of her friends. Her best friend is a boy she's known since kindergarten. They share a lot of ideas and even confide about guys and girls they date.

Marcie's grades are okay. She could probably be an A student, if she really pushed herself. Marcie got involved in a project about the "balance of nature". Her teacher wanted her to enter it in a national science contest because it was so well done, but Marcie didn't choose to enter it.

Marcie has a pretty good relationship with her parents. They feel, as she does, that "success" is not measured by grades or money, but by personal satisfaction. They never make an issue about grades . . .

QUESTIONS FOR YOUR CONSIDERATION

1. Which girl's life are you planning? _____

2. Why did you choose her? _____

3. What do you think is her biggest problem? _____

4. What are her interests, values and skills? _____

5. What are her best subjects? _____

6. Will she get further education or training? When? Of what value will it be?

7. When will the girl you chose get married? (Assume she will marry.)

8. What is her husband's education? _____

9. What will his job and salary be? _____

10. Will she continue to work if they have children? _____

11. What questions would you like to ask her if you met her?

APPENDIX B

Lifestyles 205

Interim Guide

excerpts

CONTENTS

OVERVIEW

INTRODUCTION

Lifestyles 205 includes several major components which emphasize the roles of the developing individual as a producer and consumer, and as a family and community member. Lifestyles relates directly to the learners' perceptions of themselves by focusing on the choices people make to reflect the lifestyle they want to attain. Major functions of the Lifestyles program are to expand areas of choice, to confirm choice as a normal and valuable human process, and to facilitate changes in student attitudes and behaviour.

This guide provides an opportunity for students to understand the individual and his or her interaction within the family, with the community and with the environment, by examining the complex variety of alternatives and thinking processes in approaching life decisions. Students should seek information with the intent of optimizing the decision-making process. The course will integrate knowledge with valuing in order that students might translate information into their own life situations.

With such expectations, it is reasonable that Lifestyles 205 be a grade eleven or twelve level program, suitable to all students regardless of achievement or experiential background.

RATIONALE

Many changes in society increase the need for a lifestyles course at this time. We live in an age of change in the physical and social environments. There is an increased body of knowledge and choices to be made from a proliferation of material goods and lifestyles. Diversity of family groupings, a high degree of socio-economic and geographic mobility, and the profound impact of media have increased the variety of reference groups and models from which young people make choices of what constitutes a satisfying lifestyle.

In a changing world, students will need to maintain a degree of flexibility. They must make and assess their everyday decisions while recognizing their responsibilities to themselves and others, as well as to the environment with which they interact.

The Lifestyles guide will help students to resolve current issues by personal and cooperative action, by expanding an awareness of self into an awareness of community, and by developing skills which will enable students to evaluate and integrate new-found knowledge into a viable, personal lifestyle. The application of this knowledge, to areas such as decision-making, nutrition, consumer education and human development, will enable students to make better informed choices. The program provides an examination of the interaction among the many factors involved in establishing a viable lifestyle.

GOALS AND OBJECTIVES

GENERAL GOALS

The general goals of the Lifestyles 205 program are as follows:

- To develop in students knowledge, skills, understanding, and character traits that are essential for the individual's physical, mental and emotional well-being.

- To develop in students knowledge, skills, understanding, and character traits that are important to the students'

understanding of the social, political, cultural, and economic environment.

- To develop in students skills and understanding that will encourage them to accept responsibility for shaping and directing their lives.

OBJECTIVES

One of the main objectives of this program is to encourage students to identify, formulate and discover for themselves instead of simply absorbing facts, opinions and conclusions. It is important for students to discuss and analyze both their own and others' attitudes, ideas and feelings. This will assist students in critical thinking, developing skills of data collection and interpretation, and the drawing of conclusions. It is intended that students will participate effectively in individual and group activities, listen to the opinions of others, and play an active role in society. Although the Lifestyles program is designed to achieve these objectives, it may not be possible to attain all of them with each student because some must be regarded as lifelong goals.

Specific Objectives

The specific objectives for each section of this guide are as follows:

Personal Development

The student should be able to:

1. Identify a concern related to personal development.
2. Identify the components of healthy human development.
3. Define the concept of full and healthy development.
4. Relate the consequences of lifestyle choices to self and family.
5. Identify the major factors affecting physical health, positively or negatively.
6. Relate the role of nutrition to maintaining good health and fitness.
7. Identify circumstances which dictate special nutritional requirements.
8. Appraise their own nutritional status.
9. Relate the world's food resources to the philosophy of the conserver society.
10. Identify costs of primary and secondary proteins.
11. Examine food alternates.
12. Predict future eating patterns.
13. Identify current nutritional controversies.
14. Appraise sources of nutrition information.
15. Describe the interconnectedness of food production, food processing and nutrients.
16. Identify and discuss additives in food.
17. Describe the interaction of various foods and drugs.
18. Relate dental health to general health.
19. Describe the interrelationships among exercise, good health and fitness.
20. Explain the importance of safe and healthful workplaces.
21. Categorize decisions.
22. Use the decision making strategy.
23. Relate the decision making process to community and family choices.
24. Generalize that decisions are not isolated situations.
25. Illustrate the relationship between values and action.
26. Identify sources of self-knowledge and positive self-esteem.
27. Explain stress and stress management.

Consumer and Producer

The student should be able to:

1. Distinguish among accumulation, consumption, and destruction.

2. Generalize that expenditures are based on values assigned to needs and wants.
3. Describe the conflict between the consuming individual and the conserver society.
4. Identify major expenditures.
5. Demonstrate an understanding of the concept of credit.
6. Identify legislation and agencies affecting consumers as purchasers, tenants, or borrowers.
7. Identify responsible consumerism.
8. Identify security programs.
9. Identify a variety of ways in which people produce goods.
10. Identify a variety of ways in which people receive and/or provide services.
11. Demonstrate an understanding of the concept of work.
12. Identify the roles of paid and unpaid work in one's life.
13. Identify various rewards and frustrations from working.
14. Investigate the methods of career selection.
15. Distinguish among a variety of working situations.
16. Describe ways of organizing work and the workplace.
17. Explain the effect of career choice on lifestyle.
18. Describe the changing roles of men and women in the workplace.
19. Describe the role of young people in the workplace.
20. Demonstrate an understanding of the changing roles of minority groups in the workplace.
21. Distinguish among the relationships which develop within the workplace.

Interpersonal Relationships

The student should be able to:

1. Explain ways to meet personal needs and promote individual and family well-being.
2. Demonstrate an awareness of personal values and resources by taking part in simulated experiences.
3. Distinguish personal communication styles.
4. Demonstrate an understanding of ways of analyzing human interaction and dynamics.
5. Develop an understanding of self as a sexual being.
6. Demonstrate an acceptance of others as unique individuals.
7. Examine the special needs of minority groups, such as the handicapped and the aged.
8. Examine community agencies providing services to minority groups.
9. Demonstrate ways of working cooperatively to improve the community's caring resources.
10. Identify basic needs of family members in relation to life cycle stages.
11. Compare alternative family groupings.
12. Compare roles and goals of family members.
13. Explain how the family contributes to the development of its members.
14. Identify pressures upon the contemporary family.
15. Evaluate the influence of major external forces on the family.
16. Examine parenting.
17. Identify special needs of parents.
18. Identify techniques for assisting and supporting parents.
19. Describe community agencies providing care for children and assistance for parents.
20. Identify stress and crises in the family.
21. Appraise legislation and agencies affecting family life.

OBJECTIVES	CONTENT	INSTRUCTIONAL STRATEGIES AND RESOURCES
8. examine community agencies providing services to minority groups;	Roles of community agencies	Invite a speaker to the class to discuss the operation of a local community agency. Students can inquire in their community about facilities which would enable a handicapped person to gain independence in society, at all stages in their life. Resources: - nuring homes or personal care homes in your area - Manitoba School for the Deaf - C.A.M.R. - C.N.I.B. - Senior Citizen Clubs
9. demonstrate ways of working cooperatively to improve the community's caring resources.	Cooperative action to improve the community's caring resources	Arrange for class members to contribute some time as volunteers in a local agency or home and report on their experience (1-2 hours per week). Resources: - Speakers - people involved in community agencies as volunteers - Volunteer Bureau in Winnipeg
II. FAMILY ENVIRONMENTS AND FUNCTIONS The student should be able to:		
1. identify basic needs of family members in relation to life cycle stages;	Basic structure of the family: a) stages of the life cycle - newly married pair - expectant parents - parenthood - pre-school years - early school years	Diagram the stages of the life cycle (refer to Section A - Personal Development) for food requirements throughout the life cycle. Invite to the class people in various stages of the life cycle, to comment individually or as part of a group panel about:

OBJECTIVES	CONTENT	INSTRUCTIONAL STRATEGIES AND RESOURCES

	- adolescent school years
	- launching years
	- empty nest
	- aging years
	- family needs during the life cycle
		- personal goals (current and future)
		- their families
		- their work and leisure
		- time usage
		- other topics
		- "Memories of Family," film, Manitoba Department of Education Film Library
		
		Another option is to assign individual students a particular stage of the life cycle. Ask them to interview people in that stage, and report back to the class.
		
		Resources:
		- Women and Aging: A Report on the Rest of Our Lives, Canadian Advisory Council on the Status of Women
		
		Analyze case studies to determine the degree to which basic needs are met and make recommendations for improving the situation.
		
		Resources:
		- A Family is ..., Copp Clark Pitman
		- Family, McClelland and Stewart, page 1
		- Your Marriage and Family Living, McGraw-Hill Ryerson, Chapters 12, 16, 17, 19
		- Speakers
		- People Making, Science and Behavior Books
		- Parenting: Fathers, Mothers and Others, kit, J.C. Penney
		- free
		  - New Directions for Public Policy: A Position Paper on the One-Parent Family, Canadian Advisory Council on the Status of Women
		  - One-Parent Family: ACSW Principles and Recommendations, Canadian Advisory Council on the Status of Women

OBJECTIVES	CONTENT	INSTRUCTIONAL STRATEGIES AND RESOURCES
2. compare alternative family groupings;	Varied lifestyles, cultural patterns, and alternative family groupings: - childless couples - communal family living - adoption - single parent families - reconstituted (step) families - ethnic influences	Discuss television programs showing various family lifestyles. Students may wish to describe their own families to the class. Obtain information from cultural groups or centres in your area (films, speakers). Resources: - Families: Canada, McGraw-Hill Ryerson - One Parent Families in Canada, University of Toronto Press - "Alternative Lifestyles," film, School Services of Canada, 66 Portland Street, Toronto, Ontario, M5V 2M8
3. compare roles and goals of family members;	Roles and goals of family members (age, sex, relationship): - sibling position in the family - changing roles and goals within the family during the life cycle	Students may write a short paper about the effects of an individual's place in the family (eldest, middle, youngest child). Have students make a personal lifeline (see "Lifeline Game" in Personal Perspectives, McGraw-Hill Ryerson, p. 50) to define their goals throughout their lives. Resources: - Families: Canada, McGraw-Hill Ryerson, Chapter 16 - Your Marriage and Family Living, McGraw-Hill Ryerson, Chapters 4, 19 - Re-examining Sex Roles, kit, Sunburst Communications - "Chart of Happy Living" from Canadian Mental Health Organization

OBJECTIVES	CONTENT	INSTRUCTIONAL STRATEGIES AND RESOURCES
4. explain how the family contributes to the development of its members;	Human resources in the family: - share rights and responsibilities - how the family contributes to its members	Have each student make a chart to show what each family member gives and receives from the family group. Some sample headings may be: - companionship - discipline - emotional support - food - clean clothes - house care - babysitting Resources: - Your Marriage and Family Living, McGraw-Hill Ryerson, Chapter 18
5. identify pressures upon the contemporary family;	How the family is affected by work patterns, career choices	Invite to the class, or assign class members to interview, people from a variety of jobs and careers; e.g., - homemaker - mother employed outside the home - self-employed person - workers subject to transfers (RCMP or armed forces)
6. evaluate the influence of major external forces on the family;	How the family is affected by external economic, social, and political forces. Effects of: - strikes and layoffs - high interest rates - inflation - company or industry centres - current permissive morality - federal and provincial government policies	Ask a social studies, economics or sociology teacher within your school to speak to the class about how the family today is affected by outside forces. Resources: - "Changes in Economic Aspects of Family Life," from Illinois Teacher of Home Economics, Volume XXIV, #4, March/April, 1981, p. 171 - Speakers: Bank managers, union leaders, politicians, family counsellors - One-Parent Families in Canada, University of Toronto Press

OBJECTIVES	CONTENT	INSTRUCTIONAL STRATEGIES AND RESOURCES
7. examine parenting;	Parenting: - birth planning - pregnancy - special and changing needs of children a) emotional - affection - belonging - independence - achievement - self-esteem - social approval b) physical c) intellectual d) character and social needs - responsibilities of parents	Ask students to interview their own parents about their views about the special needs of children. Resources: - Films from Public Health - Your Marriage and Family Living, McGraw-Hill Ryerson, Chapters 16, 17, 19 - Practicing Parenting, Butterick Publishing Company, student workbook also available - Preparation for Parenthood, kit, Sunburst Communications - Planned Parenthood of Manitoba - "Child Development Series," film, McGraw-Hill Ryerson - Fathers, Mothers and Others, kit, Butterick Publishing Company - "Purpose of Family Planning," film, NFB - The Growing Parent: Understanding Parenthood Series, kit, Department of Education
8. identify special needs of parents;	Needs a parent must have fulfilled	Have students complete questionnaire, "Am I Parent Material?" (Available from National Organization for Non-Parents, 806 Reisterstown Road, Baltimore, MD, 21208.) Interview classmate's parents. Resources: - "Raising Kids is Hard - When You're Alone It's Harder," a slide presentation. (See: Canadian Home Economics Journal, Spring, 1980.)
9. identify techniques for assisting and supporting parents;	Parenting courses (parent effectiveness training, self-help groups):	Resources: - speakers from P.E.T. or S.T.E.P. programs - speakers/workers from Health and Community Services, Children's Aid Society, family

OBJECTIVES	CONTENT	INSTRUCTIONAL STRATEGIES AND RESOURCES
	- S.T.E.P. - Parents without Partners - LaLeche League - other self-help groups	counsellors - post-partum counselling services
10. describe community agencies providing care for children and assistance for parents;	Agencies which provide child care (day care centres, nursery schools, social agencies, churches): - private day care - government day care - volunteer day care - costs involved - staff qualifications - activities and care provided - number of spaces provided in province	Students can visit day care centres and nursery schools, and compare them in terms of: - goals - costs - quality Resources: - Families: Canada, McGraw-Hill Ryerson, Chapter 17 - speakers from centres - parents in community with children in day care or nursery school - Coalition for Day Care (parent group) in Winnipeg
11. identify stress and crises in the family;	Stress and crisis in the family: a) money management - bankruptcy b) marriage failure - divorce - separation c) death and dying - stages of grief d) family problems - abuse (wife, child, the elderly) - alcohol - drugs - illness	Contact hospitals or doctors for people able to talk to the class about the effects on the family of the illness or death of a family member. Resources: - "The Conspiracy of Silence," film, Department of Health and Welfare - One-Parent Families in Canada, University of Toronto Press - Wife Battering in Canada, Canadian Advisory Council on the Status of Women - Your Marriage and Family Living, McGraw-Hill Ryerson, Chapters 14, 20, 21 - Violence in the Family, kit, Sunburst Communications - Living with Dying, kit, Sunburst Communications

OBJECTIVES	CONTENT	INSTRUCTIONAL STRATEGIES AND RESOURCES
		- Families: Canada, McGraw-Hill Ryerson - On Death and Dying, Macmillan - speakers - A.A., doctors
12. appraise legislation and agencies affecting family life.	Legislation affecting family life: - current acts which apply to family Support agencies: - Children's Aid Society - Klinic - Mount Carmel Clinic - psychological service centre (University of Manitoba) - Inter-faith Pastoral Centre (University of Winnipeg)	Invite a lawyer to the class to discuss current legislation affecting the family. Resources: - The Law is Not For Women, Copp Clark Pitman - Family Law in Manitoba, Government of Manitoba, 1981 - Women and the Constitution, Canadian Advisory Council on the Status of Women

APPENDIX C

Manitoba Association for Childbirth and Family Education

excerpts

MANITOBA ASSOCIATION FOR CHILDBIRTH AND FAMILY EDUCATION

Outline of Courses

BIRTH PREPARATION CLASSES (pre and postnatal)

MACFE offers a series of classes consisting of a unit of 7 prenatal birth preparation classes and four postnatal evenings. The 7 prenatal classes are best taken in the last two months of pregnancy, or as close to that as scheduling will allow.

The 7 prenatal classes provide a thorough training in relaxation, breathing, and pushing techniques in preparation for labour and delivery. Medical lectures cover the process of labour and birth, signs and stages of labour, the use of anaesthetics, unexpected outcomes (including Cesarean birth) and medical interventions. Other topics of discussion include the choices available in planning one's childbirth experience, effective decision-making, available reading material, the role of the coach, hospital procedures during labour and delivery and post-partum, the range of birth experiences and possible emotional reactions, bonding, circumcision, contraception, and post-partum adjustments for the family. Special discussion sessions for coaches led by an experienced coach provide a unique opportunity for coaches/fathers to discuss their concerns. The classes will include at least two films showing both vaginal and Cesarean births, as well as a visit from and discussion with couples (with their babies) who have recently taken the classes.

The four postnatal evenings included in the Birth Preparation series take place after a break of several weeks to allow for deliveries. The evenings are led by speakers from various health disciplines including the following:

1. Pediatrician - topics include the newborn examination, common ailments, recognizing illness, question period
2. Pediatric Dentist - discussion on preventative dental care
3. Home Economist - discussion of infant nutrition in the first year, weaning, solids, concerns
4. Child Psychologist - discussion of early childhood development.

The postnatal classes also provide an excellent opportunity for participants to share their birth experiences, parenting concerns and establish contacts with other new parents. Some topics for discussi will be using community resources, Mother's groups and self-help groups, starting up a baby-sitting co-operative and child care optio

At the end of this series, the couples will decide whether or not to continue meeting together, MACFE will provide resources to help thes groups schedule their own evenings around topics such as accident prevention, various aspects of family life, infant CPR, etc.

M.A.C.F.E. August 1982

Proposal for Initial Series of Childbirth Education Classes
Draft Copy

Introduction

This section outlines some of the beliefs and assumptions about the nature of the childbirth experience which have determined both the content of this proposed series of classes and the style in which it is offered.

1. Childbirth as a Life Crisis

Birth is not simply a medical event but a "life-crisis" - a time of change and growth that affects many aspects of one's life. A quality programme of childbirth education should deal with the emotional, marital and lifestyle considerations of childbearing, as well as practical preparation for the labour and birth. Events surrounding birth can be the opportunity to learn life skills in areas of family health and development, and consumer decision making.

We support the concept of family-centred maternity and infant care. We aim also to promote the concept of a family centred childbirth and family education and to provide opportunities to include not only fathers, but siblings, grandparents and so on, where appropriate.

In our society, a great number of parents are isolated from traditional family supports, from other new parents, as well as from previous acquaintances and colleagues. A priority of the program should be to provide the opportunity for prospective parents to find and form a "community" with other new parents in order to share information as well as support around childbearing and family issues.

2. The Need for an Integrated Approach to Childbirth Education

We wish to address the lack of continuity in childbirth education programmes (particularly the lack of early parenting information and support) by running a series of pre and post-natal classes designed as a unit. Programmes, services surrounding conception, pregnancy, birth, and parenting have traditionally been fragmented among different service providers, an approach which does not acknowledge the continuous nature of the childbirth experience and does not provide the opportunity for the development of peer support. Ideally, parents should have the option of choosing an integrated programme of classes which cover topics from pre-pregnancy planning to early parenting skills.

The 1st stage of our programme development has been to combine an 8 week pre-natal, with a 3-7 week post-natal programme. This includes a core programme of Birth Preparation, with pre-natal units on "Post Partum", "Buying for the Baby", "Infant Feeding" and "Physical Care of the Baby" along with several post-natal classes and discussion evenings.

The 2nd stage of this course development will be to incorporate early and mid-pregnancy classes (and possibly a pre-pregnancy class) into this basic serie

The programme should be determined by the actual needs and interests of the particular consumer group addressed, both in content and presentation.

The programme should be designed to permit the maximum possible choice by clients for their own particular needs. Some families would choose a comprehensive programme, experienced parents may desire a "refresher" course only. Adoptive parents, single mothers, non English speaking couples would have specific and different concerns.

The programme should provide information and opportunities for discussion at the time of greatest need and concern.

We support the ICEA motto - "Freedom of choice through knowledge of alternatives". This means that we should educate with known facts on available and possible alternatives. This may include an historical overview as well as a survey of studies evaluating medical and cultural practices. Our aim should not be to train consumers to accept or reject standard medical practices. Rather, we should help them examine the rationale for these procedures.

In classes, the emphasis should be on how to make decisions based on available information and the values of the parent consumers; rather than on advice-giving, value judgements or "right answers". We believe that there is a range of acceptable alternatives and that in providing access to credible information on choices available to them, we free parents to make the best decisions for their own families.

This approach requires thorough research into issues and options surrounding childbirth and child care, and a willingness to allot the class time required to cover all aspects of topics of concern in this manner.

Role of the Childbirth Educator

The teacher-student relationship should be based on mutual respect and shared learning.

The teacher is not "the expert" who has had a "perfect" birth and has all the right answers, nor should s(he) be protective - shielding parents from potentially unpleasant information.

While some of the information and "techniques" may need to be "taught" - lecture or demonstration style - much can be learned by sharing and discussion. A priority should be placed on encouraging an atmosphere of openness and acceptance, where concerns and differences can be freely aired. Techniques should be taught in a non-dogmatic way, acknowledging individual differences and needs and encouraging the improvisation of learned skills.

The ability to facilitate this kind of group sharing should be a priority in training and selecting teachers. It is equally important to develop the teacher's ability to come to an understanding of his or her own attitudes and biases in order that s(he) may present issues objectively, with a view to encouraging couples to make responsible choices for their own families.

In keeping with our belief that birth is a shared family event, the inclusion of experienced fathers/coaches in teaching should be a priority.

APPENDIX D

i) Women's Hospital at Health Sciences Centre
Philosophy and Objectives
Obstetrical Nursing

ii) Post Partum Integrated Care
excerpts

August 4, 1982

PHILOSOPHY AND OBJECTIVES

Departments of Nursing

I. WE BELIEVE that nursing is the provision of care generated by the patients' needs. Such needs may derive from the promotion of health, the prevention of illness, restoration during illness, and preparation for return to the community, or a peaceful death.

1. Patients' needs will be identified on a written plan of care.
2. Patients/family will participate in the planning of his care.
3. The provision of patient care will be consistent with the written plan.

II. WE BELIEVE that nursing care is based on a dynamic body of scientific knowledge, validated by research, and communicated to practitioners.

1. The planning, provision and evaluation of nursing care will be based on sound knowledge, and accepted principles.
2. Changes in nursing practice will reflect the dynamism of the knowledge on which it is based.

III. WE BELIEVE that nursing as a profession has the responsibility to define the standards of care to be provided, and to be held accountable for the quality of care actually provided.

1. Written standards will be available, against which actual care given may be measured.
2. A system of audit will be maintained.
3. The results of audit will direct changes and improvements.

IV. WE BELIEVE that nursing functions as part of the broader health team. Because of its unique constancy it is in the best position to co-ordinate the efforts of other professions at the patient's level, and to initiate collaborative efforts on the patients' behalf.

1. Professional nursing care will be available on a continuous basis.
2. Nursing interventions are co-ordinated with those of other professionals, at the patient level.
3. Multidisciplinary patient-centred conferences will be promoted.

V. WE BELIEVE that nursing care must be provided by staff who are qualified to carry out their responsibilities.

1. Direct nursing care will be provided by professional nurses.
2. Non-professional staff will engage in activities which facilitate, enhance, or support the professional nurses responsibilities.
3. A staff evaluation program will be maintained.

VI. WE BELIEVE that nurses who are charged with the responsibility of providing patient care deserve opportunities to continue their professional growth, to experience success in carrying out their responsibilities and to experience the trust and support of others.

1. Staff will be oriented to their job responsibilities and the expected level of performance.
2. Opportunities to acquire the skills and knowledge to do the job will be provided.

VII. WE BELIEVE that the planning and provision of nursing care must involve participation by the patient and his family and must take into account the community of which he is a member and its cultural values.

1. Nursing care plans include preparation for discharge.
2. Nursing care plans include special needs imposed by ethnic, cultural or social situations.
3. Nursing care plans include reference to agencies which may be involved in post-hospital care.

HEALTH SCIENCES CENTRE
WOMEN'S HOSPITAL
DEPARTMENT OF NURSING

PHILOSOPHY

The Department of Nursing, Women's Hospital, accepts and adopts the Philosophy and Objectives for the Departments of Nursing, Health Sciences Centre.

The Department of Nursing, Women's Hospital, embraces further beliefs regarding the practice of nursing, expressed through the following:

We believe that since life-style is a basic ingredient of health, nurses must be leaders in health education.

1. Patients and families will be assisted in identifying and meeting their health care needs.
2. The public's awareness of good health habits and practices will be increased.
3. The public's awareness of services and agencies available to meet their needs, will be increased.

We believe that nurses have a responsibility to be advocates for patients in promoting and maintaining their human rights and dignity.

1. Patient confidentiality and privacy will be maintained.
2. Patients will be assisted in making informed decisions regarding their care.
3. Patient safety will be ensured.

October, 1982

HEALTH SCIENCES CENTRE
WOMEN'S HOSPITAL
DEPARTMENT OF NURSING

OBJECTIVES

1. To provide quality patient care by:
   - establishing and implementing nursing standards describing the quality of nursing practice.
   - using nursing standards as the basis for evaluation of quality patient care and nursing practice.
   - utilizing the nursing process as an organized approach to individualized patient care planning.
   - selecting and appropriately utilizing qualified and competent nursing staff.
   - adhering to hospital policies and procedures.
   - respecting patient's rights.
   - practicing a multidisciplinary approach to patient care.
   - practicing family-centered nursing care.

2. To promote individual growth and development by:
   - creating an environment which allows the individual to realize his highest potential.
   - facilitating communication on a formal and informal basis; allowing the individual to participate and affect his role.
   - conducting regular performance appraisals based on mutually agreed upon goals.
   - promoting an environment in which individuals are responsible and accountable for their own behavior.

3. To support, encourage and participate in educational activities
   - assisting staff and students to identify their educational needs.

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OBJECTIVES (cont'd)

- assisting patients and families to identify and meet their health care needs.
- increasing patients and families awareness of good health habits and practices.
- increasing patients and families awareness of services and agencies available to meet their needs.

4. To initiate, conduct and assess research findings for possible implementation to improve quality of patient care.

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Revised: January, 1984

HEALTH SCIENCES CENTRE
WOMEN'S HOSPITAL

PHILOSOPHY OF MATERNITY/NEWBORN NURSING

1. We believe that the Maternal/Newborn Nursing Service at Women's Hospital has the unique responsibility of caring for women at one of the most critical periods of their lives, of including their family and of fostering interaction between the parents and their newborn child. We recognize that not all pregnancies have happy outcomes and we acknowledge our responsibility to support and comfort the grieving family.

2. We believe that each patient should be treated as an individual with her/his own uniqueness; each patient has her own needs and expectations and each patient is part of a "family" and community to which she will return at the end of her/his hospitalization.

3. We believe that as a high risk referral centre, we have a responsibility to cooperate with other members of the health team in providing skillful, knowledgeable and compassionate care.

4. We believe that we are the patient's advocates and are responsible to coordinate the efforts of other professionals in the hospital and community on the patient's behalf.

5. We believe that patient education including the promotion of healthy lifestyles, is a significant part of Maternity/Newborn nursing today, and that evaluation of the patient's learning needs is an important part of our assessment and should guide our intervention and our referrals.

6. We believe that an opportunity should be provided for continuing development of nursing personnel through Inservice Education and encouragement to participate in post basic study. We also believe that each nurse must be self-directed and is responsible for her own personal and professional growth.

March, 1983

HEALTH SCIENCES CENTRE
WOMEN'S HOSPITAL

OBJECTIVES OF MATERNITY/NEWBORN NURSING

1. a) Interaction between patients and their infant(s) will be actively encouraged.

   b) Flexibility will govern care.

   c) The grieving family will be provided with privacy, professional and family support, and the opportunity to grieve as they choose.

2. a) Individual care plans will be developed based on the patient's needs.

   b) Discharge planning will be instituted on initial contact, if at all possible, and will be realistically based on the patient's family and community support structures.

3. a) Nursing care plans will include referrals to other disciplines within the hosptial and to community agencies and services.

   b) Nursing care will be based on the Nursing Process.

   c) Nursing care will be evaluated in terms of written standards.

   d) Standards will spell out our commitment to knowledgeable, skillful and compassionate care.

4. a) The parents will be involved in making decisions regarding care of mother and baby.

   b) The patient's rights will be respected and the nurse will be her/his advocate at all times.

5. a) Standards for patient teaching/learning will be written.

   b) Each patient's learning needs will be assessed.

   c) Priorities for teaching/learning will be established for and with each patient.

6. a) Opportunities to acquire the knowledge and skills to give the highest standard of care will be provided.

   b) Nurses will be evaluated in terms of their responsibility for their own personal and professional growth. Their efforts will be acknowledged and encouraged.

March 1, 1983

HEALTH SCIENCES CENTRE

WOMEN'S HOSPITAL

INTEGRATED POST PARTUM CARE

Written by:

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INTEGRATED FAMILY CENTERED CARE

A PROPOSED CHANGE

In their publication entitled, Recommended Standards for Maternity an Newborn Care, the Department of National Health and Welfare, Canada, has stated that, "modern maternity and newborn services should be fam centered" (1968, p.2). Organizations representing a wide spectrum of professionals involved in Maternal-Child Health Care have endorsed the philosophy of Family-Centered Maternity/newborn care (Interprofessional Task Force on Health Care of Women and Children, 1978). In light of these recommendations as well as wide spread support in the literature and community, the Department of Nursing, Women's Hosp tal, has adopted a philosopny of Family-Centered Care.

Family Centered Care Defined

The Canadian Institute of Child Health (1980) has stressed the import ance of providing maternal-newborn care which enhances family unity a well as provides physical safety for both mother and baby. Their def nition of family centered is: "The delivery of safe quality care of both the physical and psychosocial needs of the mother, the father, the child and the family. The frame of reference is health rather than illness in an environment in which childbirth is appreciated as the basis of family development, and the family as the cornerstone of society" (p.5). Along these same philosophical lines, Weidenbach (1967, p.6) states, "the nurse who practices family centered maternity nursing regards childbearing not merely as a natural physiological experience but as a socially significant process, essential for creati growth and development of the family..." Traditional maternity care has focused on the mother and secondarily on her infant. It is only that health professionals have begun to recognize the fact that the process of childbirth impacts on the entire family and nursing care mu be based on the needs of the family to promote family unity and ease i assumption of the parental role.

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APPENDIX E

St. Boniface General Hospital

Philosophy and Objectives

Obstetrical Nursing

PHILOSOPHY

DEPARTMENT OF MATERNAL/CHILD NURSING

The following philosophical statement reflects the beliefs of the Department of Maternal/Child Nursing. These concepts are incorporated in the nursing care offered to our patients and serve as a guide for program development. The focus is on health care of women and children within the family, community, and society.

All patients have a right to optimal care. In regard to children this means that the child has the right to be born healthy and then continue to have quality health care throughout his/her lifespan. Each child has rights, responsibilities and privileges both as a member of the family and as an individual within a larger society. In regard to women we believe that they need to be informed of their alternatives regarding health care and to participate in the decision-making process. Nursing practice in the care of women necessitates a non-judgemental role of patient advocacy. Women are holistic beings who should not be treated as a set of organs but as unique individuals. In regard to both women and children, we believe in promoting an environment conducive to optimum health within each individual's lifestyle.

We believe that reproductive health serves as a basis for a healthy society and that childbearing is a normal physiological process which impacts upon the whole family. Childbearing necessitates adoption of the parental role and requires adaptation on the part of the individual and the family. Nursing can facilitate that adaptive process and foster positive growth for the family. Nursing recognizes that each family is the fundamental unit of society and holds the prime responsibility and privilege of rearing, educating and caring for the child.

We believe that nursing personnel have a professional responsibility to be current in their practice. Nursing incorporates the nursing process as well as the conduction of research as an integral part of nursing practice. The nurse as a learner must be self-motivated and as a result, each individual is responsible for contributing to her/his own learning. We are committed to the promotion of a positive educational milieu for patients, staff and students.

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Nurses are members of the health team and part of a larger community. Nurses do not work in isolation but bridge the gap between hospital and home. We believe in collaborating with health team members and supporting community services to promote continuity of care for mother, baby and family.

Objectives

1. To develop and maintain safe standards of care for Maternal/Child Nursing.

2. To provide a system of care which minimizes separation for mother, infant and other family members.

3. To offer and develop patient education programs which foster independence and self care.

4. To inform patients of their options regarding their health and supply opportunities and services to exercise those options.

5. To develop programs with other agencies and departments which provide for continuity of care and teaching during the childbearing and childrearing periods.

6. To promote early detection and prevention of factors contributing to high-risk status in individuals and families.

7. To develop nursing roles and staff education programs which foster the acquisition of advanced clinical skills and foster the role of the teacher/practitioner.

8. To carry out periodic evaluation to determine the quality of nursing care given and the degree to which objectives have been met.

*In the preceeding Philosophy and Objectives, the term "Patient" refers to both the individual and his family and significant others.

APPENDIX F

Winnipeg Free Press

July 26, 1984

LIFE TIME

Birth centre rejected

TORONTO — A group trying to establish Canada's first birth centre for women who want to deliver their babies outside a hospital says the proposal has been rejected because the political and medical systems are dominated by men.

Ontario Health Minister Keith Norton has refused to meet the group.

Members of the Toronto Birth Centre Committee, who have been trying for five years to get money from the Ontario government for a birth clinic, told reporters at the legislature Thursday that Norton wants to keep obstetrical care "in the Dark Ages."

Birth centres, which have been established in the United States, Australia, Britain and the Netherlands, provide alternative care for women who do not wish to have their babies delivered in hospitals.