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"Halfway towards recovery": Rehabilitating the relational self in narratives of postnatal depression

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ABSTRACT

This article explores expositions of subjectivity in accounts of postnatal depression (PND). It examines the public narratives of 19 Australian women contributing to a health information website (healthtalkaustralia.org), collected across two Australian qualitative research studies conducted between 2011 and 2014. For the first part of the paper we analysed narrative data using a combination of phenomenological and psychoanalytic techniques. We found that postnatal distress was described in embodied, relational terms and that women depicted their distress as a pre-verbal intrusion into 'known' selves. We interpreted this intrusion as a doubly relational phenomenon - informed at once by a woman's encounter with her infant and her 'body memory' of earlier relational experiences. For the second part we examined how and why women classified this relational distress as PND. We drew on illness narrative literature and recent work on narrative identity to explore why women would want to 'narrate PND' – an apparently antithetical act in an environment where there is a duty to be a good (healthy) mother. We highlight the dual purpose of the public PND narration – as a means of re-establishing a socially sanctioned known self *and* as a relational act prompted by the heightened relationality of early maternity. Our focus on the salutary aspects of narrating PND, and its links to relational maternal subjectivities, offers a novel contribution to the current literature and a timely analysis of a largely uninterrogated sociocultural phenomenon.

1. Introduction

The distress of women diagnosed with postnatal depression (PND) has been considered from different vantage points. Historically, biomedical researchers have tended to examine disease processes, hormones and psychological vulnerabilities (O'Hara and Swain, 1996; Wisner et al., 2002). They have also considered stressful life events, lack of social support and marital discord (Beck, 2001; O'Hara and Swain, 1996); however, largely within a positivist epistemology more concerned with the 'nature of disease' than women's own language about suffering.

A counterpoint is the growing body of work using feminist and health sociology perspectives – frameworks that foreground both the lived experience of early maternal distress (e.g. Edhborg et al., 2005; Rodrigues et al., 2003) and the broader social context in which that distress emerges (Oakley, 1980; Nicolson, 1998).

A third perspective has sought to integrate the psychic and the social. This is reflected in the growing interest in how concepts such as identity change and 'loss of self' are linked to postnatal distress (Beck, 2002; Everingham et al., 2006). However despite the current popularity of these concepts, there remain theoretical gaps in our understanding of self and identity in the early maternal context. The increasingly sophisticated body of work on the psychosocial self that has been emerging elsewhere in the health sociology field is yet to be incorporated into studies of PND. In particular growing interest in the relational self (e.g. Fullagar and O'Brien, 2014; Ussher and Perz, 2008), embodiment (e.g. Freund, 1990; Williams, 2000) and intersubjectivity (e.g. Crawford, 2009) has, with the exception of work by social psychologists such as Natasha Mauthner (2002, 1999), remained largely absent from the PND literature.

PND as a sociocultural phenomenon has also received remarkably scant attention. Current studies tend to either accept the concept uncritically or dismiss it altogether. Nevertheless there is an unspoken consensus across theoretical frameworks that women

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do not want to be diagnosed with PND. This is reflected in the attention paid to PND and stigma in the biomedical literature (e.g. Edwards and Timmons, 2005), and conversely in the feminist literature seeking to dismantle the concept (e.g. Nicolson, 1998).

The proliferation of fora in which the diagnosis is openly discussed and actively 'claimed', including 'mummy blogs' (see Circle of Moms, 2012), celebrity memoirs (Rowe, 2015; Shields, 2006), and PND support groups has in contrast remained largely uninterrogated. Furthermore, despite asserting the centrality of identity to postnatal distress, the PND literature has yet to incorporate reflections on the *identity work* associated with claiming a diagnosis, as discussed in the context of 'generic' depression (Kokanovic et al., 2013), terminal illness (Avrahami, 2003) and chronic illness (Adams et al., 1997; Asbring, 2001).

In this paper we address these lacunae in the literature and comment on their interplay. We reference the interdisciplinary turn in contemporary work on subjectivity (e.g. Butler, 2001) and combine feminist psychoanalytic and existential phenomenology frameworks with a poststructural reading of illness narratives. Our objective is to generate a more nuanced understanding of how distress in early maternity, and the process of diagnosing and 'storying' this distress, relate to maternal subjectivities as they exist in neoliberal societies.

2. Theoretical framework

2.1. Pre-verbal selves

Most existing PND literature describes maternal identity change as a linear, narrative arc from constructs such as 'career woman' to 'stay-at-home mother.' It attributes the distress associated with this move both to structural realities and to the dissonance between how a woman experienced herself before motherhood and how she sees herself, or fears others might see her, after maternity (Beck, 2002; Nicolson, 1998; Oakley, 1980). Importantly, it is a process that is seen to occur at a conscious, speaking 'I' level.

This is at odds with the increasing emphasis on pre-conscious or non-verbal aspects of the self in contemporary research on subjectivity. One thread is influenced by psychoanalytic thought. Judith Butler (2001), for instance, draws on object-relations theories in particular to discredit the Kantian notion of the unitary self. Butler holds that when we respond to changes in our lives, we do so both at conscious and pre-conscious levels. Furthermore, the pre-conscious is populated, or indeed 'besieged' (Butler, 2001, p. 74), by earlier experiences with an Other. Butler argues that before we become thinking, speaking beings there must be a 'primary, inaugurating impingement (…) by the Other' (2001, p. 85), where the Other is at once material caregiver and the sociocultural norms (s) he transmits. This extends the Freudian notion that our earliest relationships are 'carried over' through *Übertragung* (transference) and inform how we relate to others and feel about ourselves in subsequent relationships (Freud, 2000). It also suggests the unconscious, or pre-verbal, is an under-researched site for 'identity struggle' in women experiencing early maternal distress.

Another thread of subjectivity research focuses on *embodiment*. This references Heidegger's idea that the body is at once *Körper* (body-as-object) and *Leib* (lived body) - the vehicle through which we experience 'being-in-the-world' (Heidegger, 1967). The idea that the body can mediate experience has been important for recent thinking about illness and subjectivity. Drew Leder (1990) writes on how a body in pain becomes a body-as-object, disrupting a person's sense of lived body, and by extension harmonious being-in-the-world. There is also an expanding literature on the embodied mind. Thomas Fuchs (2012) combines phenomenological and psychoanalytic ideas to describe the notion of 'body memory' – the corporeal storing of experience that re-emerges not as explicit memory but in posture and patterns of behavior. Similarly, Elizabeth Wilson (2004) locates the mind, and by extension subjectivity, as much in the gut as in the conscious self.

Finally, subjectivity scholars have in recent years advocated a 'turn to affect' (see Wetherell, 2013), seeking to expose the non-linguistic elements that shape subjective experience, and move between subjects. Authors concerned with affect focus not only on embodiment, but also on *intercorporeality*. Lisa Blackman (2010), for instance, has written extensively on how matter, affect and even non-linguistic traumatic memories circulate between, and constitute, embodied subjects.

2.2. Maternal subjectivities

That an embodied and relational understanding of the self might be particularly relevant to early maternity is not a novel idea. French feminist psychoanalysts such as Julia Kristeva and Luce Irigaray, and more recently, maternal studies scholars such as Baraitser (2009), Stone (2012) and Hollway (2015) have devoted considerable attention to the relational maternal self. Both Irigaray (Irigaray and Wenzel, 1981) and Kristeva (1977) argue that the experience of maternity, starting with the two-in-one state of pregnancy and extending into the profoundly bodily, pre-verbal rhythms of early mother-infant 'being-with,' destabilises a woman's preexisting conceptualisations of autonomous selfhood.

Bracha Ettinger (2010) calls this process 'fragilisation.' She emphasises the intersubjective potential of such a state, but cautions that it is threatening for women in neoliberal societies, who usually function in an autonomous 'phallic' mode. Crucially for our understanding of early maternal distress, it is especially confronting for women whose infantile experiences of relationality were traumatic. Often such women were 'defensively' autonomous (see Hollway, 2015, Chapter 7) before becoming mothers, a characteristic at once prompted by a desire to escape the threat of relationality and rewarded by patriarchal systems requiring autonomous workers.

This brings us to the 'doubly relational' (Stone, 2012) nature of the maternal self – a self not only constituted by a woman's interactions with her infant, but also by her experiences of having been an infant herself. Maternal studies scholars suggest a particularly potent form of *Übertragung* in early maternity (Raphael-Leff, 2000; Stone, 2012). Joan Raphael-Leff (2000) posits that the postnatal haze of smells, secretions and intimate encounters activates a woman's pre-linguistic memories of infancy, which in turn ignite infantile states of being or, as Sara Beardsworth (2004, p. 263) terms it, an 'upsurge of forgotten body relationships.' A woman therefore encounters her baby for the first time, but also (re-)encounters her self-as-baby, or more precisely, her self-as-baby-relating-to-mother. To Raphael-Leff (2000), early maternal distress is thus located as much in a woman's past relations as it is in present maternal encounters.

The prominence of the pre-verbal and the infantile in maternal subjectivity is of course contested – Kristeva, for example, in her focus on the maternal *semiotic*, has been criticized for placing mothers 'outside culture' and reifying woman-nature/man-reason binaries (see Butler, 1990). However, recent maternal studies scholars have engaged creatively with the problem of the relational mother who also speaks. Lisa Baraitser (2009) depicts mothers who exist at the nexus (and in the interstices) between discourse, intersubjectivity and maternal materiality. She presents a peculiarly maternal subject but not one existing before culture or entirely pre-consciously. Instead, to paraphrase Blackman (2010, p. 174), she proposes a maternal subject 'living multiplicity' (both through mother-infant intercorporeality and the Foucauldian

Other) whilst attempting to 'hang together' (Blackman, 2010, p. 174) as her own 'I.' One way in which she might do this is through narration, a topic to which we now turn.

2.3. Illness narratives and subjectivity

Critical examinations of PND narratives are conspicuously scarce. Hillary Clark (2008) provides an engaging critique of Brooke Shields' autopathography (2006), but focuses more on Shields' readers than on Shields' own negotiations with subjectivity.

In the broader illness narrative literature there have been a number of approaches to the narrating self. Early work in the field focused on how people use narrative to engage in 'biographical repair' when illness interrupts 'storied lives' (Bury, 1982; Frank, 1995). This approach emphasizes the ability of narrative to productively answer the 'who am I now?' question for people encountering unexpected illness.

Authors influenced by Foucault have focused on the regulatory function of illness narratives. They have highlighted how people speak of illness in order to demonstrate that they are good patients and to self-regulate the deviance associated with not being a fully-functioning neoliberal subject (Avrahami, 2003; Kokanovic et al., 2013). In the mental health literature the role of diagnosis has been explored by Kokanovic et al. (2013), who observe that people will often actively claim and narrate diagnoses so that worse forms of deviance (e.g. laziness) might be mitigated.

Recently the illness narrative literature has also been shaped by the turn to affect. Frank's (1995) idea that non-narrated illness experiences represent 'chaos' has been questioned by authors re-orienting to non-narrative ways of negotiating illness (Woods, 2013). Others have turned attention to the relational function of illness narratives. Einat Avrahami (2003), for example, writes on the author Harold Brodkey's HIV autopathography, exploring how Brodkey employs narrative to mobilise audiences to engage 'emotionally and ethically' (Avrahami, 2003, p. 183) with his predicament.

The question of how this scholarship might apply to PND narratives is yet to be explored. To what extent is the PND narrative an attempt to re-instate biographical coherence? How does the PND narrative articulate with broader 'good mother' discourses? In what ways does it respond to the peculiarities of the relational maternal moment? How does it give voice to what can only be felt? We hope to begin to answer these questions in this paper.

3. Methods

In this article we draw on data from video and audio recorded narrative interviews undertaken to populate two sections of an Australian health information website (www.healthtalkaustralia.org). The narrative data were collected in two separate qualitative research studies conducted in Australia: *Experiences of depression and recovery* (conducted between May 2011 and June 2012) and *Emotional experiences of early parenthood in Australian families* (conducted between May 2013 and July 2014). Both studies used rigorous scholarly methods developed by the Health Experience Research Group (HERG) at the University of Oxford (Ziebland and Hunt, 2014). We performed a secondary qualitative analysis of women's spontaneous accounts of PND – seeking to better understand the nature of the experience and to explore the personal and sociocultural contexts.

3.1. Original research

Participants were recruited through newsletters, website advertising, support groups, word-of-mouth and healthcare practitioners. Ninety women and men were interviewed across Australia. Each study aimed to capture wide variation in experiences (e.g. diagnosis, disclosure, treatments (first study); experiences of same-sex parents, IVF, surrogacy (second study). Both studies recruited participants from diverse socio-demographic and ethno-cultural backgrounds.

3.2. Current sample

In this paper we present our analysis of interview transcripts with 19 women from both studies, selected because they spontaneously talked about having been diagnosed, or self-diagnosing with, postnatal depression. Women ranged in age from 23 to 51 years, and came from predominantly middle-class, Caucasian backgrounds although some recent immigrants and socioeconomically disadvantaged participants were included. The 'PND subset' of participants was significantly more homogenous than the overall sample. We were unable to explore this phenomenon further in the scope of this paper, but believe it warrants future research.

All 19 women identified as heterosexual and were either married or in de facto relationships. Eleven women had two children and seven had only one child at the time of interview. One woman had six children. Of the 19 women, 13 had received a formal diagnosis of PND, while seven self-identified as having experienced PND. The discrepancy is because one of our participants self-identified as having PND after the birth of one child and received a formal diagnosis after the birth of another. All who had received a diagnosis (bar one) were prescribed antidepressants. Of the 19 women, 15 were in full or part-time work and one was undertaking full-time study. Three women identified as stay-at-home mothers. Most women had post-secondary qualifications and were employed in white-collar jobs. One woman owned a business.

3.3. Interviews

The narrative interview was designed to explore experiential aspects and interpretive practices situated within personal narratives (Potter and Wetherell, 1987). Participants were initially asked to tell their story of experiences of depression (first study), and emotional experiences of early parenthood (second study). A topic list was used in the second part of the interview to prompt participants to discuss study-related themes if these had not already emerged. These included: life before depression, diagnosis, treatment and recovery experiences (first study) and conception, pregnancy, birth, becoming a parent, and earlier life history (second study). Interviews lasted one to four hours and were mostly conducted in people's homes. They were video or audio recorded with participants' informed consent, transcribed strict verbatim and returned to participants for verification before being de-identified and coded using NVivo (for the purpose of analysis for the healthtalkaustralia.org website). The second author (RK) was the lead investigator of both studies. Importantly, neither of the studies explicitly asked about PND. Pseudonyms were assigned to participants. Ethics approval was granted by the Monash University Human Research Ethics Committee (MUHREC).

3.4. Analysis

In our analysis we undertook an in-depth empirical examination of the sociocultural and experiential reality of women experiencing PND. We initiated the research process by reading and re-reading interview transcripts where PND had been mentioned. We then began iteratively reviewing the social sciences literature on PND and related themes and returning to the transcripts with specific

questions/theoretical frameworks in mind. We became particularly interested in expositions of subjectivity after observing the prevalence of themes of identity and 'loss of self' in the PND literature and noticing a) the limited reference to contemporary interdisciplinary writing on subjectivity in the literature, and b) the rich descriptions of early maternal subjectivities in the interview transcripts.

In our literature review we were struck by pluralist approaches to the study of subjectivity as espoused by writers such as Judith Butler (2001), who manages to integrate psychoanalytic, Foucauldian, existential phenomenological and feminist frameworks when exploring the 'nature of being.' We found a similar theoretical flexibility in the work of contemporary maternal studies scholars (Baraitser, 2009; Hollway, 2015; Stone, 2012). This inspired our interdisciplinary approach to data analysis using a combination of phenomenological and psychoanalytic frameworks. When coding we used both 'hermeneutics of meaning recollection' and 'hermeneutics of suspicion' (Ricoeur, 1970) – in the former seeking 'an understanding of the experience on its own terms' (Davidsen, 2013, p. 329) and in the latter trying 'to shed light on the material from a more distant perspective, such as psychoanalytic (…) theory' (Davidsen, 2013, p. 329). As well as using narratives as a rich source of qualitative data, we were interested in narrative performances, co-construction (between participant and researcher/imagined public) of narratives, and the ways in which narratives were both constituted by and constituted sociocultural realities.

Initially the transcripts were read independently by each author. The first author then conducted a preliminary analysis using the iterative process described above. The second author read the preliminary analysis, provided reflections on interpretations, and suggested additional literature to strengthen the analysis. This process was repeated over several months with regular meetings in person and on Skype. If there were disagreements about interpretation, each author read the relevant literature and returned with 'substantiation' for their interpretation. The authors then agreed on which approach had most coherence with other sections of narrative and the published literature.

In our first two sections of data analysis we use phenomenological and psychoanalytic insights to present a relational, preverbal ontology for postnatal distress, as elaborated by the women we interviewed.

In our third section we use narrative inquiry to examine how the process of having this distress diagnosed (or self-diagnosed) as PND, and then 'narrating PND' related to early maternal subjectivities. In particular we explore how these processes enabled a (self-)regulation of the 'disordered' maternal body *and* a relational response to (re-)accentuated relational selves.

3.5. A note on terminology

Postnatal (or postpartum) depression is a contested term. It has recently been changed to depression 'with peripartum onset' in the DSM-5 (American Psychiatric Association, 2013), reflecting uncertainty in the psychiatric community about distinctions between 'depression', 'prepartum depression' and 'postpartum depression' (see Sharma and Mazmanian, 2014). We tend to refer to postnatal depression, as one focus of the article is to interrogate how diagnoses were talked about, and postnatal depression was still the favoured term amongst participants. We are mindful of the conceptual difficulty with the term(s) (see Fullagar and O'Brien, 2014; Nicolson, 1998). For this reason we refer to post/perinatal suffering/distress where possible.

4. Findings

4.1. The speaking 'I' interrupted

4.1.1. Embodied affects

In our study several women described the prominence of corporeal experiences of PND. Amelia, a 33-year-old married marketing professional and mother of a 3-year-old girl, described her experiences after the birth of her daughter:

> At first the symptoms of the actual postnatal depression were very much physical, um, I lost my appetite completely, I would sweat suddenly, um, and I - I had a dry mouth to a point that it didn't matter how much I drank, didn't matter how much I washed my teeth, my mouth was just dry and, um, not very pleasant.

In Amelia's account we see both Leder's (1990) foregrounding of the body-as-object and witness Amelia's failed attempts to respond in a 'rational' way. This primacy of the body was echoed in Daphne's description of experiences of PND. Daphne, a 36-year-old married customer service worker and mother of an 8-month-old baby boy, described her *"episodes"* as *"purely physiological"*:

> That sickness, like in the pit of my stomach like I always have that, you know that nervous um sick feeling um in my stomach the whole - like all the time. Um and like just a burning in my chest, like this is just purely um physiological (…) and you just have that general sort of cloudy - like my mind goes all cloudy.

In both Amelia and Daphne's narratives we discern a hyper-embodiment - a body that interrupts reason spaces, resisting Amelia's 'rational' responses, and clouding Daphne's mind. These descriptions are reminiscent of Sandor Ferenczi's (in Wilson, 2004, p. 75) observation that when 'the psychic system fails, the organism begins to think.' They extend beyond biomedical notions of physical symptoms, instead invoking a more profound corporeal disruption of pre-maternal subjectivities.

4.1.2. Disembodied thoughts and visions

Disruptions were not just described in physical terms. As in other studies, women described feelings of guilt (Beck, 2002; Edhborg et al., 2005; Mauthner, 1999), inadequacy as a mother (Edhborg et al., 2005; Mauthner, 1999), and thoughts of self-harm (Beck, 2002; Mauthner, 2002) or harming the baby (Beck, 2002; Mauthner, 2002; Raphael-Leff, 2000) as core features of the condition.

In a number of narratives these themes appeared in the form of *intrusive thoughts* or *obsessions*, thoughts that women in our study and elsewhere (see Beck, 2002) described as being qualitatively different from other thoughts and particularly distressing.

Louise, a 37-year-old married writer with a 2-year-old daughter and a 10-month-old son, told us she had developed PND a few weeks after the birth of her daughter:

> I just started to have funny thoughts, lots of strange thoughts about um, the harm that could come to her. And then it just sort of became an obsession (…) it stepped into territory where I was thinking that um, I would - you know, I could, you know, not only accidentally cause harm to her but purposely cause harm to her. I started to get plagued by - by this (…) it was almost like a 24/7 thing and trying to suppress them and push them away

Louise was at pains to convey that the thoughts were not ones she had authored. They were *"strange thoughts"* she needed to *"push (…) away."* Paradoxically then, although thoughts are generally considered to be part of the 'I' that emerges through language, these were thoughts that mocked such a linguistic self. They were not consciously generated, but rather experienced as intrusions. Louise suffered from similarly intrusive *"visions"*:

> I could feel tension, fuzziness, in my wrist. I - actually this is all coming back to me now. There was a stage where I was really uncomfortable around being around knives. Um, not that I thought I was going to harm myself, but that I - I was just having these sort of visions of like my - jabbing myself in the stomach, like with a knife.

Implicit in this account is a connection between the visions and the fuzziness in the wrists - a potential for action conveyed along neural pathways not involving a conscious self. The visions were therefore at once disembodied and embodied – they occurred independently of the eyes, the bodily apparatus for seeing – but somehow found their way into the wrists, heralding the possibility of transformation from vision to action.

Louise's account has an air of Heidegger's (1967) *Unheimlichkeit* (uncanniness) – the sense of a body that has lost its resonance with mind and world and instead asserts its own malignant authority. Here, her narrative echoes Amelia's description of her body following a visceral (il)logic impervious to 'acts of reason.' However if we examine Louise's account more closely, using our hermeneutics of suspicion, we see not a body self-directing, but rather a body *intruded upon*, 'besieged by an enigmatic alterity' (Butler, 2001, p. 74). Louise's account thus hints at a Kleinian hostile 'internal object' (the (m)other within) (see Heimann et al., 1989), and simultaneously traces how this object might become 'enfleshed' (Blackman, 2010, p.172) (here most noticeably in the wrists).

We now consider in depth how Louise's example reflects women's struggles with embodied selves-in-relation.

4.2. Relational subjectivities

Relational themes appeared both explicitly, in discussions of 'bonding' and 'attachment,' and more covertly. Women mentioned an inability to bond as a symptom of depression, and conversely the establishment of a "*bond (that) is exactly like it needs to be"* (Amelia) as a marker of recovery. This was consistent with the structure of contemporary PND memoirs (Rowe, 2015; Shields, 2006), the significance of which we comment on below.

4.2.1. Loneliness-in-company

We found relational references throughout women's accounts of early maternal subjectivity. Women spoke of feelings of disconnection from their babies and concomitantly discussed a more pervasive loneliness. Bethany, a 36-year-old childcare worker and mother of an 18-month-old son, described loneliness as a key feature of postnatal suffering:

> And I'd just be sitting alone in this room at one o'clock, you know, then four o'clock, then, you know, seven o'clock in the morning just feeling like I was the only person in the world.

Remarkably, this is a description of breastfeeding. We also know that Bethany's mother and husband were sleeping in their respective rooms close by. Similarly, Rebecca, a 33-year-old married occupational therapist and mother of 3-year-old and 1-year-old sons, described how she became afraid of being alone, even in a house filled with family:

> I couldn't be left alone, even going up to my bedroom - we lived in a townhouse then so my bedroom was upstairs, the living room was down. And going up to my bedroom I felt this real sense of loss. Um, it's almost like when you're at an airport saying goodbye to your friends, it's a real cut off, a closed door, isn't it?

Both these accounts of loneliness-in-company hint at an existential loneliness, at once a Heideggerian estrangement from the world, and a pervasive feeling of 'not being held' (see Winnicott, 1973) or of internal abandonment.

Loneliness and abandonment have been broached elsewhere in the literature on PND (Beck, 2002; Edhborg et al., 2005). Often, however, these feelings are conceptualised as a natural response to the very real isolation experienced by mothers living in neoliberal societies. Bethany and Rebecca's loneliness-in-company has been less theorised (there are some notable exceptions in the maternal studies literature, e.g. Hollway, 2015) but is key if we are to understand perinatal distress not only as a structural problem, but also in relational terms.

4.2.2. Escape

Relational troubles did not always take the form of loneliness and abandonment. Some women experienced the converse sense of being overwhelmed by closeness. Hannah, a scientist and mother of 3-year-old and 11-month-old sons, found the inability to "*escape"* from her first newborn harrowing:

> And I'm just thinking don't they (other mothers) just want to hand their baby over? Don't they just want to escape for a bit? That's all I want to do, is escape.

Similarly, Georgina, a 33-year-old marketing specialist and married mother of a 2-year-old boy, described a need to *"get away"* and an overwhelming feeling of suffocation:

> I could hear every single breath that he was taking, and - and I just remember thinking I just felt suffocated. I felt absolutely suffocated.

Georgina's account resonates with Hannah's description of PND, but also paradoxically with Bethany and Rebecca's scenes of alienation - each of these narratives is an account of intersubjective disruption, of distress that is *enunciated specifically in relational terms*.

Later in Georgina's interview she described how she called an ambulance one afternoon in the early postnatal period. Georgina's baby was crying inconsolably, and Georgina became increasingly convinced that he was not breathing. In hindsight she identified that it was clear the baby was breathing: "*because he wouldn't be able to cry if he wasn't breathing."* However at the time she found herself unable to distinguish between her own sense of suffocation and her child's state. This brings us to another central feature of the relational self – the blurring of boundaries between what is self and other.

4.2.3. Mother or daughter?

> "And what I love in you, in myself, no longer takes place for us: the birth that is never completed, the body never created once for all time, the face and form never definitely finished, always

still to be moulded. The lips never open or closed upon one single truth". (Irigaray in Hirsch, 1981, p. 211)

Women's narratives frequently presented protagonists with interchangeable mother and child roles. At times women depicted themselves or their mothers as childlike figures, or their children as having maternal qualities. Importantly these characterisations were mutable, often changing within short sections of text.

To return to Bethany – she explicitly referenced her experiences with a gravely ill mother (who was in hospital when Bethany's son was born and subsequently moved in with Bethany to recuperate) when seeking to explain the cause of her early mothering distress:

I thought maybe no one can relate to my story because (…) mine's quite specific to my mother being in hospital.

However it was not just that her mother was in hospital but also that there were "*a lot of unresolved issues from when I was young,*" with a mother who frequently "*wasn't well.*" She described how this constellation of events profoundly influenced her mother-son relationship:

I remember he would wake up in the day and I would just plonk him on the floor in front of the TV because I just didn't have anything in me to give him at all (…) was just so focused on my mum because of - because of our strained relationship.

Bethany subsequently related how in that period she would *"always check on her (mother) to make sure she was still alive"*, which was reminiscent of an earlier part of Bethany's narrative in which she described checking her newborn son.

Bethany's account poignantly illustrates the relationally contingent and historically bound nature of her maternal sense(s) of self. She explicitly privileges the daughter position by describing the need to focus on her sick mother. However her identifications are more complicated than this. Firstly, her experiences of being a daughter have historically involved mothering (looking after a mother who *"wasn't well"*). Secondly, in her description of *"plonking"* her son on the floor, she at once identifies with her son who, like her, has been abandoned, *and* presents herself as the one doing the abandoning. In this way she appears to be simultaneously grandmother (i.e. her mother), mother, and child. This blurring of generational divisions was echoed in Louise's description of her intrusive thoughts and visions as a "*kind of madness.*" When asked to clarify this, she elaborated:

I don't want to be a psychotic mother. I've - I've got one, I don't want to be another one for my children.

Here Louise illustrates her experience of merging with her mother (who was diagnosed with schizophrenia when Louise was a child). She does this by referring to *"madness"* but also in the way she references *"another"* mother. This places the psychotic mother and the potentially psychotic mother side-by-side, instead of one preceding the other. Both these examples illustrate identities extending beyond the unitary 'I.' They remind us of Alison Stone's observation that 'the mother is a relational subject but doubly so: she inhabits two sets of relations transposed upon one another' (Stone, 2012, p. 24) and of Baraitser's (2009) idea of the cyclical nature of maternal time – at once existing in the past, present and future.

4.3. Diagnosis, absolution, connection

4.3.1. Diagnosing the 'unthought known'

Several women spoke of relief on being diagnosed (or self-diagnosing) with PND. Many emphasised that when they were experiencing perinatal distress they *"did not know it was PND."* However as we have described above, the 'not knowing' existed alongside a bodily knowing or 'unthought known' (Bollas, 1987) of profound distress. Women had an embodied sense of something being amiss, but without the language to explain this sense, other explanations crept in. Louise, as we have already read, felt that her postnatal experiences were *"a kind of madness."* For her, receiving a diagnosis made her feel that she was *"halfway towards recovery."* Other women similarly spoke of great relief in finding out that diverse experiences such as anger, bonding trouble, and relationship problems could be attributed to 'having PND.' The process of receiving a diagnosis seemed to convert the unthought known into a 'thought known' that was more palatable than alternative explanations.

4.3.2. Narrating the 'good mother'

One of these possible alternative explanations was made explicit by Margaret, a 39 year-old small business owner and married mother of a 4-year-old daughter and 2-year-old son:

I was glad that I was diagnosed. Um, but what happens if that wasn't - if that's not what was wrong with me? What if I just couldn't cope with being a mum?

Margaret taps into a fear that was implicit in many of the narratives – a fear that a woman could not cope with mothering or did not even *"want to be a mum"* (Louise). This fear about being a 'failed mother' is prevalent in the PND literature (e.g. Beck, 2002; Edhborg et al., 2005). In our studies, it existed alongside the tendency to structure narratives in confessional mode (Avrahami, 2003) – starting with scenes of inattentive, uncaring mothers, going on to the 'penance' of medical treatment and ending with depictions of 'übermothers' harmoniously in tune with their offspring. The structure of these narratives reflected dominant discourses in contemporary public health campaigns and in celebrity memoirs (Rowe, 2015; Shields, 2006). The diagnosis of PND thus conferred a pre-configured emplotment (Ricoeur, 1984) - a script where time was linear, recovery could be expected, and most importantly, the end result was a *good mother*. This seemed to offer particular relief to women such as Louise and Bethany, who as we saw above, had an embodied, 'inherited' sense that they were bad mothers.

The *act* of narrating the diagnosis was also important. As Butler (2001, p. 66) notes: 'The narrative 'I' is reconstituted at every moment it is invoked in the narrative itself.' This need to repeatedly reconstitute the good mother 'I' was seen in Amelia's example – she reported that she had already spoken to *"many people"* about her experiences of PND before participating in our study – as well as in Margaret's narrative, who emphasised that she *"was quite happy to tell anyone"* about her diagnosis.

4.3.3. Public narrations – from abandonment to connection

Narratives of course do not need to be public to effect a reconstitution of the narrative 'I', however in our study we found that some women did actively seek out public narrations.

Towards the end of Amelia's narrative she discussed how her family members were skeptical about her PND narrations and her

medical framing of distress:

> The interesting thing is - is that the only people that have had a negative response (…) to me speaking about this and me staying on medication have been family members.

Amelia contrasted this to the response she received when she spoke in public:

> It's really surprised me, just how little (…) negative response I've had and it's really affirmed - reaffirm - sorry actually strengthened my belief in humanity.

Elsewhere Amelia detailed how much recognition she gained from narrating her story and how she had learned that, *"I'm allowed to talk about negative things*." Again this contrasted with her family's response:

> Why are you reliving this all the time, why are (you) staying in this, why are you mulling in this?

At times the desire to narrate publicly seemed to supersede other narrative considerations, such as adhering to the confessional mode. The timing of Bethany's act of public narration was particularly startling. Our interview with her was interrupted briefly by a phone call, after which she returned to narrating. It was only towards the end of the interview that she revealed the call had been from a private hospital, seeking to arrange her admission for PND.

Until this point Bethany's narrative had taken on a redemptive form – she had spoken of early struggles with bonding and juxtaposed them with her current loving mother-son relationship. However, here her narrative veered away from its redemptive trajectory. Why was she narrating now? Why not when she had been to hospital and her story of recovery had some legitimacy? Again, as with Amelia, the answer appeared to lie in Bethany's perception that those around her, in this case her mother, were unable to receive her story:

> It's hard for me to talk to my mum about it because there's a lot of her involved in it.

Her decision to narrate, even whilst in transit to hospital, was perhaps less about the 'message' and more about the desire to be a 'narratable self' (Cavarero, 2000): to be heard by an Other. Or as Butler (2001, p. 80) suggests: 'Surely there are moments of repetition and opacity and anguish, which usually compel a journey to the analyst, or if not to the analyst, to someone – an addressee – who might receive the story and, in receiving it, alter it some?'

Amelia and Bethany's narrations are therefore fundamentally relational acts, borne of a reawakened daughter's need to be heard, and the promise of 'intimate public' (Berlant, 2008) addressees who might do the listening. Furthermore as both Butler (1990), in the context of gender performances (constituted by, but simultaneously *constituting* the 'heterosexual matrix'), and Baraitser (2009), in the early maternal setting, contend, relational acts are always iterations, but each iteration is slightly different. With new audiences come new relational configurations, new co-constructed selves, new opportunities to speak to the primary inaugurating impingement, and perhaps 'alter it some' (Butler, 2001, p. 80).

5. Implications, tensions, future directions

For some women early maternity can be conceived of as an 'involuntary experience of discontinuity' (Butler, 2001, p. 59) – a traumatic intrusion of the pre-verbal into the storied life. In this article we have attempted to expose how maternal worlds can simultaneously be experienced as 'radically non-narratable' (Butler, 2001, p. 59) and prompt a narrative response.

Our paper contributes to the current literature in two main ways. Firstly it advances a relational ontology for perinatal distress, drawing on contemporary interdisciplinary subjectivity research, in particular as it relates to embodiment, affect and intersubjectivity. Secondly it considers the little-researched but increasingly widespread phenomenon of narrating PND. In particular it examines how women use the narrative act to negotiate their early maternal relational selves. We consider the Foucauldian self-regulating function of the PND narrative, showing how women preferred to be 'sick mothers in recovery', rather than 'plain bad' mothers. However we also suggest that the PND narration was employed relationally and as a means of accessing new audiences. Here we adopt Adriana Cavarero's (2000) position on the narratable self, a self structured by its desire to be heard, and suggest a particular resonance in the early maternal period when the primary inaugurating impingement (or abandonment) is invoked. Furthermore, we hint at the agentive possibilities in finding new addressees who might help re-constitute relational selves.

We are mindful that we have presented an eclectic and at times conflicting notion of 'relational self.' There are a number of tensions, but also possibilities, in our approach. Firstly, psychoanalytic and phenomenological paradigms are not self-evidently aligned. However, in our attempt to synthesise the two, we have been inspired by authors such as Butler (2001), Fuchs (2012), Blackman (2010) and the maternal studies scholars, all of whom use pluralistic approaches to gain a richer understanding of how the Other within becomes 'enfleshed' (Blackman, 2010, p. 172).

Secondly our idea of relational intrusions could attract criticism both for contradicting the phenomenological viewpoint that *all* being/becoming is relational, and for reifying essentialist configurations of maternity as pre-cultural. We have attempted to address both concerns in our engagement with the maternal studies field and the thesis that the maternal moment offers a heightened embodied *awareness* of relational subjectivity. Writers such as Baraitser (2009) posit that in neoliberal societies we are urged to repress our attunement to the intersubjective, but that embodied maternities make such a repression untenable. To Baraitser, maternity interrupts, not because it returns women to 'nature', but because its practices offer modes of being that vex neoliberal logics.

In our analysis we have emphasised the relational in order to address what we see as a notable gap in the current PND literature. However, like Baraitser and Butler, we do not suggest that the relational and embodied are 'outside discourse.' In fact many of the extracts we present trouble distinctions between discourse and non-linguistic being. For example, in Louise's account of the *"fuzziness"* in her wrists we have privileged the non-verbal register, but of course this fuzziness could not exist without a symbolic, discursive understanding of what knives are capable of, or of what other desperate people have used them for.

In tracing these 'entanglements of embodiment and discourse' (Wetherell, 2013, p. 351) we not only contribute to the PND literature, but also to broader trends in social theory that seek to reconcile linguistic and non-linguistic ways of being and knowing.

Future research might further unpack how maternal relational intrusions are socially embedded, and pay particular attention to the singularity of women with intense distress. How are their experiences different from ordinary maternal 'excess' (see Baraitser, 2009, Chapter 3)? One salutary angle might be trauma, drawing on the expanding interdisciplinary literature on the embodied, biographically disruptive nature of traumatic memory (see Blackman, 2010). Certainly women in our study spoke of childhood

experiences of neglect, sexual abuse, and incapacitated parents, leading us to reflect on articulations between relational trauma and early maternal distress. However a more detailed exploration of this association was beyond the scope of the paper.

Finally in our focus on narration and the relational self, we again blur demarcations between the 'narrating I' and the 'relating I.' We engage with the work of Butler (2001) and Cavarero (2000) who elaborate how narrating selves are simultaneously performing, relating selves, seeking recognition from the Other. We have highlighted the fluidity and complexity of notions of autonomous selfhood and intersubjectivity by demonstrating how narrations can at once seem to reinstate an autonomous disease-afflicted (as opposed to relationally-afflicted) self and be a profoundly relational act. The distinctions become even murkier when we consider that the 'autonomy imperative' is of course a dictate of the Other (the Other as neoliberal discourse) and the hint of an agentive self is found not as a result of the autonomy, but rather as a consequence of the relationality achieved through narration. In this way self/Other and psychic/social become thoroughly interwoven, a dialectic we hope to see taken up in future research.

Clinically, our work prompts healthcare workers to heed both mother and daughter subjectivities in the perinatal period. As has been found elsewhere (Dennis and Chung-Lee, 2006) and confirmed in our study, women often feel uncared for in early maternity. Our study echoes previous calls for maternal services that 'mother the mother' (see Bilszta et al., 2010, p. 50), and provides a theoretical foundation for why this is necessary. We plan to address the considerable clinical and 'caring' implications of a relational ontology for perinatal distress in a separate secondary analysis.

In this paper we have focused less on clinical, and more on narrative encounters. We have sought to critically read PND narratives and 'recover' the relational. However we have also suggested that for women experiencing early maternal distress the relational can be rehabilitated *through* narrative. Here we have attended to the PND narrative performance, and its 'affective/discursive' context (Wetherell, 2013). Maternal subjects have been publicly enacting such narrative performances for some time now. A relationally reflexive analysis of why they might be doing this is overdue.

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