ABSTRACT This article explores multiple identities and meanings of mothering by interpreting two narrative performances of mothering in the early 1970s. One performance is from a work of art by feminist Mary Kelly, Post-Partum Document (1983), the other from a research interview conducted in the early 1980s with a DES daughter. Both women perform versions of intensive mothering. The essay shows that moving between narratives produced in a research interview and a work of art enlarges the field of narrative analysis and fills in details about how intensive mothering is a historically specific and embodied practice.

KEYWORDS: DES, diethylstilbestrol, intensive mothering, Mary Kelly, narrative, narrative analysis, performance, visual narratives

You know, I think I’d been thro- through so much with my daughter um, that it just really, the things that happened to me like you could probably throw darts at me and it really wouldn’t bother me.

(Hannah Fisher, Research interview, 1982)

I did’nt [sic] see K[elly] much this week because of the Brighton show. Now I’ve noticed he’s started stuttering. Dr. Spock says it’s due to ‘mother’s tenseness or father’s discipline’. My work has been undermined by the appearance of this ‘symptom’ because I realise it depends on belief in what I’m doing as a mother . . . . as well as an artist. I feel I can’t carry on with it.

(Mary Kelly, Post-Partum Document 1983: Documentation IV, 100)

Since the 1970s, feminist scholarship on mothering and motherhood has been increasingly attentive to the enormous diversity of mothering circumstances (Glenn et al., 1994; Ragone and Twine, 2000). This attention is reflected in the development of knowledge about the social locations and structural contexts from within which women mother, multiple identities and meanings of mothering, mothering relationships with children and others,
and the experiences and activities of mothers (Arendell, 2000). It has demystified and argued against the normative standard against which all mothering practices and arrangements in US society are evaluated: the ideology of intensive mothering (Hays, 1996).

In this article, I explore multiple identities and meanings of mothering by interpreting two narrative performances of mothering. I give sustained attention to these narratives in order to look at the particularities of embodied motherhood and to consider how perceptions and interpretations of mothering are mediated through cultural and biomedical discourses about pregnancy and motherhood. One of the narratives is a work of art produced by an artist, Mary Kelly, and the other a verbal account by Hannah Fisher, a woman I interviewed. Although narrative analysis is now firmly established in sociology, the comparison of these two narratives blurs a distinction between verbal and visual narratives that has only recently begun to be explored (Bell, 2002). Moving between narratives produced in a research interview and a work of art enlarges the field of narrative analysis and fills in details about the ways in which intensive mothering is a historically specific and embodied practice.

Both of the women are from the US (although Kelly was living in England at the time she made Post-Partum Document), white, married, middle class, and heterosexual. In addition, both women became mothers in the early 1970s, during a period characterized by cultural and political crises and social movements – so in a general sense they are speaking from similar locations and informed by similar discourses. In both of their performances, mothering intersects with, and is complicated by, biomedicine. But there are also important differences in their situations. For example, one of the women (Hannah) is a DES2 daughter. She was exposed prenatally to DES (diethylstilbestrol), a synthetic estrogen that was prescribed to pregnant women in the US to prevent miscarriage from the 1940s to the 1970s, when it was banned for use in pregnancy by the US Food and Drug Administration. DES did not prevent miscarriage but it did cause cancer, reproductive tract differences, and fertility problems in the daughters born to women taking DES during their pregnancies. It has gained almost legendary status among women’s health activists (Bell, 1999).3

By focusing attention on narratives about becoming mothers in the early 1970s, the analysis shows how two women position themselves in relation to a discourse of feminism that ‘established a harsh self-questioning about . . . motherhood’ (Snitow, 1992: 37) and that questioned relations of power and knowledge between women patients and physicians (Bell, 1999). The narrative analysis also shows their positionings between two central ideologies in US society as a whole: ‘between the demands of work life and the demands of family life, between the historically constructed images of warm, nurturing mothers on the one side and cold, competitive career women on the other’ (Hays, 1996: 16).
Both women responded to political discourses of feminism. Feminists sought change in legal, political, and social conditions, as well as a theoretical apparatus that could recognize the subjective dimensions of these changing conditions (Kelly in Iversen et al., 1997: 9). As part of this project, from the 1970s to the 1980s, feminists inside and outside of the academy dedicated themselves to demystifying motherhood and the traditional nuclear family ideal (Collins, 2000; Glenn, 1994; Snitow, 1992). US feminist discourses subjected the practice of mothering, and the institution of motherhood, to a ‘complex, nuanced, and multifocused analysis’ (Umansky, 1996: 2). Their critiques sometimes led to misperceptions that feminists were against families and, by implication, against motherhood (Collins, 2000).

One of the feminist discourses at that time sought to understand the ways in which motherhood and the traditional family ideal equate being a woman with being a mother and efface the lived experiences of mothers themselves. This critique led some feminists to focus on mothers’ subjectivity and to explore how and why mothers are ‘made’ (Bassin et al., 1994). Mary Kelly’s narrative focuses explicitly on this project. Kelly was one of the women artists in the 1970s whose work entered into ‘a critical exchange, not only within history and against dominant and androcentric practices, but also within feminism’ (Grigsby, 1991: 84).

Another feminist discourse exposed a ‘no-win situation for women of child-bearing years’: women cannot be both mothers and workers, they cannot be both non-mothers and workers, and they cannot be both mothers and non-workers without being judged as inadequate (Hays, 1996: 133). Hannah Fisher responds to this no-win situation by distinguishing mothers from women. In her view, ‘being a woman is more like having a career I would say and being a mother is staying at home’ (interview). Hannah’s choices to be a stay-at-home mother and to take primary responsibility for child care fit with the ideology of a traditional nuclear family and gender roles. This may make her look like a passive recipient of her position, yet she is engaged with and responding to the discourses around her (as well as to the circumstances of mothering a very sick child). She, like Mary Kelly, made creative and knowledgeable choices about her life, working within pre-existing structures and circumstances not of her own making.

**Mothering**

Mothering consists of historically and culturally variable practices of nurturing and caring for dependent children. The practice of mothering is constructed by women and men in specific historical circumstances, organized by gender and consistent with prevailing cultural beliefs about gender (Glenn, 1994: 3; Arendell, 2000: 1193). For most of the 20th century, ‘the most powerful, visible, and self-consciously articulated’ (Hays, 1996: 21) North American view of mothering was that:
responsible for mothering rests almost exclusively on one woman (the biological mother), for whom it constitutes the primary if not sole mission during the child’s formative years. The corollary view of children is that they require constant care and attention from one caretaker (the biological mother) (Glenn, 1994:3).

This view is called ‘the ideology of intensive mothering’ by Sharon Hays (1996). It ‘declares that mothering is exclusive, wholly child centered, emotionally involving, and time-consuming. The mother portrayed in this ideology is devoted to the care of others and self-sacrificing (Arendell, 2000: 1194). It rests on the assumption that a woman will become pregnant, remain pregnant, and bear a healthy child. In other words, it assumes a seamless progression from conception to birth. An intensive mother is held and holds herself accountable for keeping her children fed and housed and ‘for shaping the kinds of adults these children will become’ (Hays, 1996: 108). Working class, poor, professional class, and affluent mothers believe child rearing should be child-centered and emotionally involved, but they vary in their interpretations and practices (Hays, 1996: 115). Feminist scholars have shown that the persistence and growth in intensity of intensive mothering ideology serves the interests of men, ‘capitalism, the state, the middle class, and whites’ (Hays, 1996: xiii).

In The Cultural Contradictions of Motherhood, Sharon Hays writes that the ideology of intensive mothering is dominated by and exhibits a logic of family and intimate (private) life that requires a moral commitment to ‘relationships grounded in affection and mutual obligations’ (Hays, 1996: 152). This logic is opposed to the logic of (public) economic and political life that demands a moral commitment to ‘the individualistic, calculating, competitive pursuit of personal gain’ (Hays, 1996: 152). In other words, the ideology of intensive mothering is in tension with a central value in modern western culture of ‘the efficient, impersonal, competitive pursuit of self-interested gain above all else’ (Hays, 1996: 10). Intensive mothering is, or at least represents, part of a struggle in modern society, ‘a fundamental and irreducible ambivalence about a society based solely on the competitive pursuit of self-interest’ (Hays, 1996: 18). To mark and to avoid an artificial dichotomization in both intensive mothering and feminist theorizing about intensive mothering, Patricia Hill Collins advocates use of the term ‘motherwork’ instead of ‘motherhood’ in her analysis (Collins, 1994: 47). In her view, one that I share, mothering practices themselves blur dichotomization. This blurring is exemplified in the two narratives examined here, even though they cannot possibly represent (but instead hint at) the complicated and manifold ways in which motherwork is located in place, time, and also networks of patterned relationships, social practices and institutions, which themselves are constantly in flux.

Among other things, the ideology of intensive mothering obscures power and inequality in the practice of mothering. Its depiction of mothers as self-sacrificing, devoted to the care of others, and inspired by love romanticizes the
work that mothers do. It obscures the extent to which mothering is ‘an arena of political struggle’ that includes multiple, shifting, and intersecting dimensions of power relations, identified by Evelyn Nakano Glenn as ‘inequality between men and women, between dominant and subordinate racial groups, between colonizer and colonized’ (Glenn, 1994: 17). Male domination and gender inequality work ‘in tandem with racial domination and economic exploitation’ to shape the mothering experiences of women (Collins, 1994: 46).

Despite the ‘real-life’ variety of practices and arrangements of mothering, intensive mothering is a normative standard against which all mothering practices and arrangements in US society are evaluated (Hays, 1996). A variety of deviancy discourses derive from this ideological construct of mothering, aimed differentially at mothers who do not conform to this script (Arendell, 2000: 1195). Targets of these discourses are mothers who do not conform to the narrative of heterosexual marriage followed by the birth of healthy children and full-time devoted motherhood: including welfare mothers, single mothers, lesbian mothers, birth mothers, adoptive mothers, mothers who break contractual agreements or assert their autonomy in the process of utilizing reproductive technologies, and mothers of children with disabilities. Even those mothers who disagree with and/or who do not conform to the ideology of intensive mothering are nonetheless affected by it. They are judged by others according to how closely their practices fit with it and position themselves against it (Arendell, 2000; Gailey, 2000; Landsman, 1998).

Narrative

By now, there is a vibrant social science literature about interview narratives, the usefulness of narrative inquiry, and ways narratives are produced and can be interpreted in research interviews. Narratives draw upon culturally shared images and conventions to present and interpret experience, as well as to draw connections between individual and society (Hyden, 1997; Mattingly and Garro, 1994). Narrative scholars are only beginning to venture beyond interviews and texts as sources of data. This newer work intersects with the field of visual sociology, which ‘is, above all, a process of seeing guided by theory’ (Harper, 2000: 717). I define narrative as a sequence of ordered events that are connected in a meaningful way for a particular audience in order to make sense of the world and/or people’s experiences in it (Hinchman and Hinchman, 1997). In this definition, I assume that one action is consequential for the next, that the narrative’s sequence is held together with a ‘plot’, and that the ‘plot’ is organized temporally and/or spatially (Riessman, 2002: 698). Layers of convention and association inflect visual and verbal narratives and provide codes for interpreting them. For example, pitch, tone, and structural features distinguish textual narratives from other forms of
discourse. Different sets of material objects, frames, and light, shade, and symbols distinguish visual narratives from other images (Bell, 2002).

Narratives are collaboratively performed events (Langellier, 1989, 2001). As a consequence, narratives are not ‘fixed texts’, but change with each telling and may be interpreted differently by different audiences (Riessman, 2000: 9). And, as collaborative performances, narratives connect selves to one another – tellers with listeners, writers with readers, narrators with present or imagined others (Langellier, 2001:700). These collaborations can be confrontational as well as embracing. People produce narratives for many reasons; these include remembering, engaging, entertaining, convincing, and even fooling their audiences (Bamberg and McCabe, 1998: iii). A growing number of scholars suggest that:

[the] form of stories (their textual structure), the content of our stories (what we tell about) and our storytelling behavior (how we tell our stories) are all sensitive indices not just of our personal selves, but also of our social and cultural identities (Schiffrin, 1996: 170).

Visual sociologists have given more attention to photography than to other images, but visual sociology refers to ‘any research design that uses any kind of visual evidence, whether produced by researchers or not’ (Harrison, 2002: 88). Visual sociology is not a new field; in the early 20th century, visual images were included routinely in the American Journal of Sociology ‘in connection with its muckraking reformist articles’ (Becker, 1986: 225). Even at that time, however, visual materials and technologies were marginal in the discipline (Harrison, 1996: 76). Thirty years ago, Howard Becker advocated ‘the use of photographs to study organizations, institutions, and communities’ (Becker 1986: 231). More recently he recommended that the methods curriculum of every sociology department should include a ‘shooting course’ in photography to develop students’ visual imaginations by learning how to read photographs, and how to use sociological theory in making, interpreting, and presenting photographs (Becker, 2000: 334). In a review of visual methods in social science, Douglas Harper writes:

Visual materials are often narrative in form. The most common visual narrative is film or video . . . single images taken sequentially (often many per second) that, when viewed in rapid succession, seem to re-create the movement the eye sees. But still photographs can also create sociological narratives (Harper, 2000: 724).

In my discussion of their narratives, I consider how Hannah Fisher and Mary Kelly engage with and resist the discourse of intensive mothering, as well as with the production and display of mothering. Both are first-person narratives; both display and make visible the everyday, dirty practice of mothering and a mother’s desires; both put the mother at the center of the account; and both display different discourses of knowledge alongside of and intersecting with one another. Although both engage with medical/scientific
discourses in their narratives, neither woman privileges them, and both talk about becoming experts. Both of them engage with feminism. By contrasting these forms of narrative, I will illustrate in concrete ways both questions of mothering from a sociological perspective and the differing ways narratives can be created that illuminate our understanding of social structures and societal beliefs. Together, they reveal the extent to which intensive mothering is deeply felt, so deeply that it appears almost ‘natural’. Yet, set against the other, each of these narratives denaturalizes intensive mothering.

Hannah Fisher and Mary Kelly are performing to particular audiences. Hannah Fisher performs in two interviews to me, an interviewer she sees (and positions variously) as a young feminist scholar who is not a mother; she also performs to an imagined audience beyond me. Her first-person account is worked out and reflected in a tape-recorded and transcribed conversation. Mary Kelly performs to anticipated audiences of mothers, women, feminists and other artists in objects and texts collected, edited, and produced over a six-year period. In the 1970s, Kelly helped to produce feminist art. *Post-Partum Document* was one of her contributions to this effort. The two narratives bear the marks of different projects, but at the same time they are both about intensive mothering. These narratives, in other words, are located in history and culture; these two ‘subjects’ are positioned in fluctuating ‘matrices of patterned relationships, social practices, and institutions’ (Somers and Gibson, 1994: 79). In the remainder of the article, I describe and interpret the narratives, recognizing that neither of them is a ‘fixed text’, and that both of them change with each telling and may be interpreted differently by different audiences (Riessman, 2000: 9).

**Hannah Fisher: ‘I guess I just underreacted to everything’**

I interviewed Hannah Fisher in December 1982, almost a decade after she had become a mother. When I first telephoned her late one Friday afternoon to describe my study and to arrange an interview, she was crisp and businesslike. She said that she had nine hours a week to herself, and that I would have to come during that time or she would never be able to talk for an hour and a half, since her preschool-age son would disrupt us. We were able to arrange two interviews, each lasting for about an hour and a half, the second interview about two weeks after the first.

Hannah is one of 20 DES daughters I interviewed – each of them twice – for my study of the social and emotional consequences of living with risk and medical uncertainty associated with their prenatal exposure to DES, especially how they understand and respond to these uncertainties (see Bell, 1988, 1999). Of the 20 women, four had children at the time I interviewed them. Before the interviews I told each woman that I was interested in her experiences as a DES daughter, such as how she found out she had been exposed to DES, what being a DES daughter meant to her, and what she thought would
be important for other DES daughters to know. I began each interview with an open-ended question (‘How did you find out you were a DES daughter, and what was that like?’), then listened with a minimum of interruptions and connected my questions and comments to women’s responses by repeating their words when possible.5

Hannah Fisher lived in a middle- to upper-middle-class neighborhood just outside city limits in the Northeastern US, tucked in behind a very wealthy-looking neighborhood, with tree-lined streets, and mansions set back from the road. She and her husband were having their house renovated. The air smelled of paint, and the furniture in the house was in disarray. When I arrived, she led me through the house, through a room with photographs of her family covering one wall, apologizing for the state of the house, and on back to the kitchen, which had freshly painted white walls. We sat around a white table on two of the five chairs drawn up to it.

Her life was infused with intensive mothering. In her marriage, she and her husband made a decision to structure their lives by redividing their work after they became parents. She gave up her job to be a full-time, stay-at-home mother. He kept his to support the family. She told me elsewhere in the interview: ‘I know marriages aren’t supposed to be like that any more it’s supposed to be sort of fifty-fifty equal, but he wor’ he works hard and I work hard and we both enjoy what we’re doing.’ As the narrative reproduced below demonstrates, she claims and defends the identity of ‘mother’.

Hannah’s immersion in intensive mothering was reflected even in our initial telephone conversation and again at the start of the interview, when she turned to me after she had signed the informed consent form but before I asked her the first question and said, laughing, ‘10 after 10 okay we’re on I’ve been moving since 6:30 s’nice to sit down what’s next.’ Over the course of the interview, interwoven and alternating with the performance of ‘mother’, she performed ‘patient’ and ‘teacher’. She performed these identities as she continually located and relocated herself in relation to characters and situations in the story world she produced as well as in relation to me in the interview (see Schiffrin, 1996).

Hannah Fisher has three children, two girls and a boy. In the early 1970s, her first child, Grace, was born a month prematurely. Grace was born with such severe health problems that she was not expected to live. She did live, but she was hospitalized 10 times in 10 years, and had surgery twice and five invasive medical tests. When Grace was a toddler, Hannah Fisher unexpectedly became pregnant again, but had a miscarriage in the second trimester of her pregnancy. She became pregnant again as soon as she could, and after an easy pregnancy she gave birth to a healthy daughter. After two more miscarriages, she gave birth to a healthy baby boy. As she put it to me during the interview, ‘I’ve had 50 percent fetal loss.’

Over the course of the two interviews with me, Hannah told me about her marriage, her close relationship with her parents, and her participation in a
parent’s group for children with the same health problems as her daughter Grace, although these topics are absent in the narrative reproduced below. Hannah’s husband and her parents supported her efforts to become (and be) a mother. At the time Grace was born, Hannah’s parents lived nearby. She became closer to her parents after she had children. When I asked her why, she answered, ‘Well, because um we needed help, we really needed um support.’ And her parents gave it. On a daily basis for the first few months after her daughter was born, her mother helped her with household labor and with tasks associated with caring for Grace. Ten years later, Hannah and her mother still talked on the phone each day.

In the tumultuous weeks following Grace’s birth, when Hannah Fisher and her family searched to make sense of the baby’s prematurity and life-threatening abnormalities, Hannah’s mother asked whether they might have been caused by the DES she took when she was pregnant with Hannah to prevent miscarriage. Hannah Fisher soon asked this question of her gynecologist. During the early 1970s, when Grace was born, medical experts were beginning to understand that prenatal exposure to DES was damaging to children, especially to daughters (US Department of Health, Education and Welfare, 1978). Grace’s serious health problems do not appear connected to Hannah’s prenatal exposure to DES, although Hannah’s experiences of miscarrying and of giving birth prematurely are not uncommon for DES daughters.

Today, after 30 years of research about the effects of DES, experts generally agree that most DES daughters are eventually able to bear children but, as it was put in a recent review of the medical and scientific literature, ‘this may only be possible after considerable effort and is far less likely in those women with genital tract abnormalities [of the cervix, vagina, or uterus], in whom there is a two-thirds chance that each pregnancy will be unsuccessful’ (Swan, 2000: 798). DES daughters are less likely to become pregnant than women not exposed to DES; and when they do become pregnant, DES daughters are much more likely than women not exposed to DES to have ‘preterm births, spontaneous abortions, or ectopic pregnancies’ (Kaufman et al., 2000: 487–8). Even though she does not draw a connection between her prenatal exposure to DES and her miscarriages and/or Grace’s premature birth, Hannah’s experiences exemplify the difficulties some DES daughters have, even those who eventually become pregnant and bear children.

The interview narrative from Hannah that I quote here emerged in answer to a question I asked her towards the beginning of the first of the two interviews. She had just described what had happened in the time between the births of her first and last children, including the ‘50 percent fetal loss’. I wondered how she had handled these experiences, so I asked her. We collaborated to produce a narrative that embodies and performs what she did and why, how she felt, and what she learned. My analysis of the narrative continues a process that began when we met, during which we drew upon our ‘culturally shared
stock of knowledge’ (Mishler, 1999: 110) and our mutual, locally situated knowledges achieved during the interview in which ‘we continually made and remade the sense of what we were saying and hearing’ (Mishler, 1999: 95).

For Hannah, mothering is conditioned by her difficulties in producing children and the work of nurturing a child with a disability. Miscarriages and premature births interrupt the intensive mothering narrative of linear progress (van Balen and Inhorn, 2002). Chronic illness and disability are devalued statuses, and so people with chronic illnesses and disabilities are devalued. Within this cultural context of devaluation, mothers of children with disabilities and chronic illnesses have difficulty establishing their children’s – and their own – full personhood (Landsman, 2000: 183). Ironically, it is also difficult for mothers of these children to successfully claim an intensive mothering identity even at the same time as they are engaged in the material and nonmaterial work of nurturing. Like other mothers of children with disabilities, Hannah had to fight hard on behalf of Grace and, like them, she depicts herself heroically. In the face of adversity, she became a remarkable mother.

I GUESS I JUST UNDERREACTED TO EVERYTHING
  001 Susan: how did you
  002 how did you get
  003 how did you, handle it during those years though
  004 Hannah: well what happened was (unclear-4)
  005 well I’ll tell you what happened um,
  006 I had my miscarriage on [New Year’s eve],
  007 as soon as I could
  008 I became pregnant again,
  009 you know that’s the best way to get over having a miscarriage, (inhale)
  010 and I had a hyst’
  011 but after right after I had that
  012 I had a hysteroscopy?
  013 that’s or a hysterogramm?
  014 something like that
  015 to see if they could figure out why
  016 I had the miscarriage
  017 and it’s something tha’ I guess they do do to DES daughters, (inhale)
  018 gives you a clearer picture of your uterus (inhale)
  019 they wanted to see if
  020 I had a double uterus
  021 or if it was you know “T” shaped
  022 that I couldn’t carry a baby (inhale),
  023 (voice getting softer) you know cause my my first daughter was premature
  024 and now this baby, which appeared normal
  025 um uh miscarried (tch),
  026 (voice gets louder again) they found that
  027 I did have an unusual shaped uterus
but it wasn’t severely malformed,

Susan: mmm

Hannah: it wasn’t, ‘T’ shaped,

Susan: mhm

Hannah: you know that I should be able to carry, a baby to term, (inhale)

and, um (p)

in between this time

I also had adenosiss

somewhere between Grace and the miscarriage

Susan: mhm

Hannah: you know that was confirmed,

through my first DES, examination

that I had um, a cervix like hamburger

that’s what I remember

Susan: that’s wh’ who’ the

Hannah: yeah

Susan: gynecologist told you that

Hannah: he said yeah

it was like hamburger, raw hamburger,

and he had to cauterize it

Susan: what was that like to hear that,

Hannah: how did that make you feel

Susan: well, you see,

you know I had,

I had spent a lot of time in [a hospital with Grace]

I had seen a lot of really gruesome thinngs, (inhale)

so somehow I,

I think it just rolled off my back,

it did

I’d really been, you know through a lot?

and um (p)

you know, I think

I’d been thro- through so much

with my daughter

um, that it just really,

the things that happened to me

like you could probably throw darts at me

and it really wouldn’t bother me, (inhale)

you know I became.

probably isn’t a good way to be

because um, (swallows)

I guess I just underreacted to everything

and maybe it was a defense,

but that was how I handled things by underreacting

and just

Susan: mhm

Hannah: you know (p)

you know there are so many instances

where you had to be calm

and you know speak to, physicians about different things
In this narrative, Hannah talks about events that occurred in the early 1970s, when physician experts were just beginning to understand that DES was carcinogenic and that it changed the structure and function of DES daughters’ reproductive tracts. Hannah refers to diagnostic tests that were beginning to be standard protocols for DES daughters, and to effects that were beginning to be observed in DES daughters: miscarriages (typically in the second and third trimesters), premature births, adenosis (a condition in which cells that ordinarily are found only in the uterus are found on the walls of the vagina and surface of the cervix), cauteryization (a procedure in which abnormal cervical tissue is destroyed with a chemical or an electrically heated instrument), T-shaped uterus (the inside of the uterus is different from normal, shaped like a “T”), and hysterogram, also known as a hysterosalpingogram (a kind of x-ray picture of the uterus and fallopian tubes).

Hannah Fisher produces her identity as a mother in the story world in a multilayered use of contrasts. She compares what is happening to her body and her responses to this with what is happening to her daughter’s body and her reaction to it. Both of these experiences affect her ability to be seen as a proper (intensive) mother. In response to her experiences of pregnancy, the premature birth of a very sick child, miscarriage, and the identification of DES effects, she becomes conversant and comfortable with biomedical language (e.g., ‘hysterogram’ [line 013], ‘adenosis’ [035]) and logic (e.g. a severely malformed uterus can cause premature birth or miscarriage [019–031]). In response to gruesome things she sees happening to Grace [060–061] and perhaps to other children in the hospital with Grace [052–053], she makes herself calm [075–077] and prepares for an attack so that she can be a protective mother [063–072]. In another contrast, she lists procedures performed [012–013, 047] and diagnoses made about her body [026–030, 035, 040], but leaves the ‘gruesome things’ [053] performed on her daughter’s body to my imagination [060–061]. Not speaking in this narrative about her daughter’s body, in contrast to having said a great deal earlier in it about her own body, is a way of ‘wielding silence’ (Pollock, 1999: 189). It enacts resistance: ‘As the guardian of secret ways, the self may or may not bare the secrets she carries’ (Pollock, 1999: 189).

Withholding information is a form of power. In producing this narrative with me, Hannah enacts one of the strategies she used to deal with her own and her daughter’s needs. She had had limited options available to her for dealing with medical experts. Silence was one of them. Here, she simultaneously demonstrates and ‘does’ silence, positioning me in the same location as the experts who treated her and her daughter, against whom she wielded silence. Elsewhere in the interview, she provided detailed descriptions of ‘gruesome things’ that led to the strategy of silence, and of strategies other than silence that she used in order to secure and monitor medical care for her daughter. Immediately following the end of this story, for example, I asked her what kinds of ‘instances’ she had in mind, repeating a word Hannah
Fisher had just used (‘you know there are so many instances/where you had to be calm’ [075–076]). In response she then described an event very early in Grace’s infancy. It began with several days of worsening health. Her daughter ‘cried more and more and she threw up more and more’. Finally Hannah and her husband brought Grace to the emergency room in the middle of the night. The surgeon who was called to fix her told them that Grace was near death and that they had ‘really failed as parents’ because they had waited too long to take her to the hospital.

At the time I interviewed Hannah, I was doing women’s health work, starting out on a career in sociology – I was a post-doctoral fellow – and I had just begun to find out that becoming a mother was not going to be easy for me. Along with my attempts and my desire to have children, I was giving a lot of attention in my work to empowering women through access to birth control, abortion services, and motherhood by ‘choice’. Feminism of the 1970s was more than a ‘cultural climate’ (Mishler, 1999) for me; it was where I situated myself, a lens through which I engaged with Hannah and the other DES daughters I interviewed in the early 1980s. I missed cues Hannah gave to me about the overwhelming importance in her life of mothering – her descriptions of working from dawn to dusk, of having little time to herself, of being exhausted at night – which I now see and understand more clearly. Instead, I picked up on other topics in her account, notably those related to her encounters with medicine.

Hannah and I locate her narrative in the context of women’s health movements in the 1970s. Even though Hannah Fisher does not identify herself as a women’s health activist and she and I do not agree about the relative importance of these critiques of medicine or adopt them similarly, we nonetheless are both actively engaged with the issues raised by them, and this engagement is reflected in the narrative. She referred to embattlement, and to her strategy of learning and deploying the biomedical discourses of DES, pregnancy, and serious disease in infancy and childhood. I responded to the example of dehumanizing and disrespectful use of terminology in physicians’ approach to women patients. The developing discourse between us reflects and participates in the politics of women’s health, in which previously taken-for-granted ideas about what constituted ‘good’ medical care for women were called into question (Swenson, 1998). Women’s health activists challenged the cultural authority of medicine to develop knowledge about women’s bodies. They also exposed physicians’ sexist attitudes towards and treatment of women patients. The goals of multiple and overlapping women’s health movements in the 1970s ranged ‘from improved patient package inserts for contraceptives to informed consent and patient’s rights, from better birthing practices to knowledgeable lesbian health care, from inclusion of women in clinical trials to increasing numbers of women physicians’ (Clarke and Olesen, 1999: 14; see also Auerbach and Figert, 1995).

Hannah’s story began as part of a general discussion about her experiences
in relation to DES. For her, the overriding theme of the experience was pregnancy and miscarriage, and mothering a child with severe health problems. She did not experience a seamless progression from conception to birth, or a healthy infant, in contrast to assumptions embedded in the ideology of intensive mothering. Each part of the narrative begins with events in pregnancy, and at the end of the narrative when she says she needs to speak to physicians about different ‘things’ [077] the inference is that these ‘things’ are about care for her child. My question ‘how did you, how did you get, how did you, handle it during those years though?’ [001–003] asks her for two sorts of information. In one sense the word ‘handle’ concerns actions (what did you do to handle or manage things) and in the other concerns emotions (how did you feel about the events happening to you, how did you handle your feelings). Hannah Fisher gave answers to both in her narrative.

The narrative begins with a response to my initial question about how she handled ‘it’. The narrative explains events that do not make sense: she became pregnant but had a premature baby [023]; then she became pregnant but miscarried [006, 024–025]; she was told she had ‘a cervix like hamburger’ [040] but was not fazed by the gruesome metaphor.

In my reading, she divides the narrative into two parts. The first part of the narrative [001–033] uses medical language and is quite detailed in its description of what was done to and seen in Hannah Fisher’s body, but is vague about who did and saw it. In it, she positions herself as a woman patient. Not identifying her caregivers, and referring to them only as ‘they’ [lines 015, 017, 019, 026], helps to construct an image of distanced, objective knowers, and disembodied knowledge. She uses visual images: they ‘see’ into her body [019] and try to get a ‘clearer picture’ of her uterus [018]. What they find is ‘unusual’ [027] but based on what her uterus looks like, still she ‘should’ be able to carry, a baby to term’ [032], although she hasn’t been able to do this in either her first or her second pregnancy. Hannah becomes a spectator; her body becomes a specimen. I, like she and ‘they’, become a spectator too as she takes me on a visual tour of her uterus [020–021, 027–030].

With her use of visual metaphors, Hannah Fisher reproduces and locates herself in a world created on the basis of visual knowledge, which has traditionally been used to signify a way of knowing associated with modern science (Foucault, 1980). This visual way of knowing distances the observer from the observed, separates the observed from the contexts in which they are ordinarily situated, and removes the observed to a homogeneous, neutral space in which what is seen can be explained. In Hannah’s story, physicians use medical technology to look into her body, to get a clear picture of her uterus, and to compare her uterus both with that of the anatomical normal female body [027–028] and with the (ab)normal anatomy of DES daughters’ bodies [020–021] that was beginning to be understood ‘to see if they could figure out why I had the miscarriage’ [015–016]. Hannah names two different procedures for visual diagnosis: first, a hysteroscopy [012] in which a
fiberoptic telescope is inserted through the vagina and cervix into the uterus enabling its user to see inside a woman’s uterus; and second, a hysterogram [013] (also known as a hysterosalpingogram, HSG, or tubogram), in which a dye or other contrast medium is introduced into the uterus through the cervix for an x-ray examination of the uterus. Although she can name the procedures, Hannah does not know which of them was used or even whether the procedure was one of these or ‘something like’ a hysterogram [013–014]. She does know the results discovered: she should be able to carry a baby to term [032].

In the second part of the narrative, Hannah’s use of the terms ‘rolled off my back’ [055] and ‘I just underreacted to everything’ [069] also positions her as a woman patient in relation to medicine, but here the images are of attack and defense. This image of conflict between doctors and women patients is consistent with a feminist discourse of women’s health politics that had emerged in the late 1960s (Bell, 1999). But in Hannah Fisher’s narrative, the coda of the story complicates the image of attack and defense. Underreacting and allowing things to roll off her back was a strategy she chose. In the struggle for power, she chose to take a position of distance and calm in order to speak [076–077]. She needed to enter into the world of biomedicine and to engage with it successfully for herself and her daughter’s health care to be a good (intensive) mother. In the interaction between us, Hannah Fisher performs this distanced, objective, visually adept self. I interrupt this discourse after she says she had a cervix like a hamburger [042]. In her response to me, she moves the discourse from ‘hamburger’ (the embodied world of food and feminist critique) to ‘cauterization’ [045–047]. This linguistic move fixes the word ‘hamburger’ as part of a diagnosis (‘it was like hamburger, raw hamburger and he had to cauterize it’ [046]) and restores the discourse to a medical one. In our interaction it functions both to acknowledge my horror and implicit (feminist) critique of medicine and to demonstrate to me how she handled things, underreacted, became calm, and was able to communicate with physicians. Instead of fighting against doctors, and perhaps turning away from the world of scientific medicine, Hannah Fisher adopted their language and used this as a strategy for taking care of her daughter and herself.

The narrative also positions Hannah Fisher in relation to me. She performs ‘mother’ to me. My question was ‘what was that like to hear that, how did that make you feel’ [048–049]? She explains to me that just as she had transformed hamburger to cautery, she had avoided feelings in favor of thought so that she could take care of her daughter. She had set aside her feelings and needs in order to care for the needs and feelings of her daughter. In the interaction, Hannah positions me, and I become, the ‘feeling’ person in this story. I am the person who reacts viscerally, with emotion, to the words ‘cervix like hamburger’ [040], indicated by the false starts in my response to her when I say ‘that’s wh’ who’ the’ [042]. Hannah Fisher does not propose that the doctor’s observation that her cervix is like hamburger is nonsensical; I do.
Hannah Fisher becomes calm and enters a world in which the details of intensive mothering are left unsaid: ‘I had spent a lot of time in [a hospital with Grace] I had seen a lot of really gruesome thinngs’ [052–053]; and left inferred by the repetition of her talk: ‘I’d really been, you know through a lot? and um you know, I think I’d been tho- through so much with my daughter’ [057–061].

Hannah and I position ourselves in relation to each other, she as ‘mother’ and I as ‘not-mother’. Towards the end of the interview she asked me ‘do you have children?’ and after I answered ‘unh-unh’ she laughed and said ‘I hope I haven’t scared you.’ The conversation continued as follows:

Susan:  do you feel like you will [scare me]?
Hannah: well you’re probably bright enough to know that this is just one person’s experience.

Hannah’s laughing apology after I had answered her question, followed by her patronizing tone and my refusal to tell her whether or not she had scared me, reflect our continuing positioning and repositioning throughout the interview. Of course, I had responded with horror earlier in the interview, a response that is part of our developing knowledge represented in this exchange. After establishing that she is a mother and I am not, or more precisely that she is an experienced and expert mother whereas I am neither, I try to re-establish my authority as scholar-interviewer by responding to her question with another question instead of an answer.

Hannah Fisher is judging herself against standards of women who can easily produce ‘healthy’ or ‘perfect’ children, and using intensive mothering as her defense. Her narrative may make readers uncomfortable because in it she talks about painful aspects of her life and intensive mothering. Mary Kelly’s narrative may also make audiences uncomfortable about embodiment and desire in mothering. It displays images and feelings that are typically hidden, it opens up her relationship with her son for view and invites viewers to look at and judge her practices, and at the same time it looks at and makes judgments about normalizing practices. In Post-Partum Document, she is playing with, scrutinizing, poking fun at and simultaneously doing and subverting intensive mothering. Although Mary Kelly worries about her son’s health, and her narrative includes documentation of temporary illnesses, he is a healthy baby boy.

Mary Kelly: Post-Partum Document

Mary Kelly began work on her extended documentation of a mother–child relationship, Post-Partum Document, in 1973 and ended the project six years later, in 1979. It is a work of art that has been shown in museums and reproduced (in black and white) in a book of the same name. Post-Partum Document is composed of 135 objects (each encased in a plastic frame), divided into an introduction and six sections. Each of the seven divisions
corresponds to a different time and a different relationship between the artist, Mary Kelly, and her son, Kelly Barrie, beginning from her son’s birth to the time he could write his whole name, at the age of five. The framed objects include (among other things) Barrie’s well-worn newborn undershirts; dirty diaper linings; collected bugs and plants; illegible scribbling as well as individual letters and words he wrote; transcriptions of his words and of conversations between the two of them; feeding charts and extracts from a journal kept by Mary Kelly, and so on. None of the 135 objects include pictures of the artist or her son.

The different sections are all given the label of Documentation (I, II, III . . . VI), and contain different sorts of objects. Documentation I, for example, describes Kelly’s son’s daily nutritional intake (what he ate/drank and how much he ate/drank and how much he excreted) for a month-long period of time during which he was weaning, moving from an exclusively liquid diet to the introduction of solid food. This was considered the most scandalous documentation at the time it was first displayed, because the objects in it included 28 used diaper liners – each of them framed – on which the input and output were printed. The question ‘What Have I Done Wrong?’ posed in relation to the diaper liners, is about why the input/output don’t match up (that is, why some of the outputs are ‘not normal’) and what this gap signals about Kelly’s capacity to mother. This question can also be read in reference to making these particular objects into art (as opposed to trash); and to suggesting that, in Dorothy Smith’s words, ‘the telling of this world is a potentially endless detailing of particulars’ (Smith, 1987: 6).

Each documentation begins with a text, written in the third person, that provides an introduction to a period of the mother’s and infant’s experiences represented in it. This text is followed by a set of interwoven objects and texts ‘found’ or produced by Kelly. The sections end with a discussion of ‘maternal femininity’ from the perspectives of Freudian and Lacanian psychoanalysis each given the title ‘Experimentum Mentis’ (Kelly, 1983: xxii), before closing with a Lacanian drawing and a question referring to and flowing from the objects and texts. Repetition in the structure of each of the documentations, as well as repetition in the sequences of objects contained in each, contributes to the power of the narrative as a whole. Furthermore, Post-Partum Document draws upon culturally shared images and conventions of intensive mothering (dirty diapers, feeding charts and folded vests, for example) to present and interpret Kelly’s experiences in becoming and being an intensive mother. Instead of pitch, tone, and silence – strategies used to distinguish narratives from other forms of discourse and to provide rhythm and meaning to the story – Post-Partum Document uses different sets of material objects, arranged in a variety of ways, interspersed and connected with texts and drawings, and different voices. Together, they lend moral force to Kelly’s arguments about the production of mothering.
Post-Partum Document is, in other words, a first-person narrative by a mother/artist about her lived experience of events in her son’s development, from weaning from the breast, to learning to speak, starting school, asking questions about sexuality and, finally, learning to write. According to critic Paul Smith, Post-Partum Document:

... is specifically a story, chronological and linear, working on the level of traditional narrative in the sense that there’s a problem posed and a resolution reached (which, here, is the final imposition of the social and symbolic upon the child) (Kelly and Smith, 1996: 65).

As in narratives more generally, the different documentations are held together by a ‘plot’, and one action is consequential for the next. In book form, the narrative is produced linearly, from beginning to end. As an exhibition, it occupies a room, and can be seen or read in different sequences, according to choices made by viewers. Intensive mothering is everywhere in this narrative, from the content of the different documentations, to the careful and repetitive attention given to the production of each mundane object, to the sensuous, funny, and discomfiting images and feelings evoked by the images and texts.

The introduction to Post-Partum Document begins a multilayered ethnography and interrogation of middle-class, white, married motherhood in the 1970s, by displaying a series of four objects, well-used newborn undershirts (or, as Kelly called them, ‘Folded Vests’; see Figure 1) inscribed with successively complicated diagrams, and interweaving text and material objects. Kelly writes, in the ‘Introduction’, that:

in the Post-Partum Document, I am trying to show the reciprocity of the process of socialization in the first few years of life. It is not only the infant whose future personality is formed at this crucial moment, but also the mother whose ‘feminine psychology’ is sealed by the [gendered] division of labor in childcare (Kelly, 1983: 1).

Among other things, Kelly says, each of the documentations questions ‘the ideological notion of “natural capacity”’ and queries the expediency of the sexual division of labor’ (Kelly, 1983: 41), the ‘structural imperative of heterosexuality’, and the needs of capitalism (Kelly, 1983: 1).
At the time Mary Kelly made *Post-Partum Document*, feminists took exception to traditional psychoanalytic (especially Freudian and Lacanian) conceptions of the construction of human subjectivity. Jacques Lacan connected language, subjectivity, desire, and sexuality with the phallus. One consequence of the theory is to split language from feelings, to associate language with abstractions, and to connect language with the Law of the Fathers (Kristeva, 1977). Kelly both adopts and subverts Lacan’s discourses of psychoanalysis. For example, defining the sequence of *Post-Partum Document* temporally and mapping her son’s development of language adopts Lacan’s framework. Yet at the same time, she calls this framework into question. In the last documentation (Documentation VI), Kelly produces her own version of a ‘Rosetta Stone’. The Rosetta Stone, displayed at the British Museum, provides a key for translating one ancient Egyptian language into another. Each of the 15 ‘Rosetta Stones’ in *Post-Partum Document* is, like the Rosetta Stone, divided into three language systems: her son’s letter shapes and writing, their joint construction of the English alphabet, and her diary. Documentation VI explores the connections among Barrie’s acquisitions of language, his entry into preschool, and ‘the complex of institutional practices and systems of representation which produce the social subordination of the mother’ (Kelly, 1983: 167).

First-person texts appear throughout *Post-Partum Document*. For example, the epigraph quoted at the beginning of this essay is from Documentation IV, when Kelly’s son was between two and a half and three years old. The text is from Mary Kelly’s diary. It is inscribed on a fragment of her son’s comforter:

I didn’t see K[elly Barrie] much this week because of the Brighton show. Now I’ve noticed he’s started stuttering. Dr. Spock says it’s due to ‘mother’s tenseness or father’s discipline’. My work has been undermined by the appearance of this ‘symptom’ because I realise it depends on belief in what I’m doing as a mother . . . . as well as an artist. I feel I can’t carry on with it (Kelly, 1983: 100).

In all likelihood ‘Dr. Spock’ is pediatrician Dr Benjamin Spock, author of *Baby and Child Care*, a best-selling child-rearing manual. Spock’s book provides expert advice to parents about topics ranging from what supplies to collect in anticipation of a newborn baby to symptoms of illness or distress (such as stuttering) in infants and children. According to Spock, a good parent should be guided by a child’s desires (Hays, 1996: 54). In this passage, Kelly describes something that her son has begun to do (stutter), her attempt to understand what this means, her turn to an expert for advice about it, and her response to the advice. The behavior is transformed into a symptom because of her attentiveness to her son and her decision that this recent change warrants a consultation with Spock’s book. At the same time, the behavior probably has appeared because she has not been attentive enough for a week while preparing to show her artwork at an exhibition (‘the Brighton show’). Kelly is torn – she is too tense for her child’s well-being, and
at the same time her tension about her child’s symptom undermines her ability to make art. As one of eight framed diary/comforter objects (Kelly, 1983: 98–105), this particular diary entry focuses attention on the production of Mary Kelly’s identity as a mother, her ambivalence about being a mother and an artist, her worries about the judgment of her performances by experts, and her responses to them. Kelly’s words display how she feels about being caught between two central ideologies – ‘the historically constructed images of warm, nurturing mothers on the one side and cold, competitive career women on the other’ (Hays, 1996: 16).

In another of the eight objects from Documentation IV, ‘Transitional Objects, Diary, and Diagram’ (Figure 2), Mary Kelly writes of her son’s ‘sudden attachment’ to her, displayed by his expressions of hostility to anyone (including her husband/his father) ‘who acts as a third party’ in their relationship. Although she is attempting to be guided by her son’s desires, as advised by Spock, she doesn’t know what his desires are, and this upsets her.
In other sections of *Post-Partum Document*, Kelly includes excerpts from her diary in different ways, for example setting them alongside of transcriptions of taped conversations with her son about his experiences at nursery school (in Documentation VI). These texts, like those in Documentation IV, focus attention on how mothering is produced in interactions with her son, dialogues with herself, and experts.

In Documentation V, ‘Classified Specimens, Proportional Diagrams, Statistical Tables, Research and Index’, Kelly layers different discourses in a particularly compelling way (see Figure 3). Documentation V consists of 33 objects from the time Kelly’s son was two and three quarters till he was just over four years old (July 1976–September 1977) (Kelly, 1983: 113–59). As the title of this documentation indicates, this part of Kelly’s narrative engages with discourses of knowledge. Kelly’s son found leaves, flowers, snails, bugs, and moths, picked them up, investigated them, and gave them to Kelly. She mounted 11 of these objects on blocks of wood, then stamped each with the scientific and common name, date and name of the collector, and place of collection. Placed in individual frames next to each of these 11 objects are two pairs of representations. One pair consists of a proportional diagram of the object juxtaposed above the transcript of question and answer exchanges between Kelly, her son, and occasionally her husband, about sexuality, the body, and gender. The other pair consists of a photocopied fragment of a single diagram of a full-term pregnancy taken from a textbook juxtaposed above an index of medical-scientific words representing the anatomy and physiology of a woman’s body; in this pair the pregnancy diagram is rotated and the diagram of the full-term fetus brought more fully into and out of view from one frame to the next, and at the same time the list moves through the alphabet, from Index A through Index T-U-V. In each of 11 sets of frames, there are multiple discourses. The question asked at the end of this
Documentation is, ‘What Am I?’ This parodies both art and natural history museums by putting, in Kelly’s words, ‘objects of everyday life’ into a ‘kind of framed space – an unexpected place’ to ‘set up certain conditions for a critical reading. . . in a particular institutionalized context’ (Kelly, 1996: 63, 65). It locates their relationship within a network of social practices and institutions.

One juxtaposition in Documentation V is that of the particular and the general: this son gives a gift to his mother, and asks his mother questions about her body, sexuality, and gender. He explores these in the context of their daily lives (climbing into his parents’ bed, eating supper, following his mother into the bathroom). These particular interchanges and details are framed alongside a diagram from a textbook and an index of words about female anatomy and physiology in general. Images are vital to the construction of medical knowledge (Kapsalis, 1997). They construct scientific objects, orderly relationships, and standardized anatomy and physiology against which individual variations are viewed as deviations.

Another intersection in Documentation V is the everyday with the scientific. Here the explorations of a child take on the guise of scientific research by being transformed into framed and classified objects; yet although their form mirrors the form used in the medical diagram and index, they do not have the same cultural authority. The child’s source of knowledge is his mother; the source of knowledge represented by the index and medical diagram is western biomedical science. By placing the inquiries of a three-year-old alongside the inquiries of doctors of medicine, Kelly questions the basis of science and the means by which it persuades us to believe in its authority and give it power.

A third intersection is feminist and psychoanalytic interpretations of subjectivity, language, and desire. Kelly aligns herself with feminist critics of psychoanalysis when she writes in ‘Experimentum Mentis V On the Order of Things’, ‘The mother’s relation to castration, to the Father and the Law, is called into question by the sexual researches of her child’ (Kelly, 1983: 160). The transcribed interchanges between Kelly and her son provide evidence to support Kelly’s critique not only of science but of psychoanalysis. In addition, the juxtaposition of texts, images, and objects calls into question the primacy of language in the production of identities. Kelly simultaneously assumes shared cultural knowledge about key psychoanalytic and feminist texts (Kelly, 1983: xxii), takes on the voice of Lacan and parodies it (Iversen, 1983: 208). Twenty years after she began Post-Partum Document, Kelly said that it ‘functions as part of an ongoing debate over the relevance of psychoanalysis to the theory and practice of both Marxism and feminism’ (Kelly, 1996: 20). In it, Kelly is deconstructing femininity as something fixed and essential; she is depicting it instead as something fluid and precarious, a product of psycho-social representation.

All of these multiple discourses are juxtaposed and interwoven in Documentation V. Post-Partum Document shows and tells how intensive mothering is constructed, complex, and often contradictory. Readers and vis-
itors navigate their way through time and space, collaborating with Kelly in narratives that can change with each telling. Embodying a dizzying array of images and texts, the narrative encourages reflection on relationships ranging from those between mothers and infants or mothers and sons, husbands and wives, women and experts; to language and emotion; and femininity, capitalism, and heterosexuality. At the same time, this rich and expansive narrative, especially seen in juxtaposition with Hannah Fisher’s, is still partial and limited in its demystification of intensive mothering. Not only does it assume ‘ability’ and ‘health’ but it also reflects a lived experience circumscribed by particular patterns of emphasis (e.g. gender, sexuality, class) and omission (e.g. race, nation).

Discussion

Moving between narratives produced in this research interview and work of art fills in details about the ways in which intensive mothering is a historically specific and embodied practice and enlarges the field of narrative analysis. Mary Kelly and Hannah Fisher make events in their lives meaningful and engage in ongoing construction of their identities in narratives. They show how cultural discourses of science, medicine, psychoanalysis, and mothering play a role in their sense-making. They position themselves in relation to these discourses. Both are doing versions of intensive mothering and at the same time both are making critical commentary on intensive mothering and medicine. They draw upon images and conventions to present and interpret their accounts of mothering.

Both of the narratives contain temporal order, ‘points’, arguments, and moral force. These two narratives also blur boundaries between text and image, words and pictures. Mary Kelly interweaves verbal and visual discourses in her narrative to subvert the ‘normal’ and ‘normalizing’ practices of mothering, medicine, and art-making. Just as she moves between writing and picturing, she demands that audiences move between looking and reading in the same narrative. Her combination of words, transcriptions of conversations between her son and herself, medical and psychiatric discourse, and her own internal dialogues, simultaneously distance audiences, and engage them with these different discourses. Moving back and forth between visual and verbal helps to build moral force in her narrative.

Hannah Fisher’s verbal narrative contains powerful culturally shared visual images and conventions of fighting and doing medicine. These images help her to position herself as a heroic intensive mother. She was overwhelmed; she persevered, and she rejected the use of her emotions as a basis for action. She did what she had to do. She put up a shield that could absorb darts, and adopted a calm and distanced scientific stance. Ironically, in the narrative, this stance was even more distanced and unfeeling than that of one of her physicians in his description of her body. Her verbal images draw listeners into her
story, puzzling over them, engaging them in the discourses of science and mothering.

These two narratives also work together to explore the meaning of intensive mothering and to develop a critique of it. Hannah Fisher and Mary Kelly enact intensive mothering in multiple ways, from the excruciatingly detailed representations in Mary Kelly’s documentations to the strategic expertise in Hannah Fisher’s. First, both of them show how mothering is time consuming. Hannah Fisher uses precise amounts of time to tell me how time consuming it is (when we talk on the phone she tells me she has only nine hours to herself each week; as we sit down to start the interview, she tells me she has been moving since 6:30 and now it is after 10; I can infer she has been moving/working for three and a half hours). She does not describe the mundane tasks that take up these hours. She leaves it to me to ask her for clarification or to fill in the details myself. Mary Kelly writes of and shows the sorts of things a mother does when she is ‘moving’ but she does not calculate the amount of time these things take. Her pictures and words fill in what is left unsaid by Hannah Fisher. For example, the well-worn vests are products of many wearings by and washings for a newborn baby. The sequence of four identical vests suggests an endless repetition of changes of soiled clothes, washing and drying, dressing and undressing. The images don’t tell whether or not Kelly has a washer and dryer or takes trips to a laundromat, or washes the clothes by hand, but they invite viewers to wonder; they don’t reveal times he was sick and needed more changes of clothes, or how he wore them (underneath shirts, or as shirts themselves), or how fussy he was when being dressed, or what it felt like to tie the sides of the shirts together. But they invite viewers to fill in further details such as these – that is, to fill in the hours, days, and weeks of time spent dressing and undressing this newborn and washing and drying this newborn’s clothes.

Second, both of them also show that mothering is self-sacrificing. Hannah Fisher does and would sacrifice her feelings and her body for her daughter. She lets a potentially dehumanizing pronouncement by her gynecologist roll off her back instead of responding to the words emotionally. Beyond words, she would (probably) even be unbothered by darts thrown at her in an effort to remain calm and to be able to talk with physicians. Mary Kelly displays her worries, in the form of extracts from her diaries, about the negative consequences of taking time away from her son to prepare for an upcoming art show. Typewritten and displayed on a fragment of his comforter, they show how she might be torn between her needs and his, between wanting to be an adequate mother and an adequate worker (artist). That the text and the comforter became part of a work of art shows that she wasn’t entirely self-sacrificing. But at the same time, the sequence of texts and blanket fragments in eight framed objects suggests a continual return to the dilemma without a resolution.

Third, both of them show how emotionally involving mothering can be.
Mary Kelly’s reverent treatment of her son’s clothes, comforter, diapers, scribbles, collection of bugs and flowers; and her words responding to and interpreting them creates an endlessly absorbing world. *Post-Partum Document* tells of a world that consists of ‘a potentially endless detailing of particulars’ (Smith, 1987: 6). She worries about unexpected new behaviors (his stuttering), and celebrates his investigations of the natural world. When her son interrupts her and her husband ‘kissing on the lips’ at two in the morning, she tape-records the exchange and then reproduces it as an example of her son’s research (see Documentation V image in Figure 3). She and her husband laugh, and turn to him, apparently tickled by his question and his excuse for the interruption (‘I don’t want to sleep in my room. There’s ghosts and snakes and spiders and crabs up there.’) They give up their privacy and sexual pleasure, even in the middle of the night, for the pleasure of his company. Hannah Fisher’s emotional involvement with her daughter and her miscarried baby are expressed in the softening of her voice when she tells me ‘you know cause my my first daughter was premature and now this baby, which appeared normal um uh miscarried’ [023–025]. The way she pairs ‘I couldn’t carry a baby’ [022] when she’s speaking softly and ‘I should be able to carry a baby’ [032] when she’s speaking more loudly, about the report of what the tests showed, tells of a world of responsibility and sadness. Her absorption in mothering is also indicated by her decision to underreact to things so that she could remain calm, even knowing that this probably wasn’t a good way to be (for her?), because her daughter needed her.

Fourth, both of them engage with experts, and weigh, value, and compare themselves as mothers against what experts say. Dr Spock, Lacan, and Freud, all appear as characters in Kelly’s narrative. For Hannah Fisher, the experts appear as ‘they’ [015, 017, 019, 026], ‘the gynecologist’ [044], and ‘physicians’ [077]. Fisher tells, in the structure and content of her narrative, how medical experts interpret the cause of her troubles, and the way they use scientific reasoning to do this. In the interactions between us, she and I insert an alternative frame of meaning, an embodied, visceral one, with words, my false starts, and her inflections of her voice and her silences.

Mary Kelly contests intensive mothering at the same time as she gives evidence of her immersion in it. Most obviously, this is a work of art that fabricates a metaphoric world of mothering from the mundane world occupied by mothers (my formulation follows Radley, 2002, who discusses artistic transformation in illness). Her materials include plastic, glue, ink, tape recorder, and paper as well as the detritus of everyday infancy and childhood, fashioned into a narrative. The details themselves reach out and invite reflection about why they bear framing and to whom they might be worthy of collection. Why do these objects matter? Kelly and her son are not pictured. Why not? Kelly’s juxtaposition of a framed moth (Common Name, Buff Arches) with an alphabetized list from an index beginning with the word ‘rectum’ and ending with ‘syphilis’ is jarring. What is science? (Figure 3).
Setting this research interview and work of art together does more than explore the meaning of intensive mothering. It makes an argument that moving between visual and textual narratives is a valuable direction for sociologists to take. Visual sociologists argue that people are able to make statements with images that cannot be made with words (Harper, 1998: 38). For example, the image of tiny, used, flattened, framed vests evokes for me a newborn baby and gives expressive form to the ineffable experience of holding, smelling, looking at, and taking care of a baby. At the same time the image represents work that goes into producing a healthy baby and not coincidentally a work of art; and perhaps the turmoil encountered by trying to accomplish both. These framed objects

... contain far more than a graphic representation of concrete ‘realities’. Much of their richness as data derives from their ability to capture elements that cannot be quantified with numbers or fully described by words, elements such as body language, direction of gaze, or the nuances of human emotion (Rich, 2002: 410–11).

Beyond making statements, ‘the visual domain allows the researcher to gain insights, sometimes blinding in their power and vivacity, to representations of social relations and codes of meaning’ (Pryce, 1996: 109). The repetitive sequences of objects in Post-Partum Document, for example, can jolt viewers into thinking about connections between the lives of individual mothers and babies and experts, the structure of jobs in advanced capitalist society, and gendered relationships between women and men. Thus, visual images move meaning beyond what can be accounted for in texts.

But this formulation of images dichotomizes visual and textual, as if they can be clearly distinguished. To some extent this formulation is strategic, in its argument in favor of bringing ‘the’ visual in to sociology. But to some extent it is disingenuous. Post-Partum Document is not ‘just’ visual, and a central organizing metaphor in it is the developing ability of Kelly’s son to write his name. Its self-conscious integration of the two is itself a commentary on relationships between showing and writing, seeing and listening. Conversely, there are images in Hannah’s narrative, for example ‘cervix like hamburger’ or ‘throw darts’, which thicken the meaning of her account. From this perspective, images are so thoroughly embedded in our worlds, that not to take them seriously, and not to work at making them part of analysis, is to reduce our understandings of subjects’ worlds.

In the end, putting these two narratives together disrupts a standard telling or witnessing of either one. The analysis of verbal and visual narratives provides a way of linking the feelings, ideas, and relationships of two women with their social settings, of seeing how they engage, reproduce, and resist cultural and scientific discourses of mothering. Looking at these narratives helps us to explore and bring to light practices of intensive mothering, simultaneously locating them in place and time and acknowledging their fluctuat-
ing meanings. This approach privileges positionality and subjectivity, the
different contexts, settings, and aims of their narratives – a post-partum
documentation for museums, a woman with a healthy son, and an interview,
a woman with 50 percent fetal loss and a sick daughter. At the same time that
it seeks to recognize the multiplicity of social experiences and perspectives, it
makes statements about regularities in the social world and works to develop
systematic knowledge.

NOTES

A version of this essay was given as the inaugural lecture for the A. Myrick Freeman
Professorship in Social Sciences, Bowdoin College, Brunswick, ME, 22 April 2002. I
would like to thank Mary Kelly for generously giving me permission to reprint three
images from Post-Partum Document, and the woman I call Hannah Fisher for her
willingness to be interviewed by me. I am grateful to Sara Dickey, Catherine Kohler
Riessman, Jane Attanucci, Susan Reverby, and Kathy Davis for reading and respond-
ing to different versions of this essay.

1. A pseudonym.

2. DES (diethylstilbestrol) is a synthetic estrogen that was prescribed to pregnant
women in the US to prevent miscarriage from the 1940s to the 1970s. ‘DES
daughters’ are women who were exposed to DES prenatally, when their pregnant
mothers (‘DES mothers’) used DES.

3. The relative risk of reproductive tract cancer – vaginal and cervical clear cell
adenocarcinoma – for the roughly 2 million DES daughters in the US is very high,
but the absolute risk is rare. The incidence has been estimated to be 1 in 1000
DES-exposed women (Swan, 2000: 795). As of 1997, 680 women in the US were
registered with DES-related cancer and 80 percent of them were still living
(http://www.descancer.org/des.html).

4. Of the other three mothers, two of them were DES cancer daughters and had
adopted children; the other was a DES daughter who had given birth to a baby two
months before I interviewed her. For the DES cancer daughters, mothering cannot
be disentangled from their experiences of cancer; the other mother had worried
about the possibility of trouble conceiving and carrying a pregnancy to term but
had not had any difficulties. In a review of all 150 letters to the editor published
in The DES Action Voice, 1979–2001, I identified 52 letters concerning the general
topic of pregnancy and childbearing. Like Hannah Fisher, almost all of the 52 letter-
writers pursued motherhood, most of them through conceiving and birthing a
child (but three of the letters were from women who had chosen adoption). The
dominant discourse in them was of intensive mothering. Only three letter-writers
explicitly contested motherhood as a goal. Most often, I found a chorus of stories
that were variations on a theme in Hannah’s. A DES daughter would have trou-
ble, but in the end she gave birth to one or more healthy children (21/52). Some
DES daughters were less successful than Hannah Fisher. These women told stories
with ‘unhappy endings’ (7/52). Some of the women gave birth too soon, to babies
who died. Others were unable to conceive at all. A third group of women were still
in the process of trying to become mothers (8/52).

5. Whenever possible I interviewed women in their homes. Their ages ranged from
23 to 40, and the interviews were conducted between 1982 and 1995. I recruited a
purposive sample of young adult women, ten who had had cancer and ten who
had not, from sources designed to yield DES daughters with a wide range of experiences: clinics treating DES daughters, physicians specializing in the treatment of DES cancer, a class action lawsuit, DES Action, and the DES Cancer Network. I conducted two focused, in-depth tape-recorded interviews typically one to two weeks apart with each woman. I used an interview guide that included the following topic areas: how they learned of their exposure and what this was like; what their knowledge of popular and professional literature concerning DES was; how their experiences had changed over time; whether they had had any medical problems they associated with their exposure to DES and how they had responded to this; how they managed their medical care; which relationships with others (in their families, friendships and work and school situations) had been important to them in relation to DES; what had been the nature of their contact with other DES daughters; and their visions of the future regarding work, family, etc. After the first interview each woman completed a questionnaire giving biographical details. After the first interview, I reviewed the tape to ensure that all of the topics on the interview guide would be covered by the end of the second interview. Each interview lasted approximately 1½ hours.

6. The transcript is a translation of speech into text, and in this respect it is an interpretive practice. I preserve false starts, hesitations, and repetitions, and give each clause a separate (numbered) line. Brief pauses are indicated by a comma; pauses lasting longer than one or two seconds are indicated by ‘p’. Nonverbal sounds are given in parentheses ‘(inhale)’. Words or syllables of words that are drawn out are indicated with double letters ‘aand’; emphasis on one syllable of a word is indicated with underline. When pitch is higher at the end of a word it is marked with a question mark ‘hysteroscopy?’ In some places I have been unable to hear words clearly (‘unclear-4’ [words]). To preserve anonymity, I have used pseudonyms (‘Hannah Fisher’); removed some identifying details such as the names of people and places [a hospital]; and changed some dates and ages.


REFERENCES


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