Pregnancy means your body is out of your control, you share the ‘space’ with another, you are subject to advice from experts, friends and passers-by about how you should eat, drink, play and work; and ‘everyone’ knows your brain shrinks. What’s more you may not bond with your baby for quite a while, by which time you are exhausted from lack of sleep. So what is ‘normal’ about pregnancy?

Images of pregnancy and childbirth seem ever-present in the media, and information and advice to prospective parents abounds. The pregnant (and postnatal) woman has traditionally been of concern socially, morally, sexually, medically and physically to researchers, clinicians and those who surround her (Moscucci, 1993; Mullin, 2002). Yet the experience of becoming and being pregnant remains mysterious, not least because technologies have ensured that there are now several ways to conceive and give birth, whatever your relationship status, age or sexuality. So is there such a thing as a ‘normal’ pregnancy? And, if so, what have psychologists contributed towards understanding it?

Women’s pregnant bodies demonstrate changes in shape, size and appetites, each of which evoke psychological implications (Houlouras, 2006; see also Harriet Gross’s article on p.202 of this issue). Consequently psychological research on pregnancy, childbirth and motherhood has focused on diverse substantive topics selecting different epistemologies, standpoints and methods.

The changing nature of pregnancy
When I was born, 60 years ago, pregnancy and childbirth were hit-and-miss affairs. Oral contraceptives were things of the future. Termination of pregnancy and childbirth were hit-and-miss affairs. Oral contraceptives were things of the future. Termination of pregnancy was illegal, with many deaths or morbidities caused through ‘back-street’ abortions. Other women with unwanted pregnancies gave their babies up to adoption agencies. Women who accepted the pregnancy, likely to be married, wore tent-like clothing presenting contradictory symbols of both ‘chastity’ and maternal pride. Sexuality was determinedly disengaged from the process of ‘having a baby’ and as a consequence fathers were markedly absent from the labour room.

In the 1940s and early 50s women had the choice to give birth at home or in hospital. Physically healthy middle-class women were more likely to choose hospital because they could afford it and it provided opportunities for a rest. These women had a generally easier time and were more likely to give birth to a live healthy baby (wherever they chose to be ‘confined’) than those women whose lives were less privileged.

Things have changed. Mothers’ expectations are now for fewer children, later in their lives and, whatever their educational status, it is likely that the majority of mothers will work outside the home at least part time. Mothers have greater control over their own fertility. Mothers are sexual beings. Mothers are concerned over their own health status and shapes. Motherhood is no longer experienced as the ultimate feminine achievement and although it is about being feminine, that does not have the same meaning for my daughter as it had for my mother (Nicolson, 2002).

In the contemporary landscape pregnancy remains a medical event but there has been a subtle change from the ‘doctor knows best’ to the rhetoric of informed choice and ‘risk’. While most people greet announcements of pregnancy with cries of ‘Congratulations’, a search of psychological literature over the past 30 years suggests an increasing focus on mental ill health, eating disorders, re-experiencing earlier sexual abuse, anxiety and depression (e.g. Nicolson, 1998). Also noted are broader health-related risks from HIV/AIDS and other sexually transmitted diseases, smoking, diabetes, obesity, unwanted and unplanned pregnancies (particularly in the case of teenage mothers).
mothers). The potential hazards investigated by psychologists frequently embrace dual concerns for the ongoing health status of the mother and that of the newborn baby. Particular groups of women, such as teenage and older mothers and those with a history of psychiatric disorders or depression and anxiety, are frequently singled out for special attention, where concern is expressed both for them and for the baby.

Pregnancy has always been physically hazardous to some extent, so the long gone days of the ‘wise women’ were not necessarily ‘good old days’. Although modern medicine and technological advances have reduced the risks of morbidity and mortality (for women and neonates/newborn infants) (Shorter, 1984) the trade-off has been that medical practitioners have exerted control over pregnancy and childbirth and power over definitions of what is ‘normal’ (Donnison, 1988; Oakley, 1980; Ussher, 2006). This is most recently evidenced by the outputs of government agencies, such as the National Institute for Health and Clinical Excellence giving advice to clinicians in the UK on antenatal care (http://bit.ly/aZGER6, 2008) and the US Food and Drug Administration, who issue advice to pregnant women. A range of foods have been identified as ‘taboo’ for pregnant women, such as soft or blue cheeses, shark or marlin, fats and sugar, nuts, caffeine and alcohol (www.eatingforpregnancy.co.uk). We found in our recent study that while young women take seriously the advice coming to them from government sources and via magazines and websites, they also pay attention to the examples set by their own mothers and grandmothers (Fox et al., 2009). Ultimately if craving for blue cheese is strong enough then pregnant women are likely to eat it regardless!

The ‘normal’ pregnant body
Pregnancy is... a period during which normal service is suspended, when the body apparently slips its moorings and refuses to ‘obey’ in the commonplace ways (Warren & Brewis, 2004, p.221).

How do women respond to their bodies being out of their control? The literature on pregnant women’s attitudes to their bodies shows how, while pregnancy enables women to transgress the idealised female body discourse, such a construction reinforces the cultural thin ideal as the norm for women in Western culture (Johnson et al., 2004). However, there is (unsurprisingly) for many women a pride in their pregnant body, with the temporary release from the pressure of dieting. Pregnant bodies also emit embarrassing leaks from breasts and bladders, engender ‘morning’ sickness, result in discomfort, sleeplessness and pain and the inevitable etching of experience on the body by way of enlarged veins and stretch marks. Pregnancy health-related websites advise pelvic floor exercises for stress incontinence and breast-pads for leaking breasts with the message not to worry and that this is ‘normal’ (e.g. tinyurl.com/4ypth5mo). The underlying messages, though, are that pregnancy can wreak havoc on your hormones.

The ‘normal’ pregnant brain
Young women in 21st-century Britain expect and often need to work outside the home after childbirth. Mothers continue to achieve in professional life, and their actions and proven abilities hopefully close the book on the 19th- and 20th-century ‘experts’ who both pathologised and regulated the female body and mind through discourses of deficiency blamed on female reproductive hormones. The onset of puberty, premenstrual syndrome, postnatal depression and psychosis, breast-feeding and the menopause in particular were all proposed as times when women were emotionally and intellectually less able than their male counterparts (Nicolson, 1998; Ussher, 1989, 2006).

But does the ‘achieving mother’ mark the end of this story? Perhaps it does not. Some psychologists have ‘found that the brain shrinks a little during pregnancy… then returned to normal after delivery’ (DeAngelis, 2008, p.29). In the summer of 2009 a young woman graduated with a first class degree and later that day delivered her first baby. The newspaper report stated that she was pleased but surprised at her academic success because her brain had felt like ‘mush’. It may be that cognition and short-term memory are indeed impaired during the first trimester (Kinsley & Lambert, 2006; and see Christian Jarrett’s article on p.186 of this issue). However, reports of research on so called ‘baby brain’ (e.g. tinyurl.com/cyc34zua) are contradictory, or very subtle, as one Australian researcher put it. Why do up to 80 per cent of pregnant women...
Bonding with the fetus and baby

While it has been argued that a pregnant woman is merely a passive container for the developing fetus (Bailey, 2001) others have demonstrated that technologies such as ultrasound that provide detailed scans of the fetus in the womb enhance emotional bonding between the woman and her future baby (Zechmeister, 2001). From a Kleinian psychoanalytic perspective Raphael-Leff (1991) proposed that even without being able to see the scan of the unborn baby, the mother unconsciously actively nurtures the infant within her body. This, she suggests, equates with the way in which a mother processes the preverbal infant's anxieties and returns them in a tolerable form to make the baby feel more secure. Thus the nurturing during pregnancy is far more than just a means of warehousing the fetus – it is the beginning of a relationship.

The classic studies by Klaus and Kennel (1970) and their colleagues have demonstrated that bonding between the mother and the newborn can be encouraged by allowing them to be alone together after the birth rather than taking the baby from the mother in order for her to rest, which was the case until about 25 years ago. These results were replicated by others, which led to policy changes in maternity care and the knowledge that all things being equal, the more the mother and baby get to know each other, before and after the birth, the stronger their relationship over time.

However, maternal affection may not be immediate, and as many as 40 per cent of first-time mothers do not feel love for the baby following birth (Robson & Kumar, 1980). More recently, scales of mother–infant bonding have been developed to predict postpartum disorders (Hornstein et al., 2008) and the links between attachment, postpartum disorders and potential child abuse (Brockington et al., 2000).

Women's true destiny?

In the common view, every woman fulfills her destiny once she becomes a mother, finding within herself all the required responses, as if they were inevitable, held in reserve to await the right moment. (Badinter, 1981, p.xxi)

Pregnancy and childbirth per se are the province of women alone. But how much does becoming a mother fulfill women's (implied) sole destiny? Does the capacity to bear children link in any psychological way to instinctive love/attachment to the baby?

Support for a 'destiny fulfillment' view has come very much from 'popularised' versions of Freudian psychoanalysis that suggest that pregnancy, childbirth and motherhood resolve women's desires to do other things such as have a successful professional career. However, feminist psychologists have shown that Freud himself did not actually argue that biology was destiny in this way, but talked about women and men as having the chance to take feminine or masculine pathways in life (Sayers, 1982). Similarly sociobiology and evolutionary psychology have been used to justify the notion that women's brains are 'hard wired' to bear and rear children. But this is not the way that experts in the field interpret the evidence. Once again the focus of evolutionary psychology and gender is about negotiating the context of biology, psychology and the social context rather than a crude determinism (Campbell, 2002). More recently the perceived need to teach parent-craft to both women and men hints more strongly that the capacity for motherhood alone does not necessarily imbue women with intrinsic skills (Deave et al., 2008).

Pregnancy, motherhood and identity

Academic work on motherhood as an emotional destiny fades out after the late 1970s, although some of what we learnt then remains important; for instance, that pregnancy and motherhood are key life transitions for women with their own developmental stages, so that becoming a mother increases a woman's sense of entering adulthood (Leifer, 1977) and provides greater self-knowledge and sense of a place in the world (Breen, 1975). Some feminist psychologists, myself included (Nicolson, 1992), railed against
the emphasis on women as mothers for fear of equating this with the idea that women were only mothers. Smith (1992) noted that most psychological studies of pregnancy took a positivistic medical view and there was indeed more to be understood about the complex experience of ‘normal’ pregnancy as a life transition. Have we learnt anything about this in the intervening years? The reconnection that some social and health/clinical psychologists have made with psychoanalytic literature, particularly Kleinian object-relations perspectives, has brought ideas of difference to centre stage so that the emphasis is upon understanding the ambivalence of becoming a mother (DiQuinzio, 1999). This has led to a revisiting of the ‘emotional journey’, frequently in the context of self-help books, through pregnancy to motherhood acknowledging that emotions are more than responses to hormonal changes (Ganley, 2004). It was once common practice for lay and professional ‘advisers’ to suggest becoming pregnant could heal relationship problems, even though generations of researchers have shown that the stress of new parenthood is more likely to exacerbate ongoing troubles (see for example Nicolson, 1998). Becoming pregnant can be scary alongside emotions and anxieties about the relationship with the baby’s father, fears for health, bodily changes and how to cope emotionally, physically and practically with the new baby.

**Final thoughts**

While most women in 21st century Western societies have relatively trouble-free ‘normal’ pregnancies little attention is currently paid to the psychology of these experiences from the woman’s perspective. As other articles in this issue show, pregnancy is a crucial life transition with psychological, relational and emotional risks over and above those of morbidity and mortality policed through the medicalisation agendas. How does the quality of the experience becoming a mother impact upon a woman’s psychological well-being over time? In what ways do cultural values impinge upon psychology at this time in a woman’s life? Why is the label ‘postnatal depression’ (or postpartum depression) still used as a wider and wider catch-all category despite evidence from psychologists with expertise in women’s health and lives demonstrating its limited value? The mental well-being of mothers now appears to be less a matter of depression through social isolation and more one of depression brought about through guilt, anxiety and the stress from not feeling good enough as a mother, partner or professional. The recent example of 43-year-old Catherine Bailey, a mother of three described as ‘loving’ and a ‘top City lawyer’ found dead in the Thames, whose suicide was attributed to postnatal depression, speaks volumes. The coroner’s extrapolation that Bailey had found it hard to meet the demands of motherhood and the high standards she set herself is far more telling than any clinical label.

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