Hope and Grief: Mothering and Mental Illness

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Abstract

Mothering generates powerful emotions that transform a woman's sense of identity and the way she narrates her life story. This article is concerned with motherhood across a life trajectory, using one woman's oral history interview to illustrate how these emotional imprints can be discerned in maternal narratives decades later. Motherhood is profoundly shaped by gendered systems, structures and family arrangements, with changing expectations leaving lasting emotional traces. Diana's memories of mothering, from the joy and hope of her 1970s pregnancy that aligned with societal norms, to the profound challenges of the 1990s when her daughter was diagnosed with anorexia nervosa, highlight the significant impact of motherhood on identity. The study prioritises Diana's spoken words, revealing how maternal memories retain emotional depth but shift in interpretation. Memories from various parenting stages intertwine to illuminate broader themes of motherhood, particularly influenced by medical interventions and gendered societal expectations. Diana's life course narrative reveals the disparity between anticipated motherhood and its complex realities, addressing a broader gap in parenting scholarship that often overlooks later stages of parenting. This research demonstrates the value of life story interviews in understanding connections between personal experience, historical change and emotional recall.

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Note on the Use of Italics

Diana's spoken words in the running text are in italics, with bold italics showing emphasis in both the running text and block quotations. This approach integrates Diana's voice and perspective into her life story. Like

other oral historians, I use this style to emphasise the interviewee's voice and visually distinguish between her spoken words and my construction of the historical narrative.[1]

Probably the Most Important Thing I Have Done in My Life

A retired Melbourne schoolteacher, who I call Diana, wrote that she was *very happy* to take part in my oral history mothering study, *as parenting has probably been the most important thing I have done in my life*.[2] Several weeks later, during her interview, Diana recounted the intense joy she felt when she saw her baby using ultrasound technology (Figure 1) as she anticipated the birth of her first child. However, this joy was short-lived and Diana's comment about parenting was not the positive affirmation of her role that I had understood. In all her imaginings about her future motherhood, Diana was blissfully unaware of the long-term emotional effects of her younger daughter's mental illness on her family.

This article explores Diana's grief in retirement at the loss of hope that her younger daughter, who developed anorexia nervosa in her teens, may ever achieve health or future independence. Jan Gothard writes that most parents expect that a child will bring joy and 'hope at the very least for the health, happiness and, ultimately, future independence of our offspring'.[3] Yet, Diana faced confusion and blame while battling for her daughter's medical treatment, feeling unsupported by the cause-focused family therapy of the 1990s. Her grief intensified over decades due to the unpredictable nature of her daughter's illness, illustrating the relational nature of grief and the lasting impact of evolving anorexia nervosa perceptions on families—particularly mothers.[4] Diana's story is a poignant example of cherished hope and maternal grief when reality diverges from the family imagined during pregnancy.

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1 I first saw this approach used by oral historian Alistair Thomson who noted that he modelled it on histories by Rhys Isaac and Martha Hodes. For other examples, see: Nicolette Snowden, '"There Was Still a Bit of That Paternalistic Crap Going On": Revealing the "Forgotten" Labour of Working-Class Women in an Australian Industrial Coal Region', *Studies in Oral History: The Journal of Oral History Australia*, no. 46 (2024): 22–53; Alistair Thomson, *Moving Stories: An Intimate History of Four Women across Two Countries* (Manchester University Press, 2011).

2 'Diana' (pseudonym), interview by Miranda Francis, Melbourne, April 2016. In accordance with the interviewee's wishes, all names and identifying information have been changed for privacy reasons. All subsequent discussion and excerpts refer to this interview.

3 Jan Gothard, *Greater Expectations* (Fremantle Press, 2011), 31.

4 Anne M. Williams-Wengerd and Catherine Solheim, 'Grief Experiences in Parents of Adult Children with Serious Mental Illness', *Journal of Family Theory & Review* 13, no. 4 (2021): 530, doi.org/10.1111/jftr.12434.

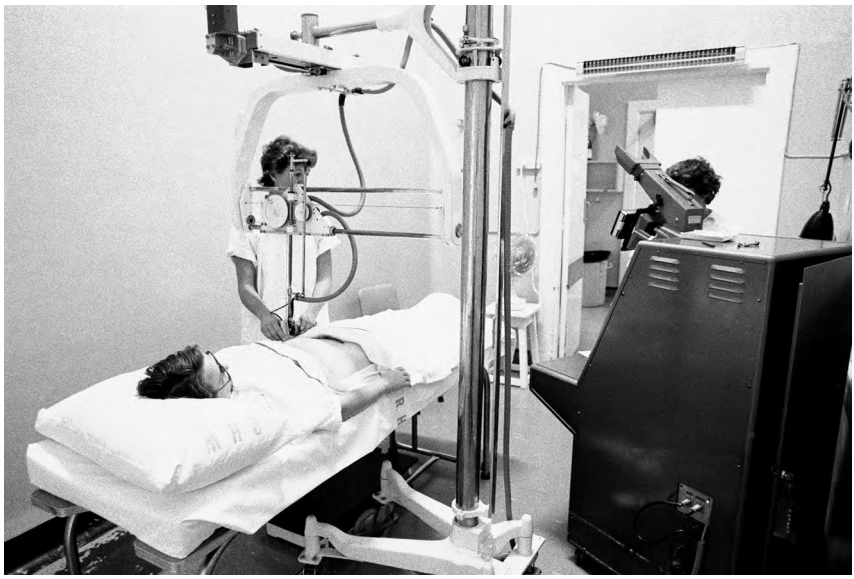

Figure 1: Photograph of anonymous woman (not Diana) undergoing an ultrasound in 1973, Australia.

Note: The caption from the National Archives of Australia catalogue reads: 'Australian physicist pioneers medical diagnosis by ultrasound'.

Source: NAA: A6180, 20/3/73/15.

Oral History as Source Material and Methodology

Diana's interview was one of 28 I conducted between 2015 and 2019 for a PhD awarded in 2023.[5] I used oral history as both source material and methodology to explore women's memories of mothering in twentieth-century suburban Melbourne. Oral history focused attention on the emotional and interior lives of mothers, shaped by both cultural and social processes and individual experiences, conveying the complex emotional work of mothering.[6]

5 Miranda Francis, 'Mothers Remember: An Oral History' (PhD thesis, La Trobe University, 2023).

6 See special issue of *Past & Present*, especially: Sarah Knott, 'Theorizing and Historicizing Mothering's Many Labours', *Past & Present* 246 (2021): 1–24, doi.org/10.1093/pastj/gtaa032.

My methodological approach involved unstructured interviews in participants' homes using a life story or whole-of-life history approach, collecting and analysing complete life narratives rather than focusing on isolated events or specific time frames.[7] These one-to-one biographical interviews focused on childhood, family and motherhood, with interviewees guiding their narrative. However, as Joan Sangster notes, academic oral history is not an equal relationship; I accessed memories and private archives as a historian, not a friend.[8] Influenced by Kathryn Anderson and Dana Jack, I aimed to 'listen in stereo' to both what the interviewee was explicitly saying as well as the subtexts of her words, which can sometimes be muted by social expectations.[9] Attentive to the intersubjective relations at play in the interview, I was mindful of the ways 'sensitivity can enrich subsequent understanding' of an emotional life.[10]

Each interview, lasting two to five hours and often spread over multiple sessions, was audio recorded. I used a portable recorder and reflected in a journal post-interview before generating the transcripts. Transcription is an approximation, recognised as such by researchers.[11] For analysis, I re-listened to the interviews, highlighted transcripts and reviewed my notes to better understand the interviewee–interviewer relationship, body language and context. This allowed me to identify themes and patterns, a common approach in oral history.[12] Building on the work of feminist oral historians such as Katie Holmes, Angela Davis and Laura King, this method underscores the importance of oral history in understanding family relationships and the complexities inherent in navigating shared authority in research.[13]

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7 The life story method of interviewing is used internationally by oral historians and was the subject of a two-day symposium run by National Life Stories (British Library) in 2023. For a review of the literature, see: Donald A. Ritchie, 'Life Stories: A Field Review', *Oral History* 52, no. 3 (2024).

8 Joan Sangster, 'Telling Our Stories: Feminist Debates and the Use of Oral History', *Women's History Review* 3, no. 1 (1994): 11, doi.org/10.1080/09612029400200046.

9 Kathryn Anderson and Dana Jack, 'Learning to Listen: Interview Techniques and Analyses', in *Women's Words: The Feminist Practice of Oral History*, ed. Sherna Berger Gluck and Daphne Patai (Routledge, 1991), 11–26.

10 Michael Roper, 'Analysing the Analysed: Transference and Counter-Transference in the Oral History Encounter', *Oral History*, Autumn (2003): 20.

11 Francis Good, 'Voice, Ear and Text: Words, Meaning and Transcription', in *The Oral History Reader*, ed. Robert Perks and Alistair Thomson (Routledge, 2016), 458–69.

12 See: 'Part III: Interpreting Memories', in *The Oral History Reader*, ed. Robert Perks and Alistair Thomson (Routledge, 2016), 297–444.

13 Angela Davis, *Modern Motherhood: Women and Family in England, 1945–2000* (Manchester University Press, 2012), doi.org/10.7228/manchester/9780719084553.001.0001; Katie Holmes, 'Does It Matter If She Cried? Recording Emotion and the Australian Generations Oral History Project', *The Oral History Review* 44, no. 1 (2017): 56–76, doi.org/10.1093/ohr/ohw109; Laura King, *Family Men: Fatherhood and Masculinity in Britain, 1914–1960* (Oxford University Press, 2015), doi.org/10.1093/acprof:oso/9780199674909.001.0001.

The 'Good Mother' and Maternal Time

What makes good and bad mothering has been the site of contest, attention and anxiety in the twentieth and twenty-first centuries.[14] Experts' attention intensified in the postwar period, as mothers were increasingly seen as carrying responsibility for the emotional and physical health of their children. Philosopher Sara Ruddick argues that the idealised 'Good Mother' casts a long shadow on many mothers' lives.[15] Diana's life story shows that this shadow persists long after the early years of childrearing. As ideas and expectations around mothering evolve, they leave an emotional legacy mothers carry well into later life.

Diana's recollections merge past and present. This is a common characteristic in oral history due to what Alessandro Portelli calls the 'time of the telling', which influences how events are remembered and told.[16] This merging is particularly apparent in narratives of mothering, as the relationship between mothers and their children is ongoing and changing. One set of memories overlays and shapes earlier ones, making emotional recall central to the experience of mothering. Since motherhood never truly ends, the emotional weight of mothering leads to a more pronounced merging of past and present. British philosopher Alison Stone notes that the mother's past is 're-created in a new shape' with her child.[17] Expanding on Stone's ideas, Carla Pascoe Leahy alerts us to the concept of 'maternal' time, which is cyclical rather than linear, shaped as mothers remember and re-enact their relationship with their own mothers when raising their children.[18]

The interview with Diana, the basis of this article, describes ongoing relationships. For Diana, the time of the maternal 'event' is not finished; it continues and remains part of her present life. While she focused on specific historical periods in her interview, these relationships are very much alive. This is true of all memories. Our memories shape our identity. As Alistair

14 For further information, see: Susan Goodwin and Kate Huppatz, 'The Good Mother in Theory and Research: An Overview', in *The Good Mother: Contemporary Motherhoods in Australia*, ed. Susan Goodwin and Kate Huppatz (Sydney University Press, 2010), 1–24, doi.org/10.2307/j.ctv1sr6kgj.5.

15 Sara Ruddick, 'Talking about Mothers from Maternal Thinking: Towards a Politics of Peace (1989)', in *Mother Reader: Essential Writings on Motherhood*, ed. Moyra Davey (Seven Stories Press, 2001), 189.

16 Alessandro Portelli, 'Living Voices: The Oral History Interview as Dialogue and Experience', *Oral History Review* 45, no. 2 (2018): 246, doi.org/10.1093/ohr/ohy030.

17 Alison Stone, *Feminism, Psychoanalysis, and Maternal Subjectivity* (Routledge, 2012), 8–9, doi.org/10.4324/9780203182932.

18 Carla Pascoe Leahy, 'The Mother within: Intergenerational Influences upon Australian Matrescence since 1945', *Past & Present* 246 (2020): 276, doi.org/10.1093/pastj/gtaa041.

Thomson notes: 'who we think we are now and what we want to become affects what we think we have been'.[19] This intertwining of past and present selves is particularly evident in maternal life stories, as becoming a mother, or matrescence, is a major psychological and social transformation.[20] Diana's life story shows that maternal identity is shaped and reshaped across a life course.

Interview with Diana

Diana (b. 1947) grew up as an only child in suburban Geelong, a regional port city 75 kilometres from Melbourne. Her father was the primary breadwinner and worked as a fitter and turner at the nearby Ford Motor Company. Diana spent many hours playing on her own in her maternal and paternal grandmothers' houses—both within walking distance of her house. Cousins *filled in a kind of gap* but her desire to have children, according to family legend, began young. Her grandmother remembered Diana announcing firmly at four that she was *going to have **six** children but no **husband***. This strong desire to have children remained two decades later. It became such a *sticking point* in the 1970s that Diana, while on a working holiday in London, left her boyfriend Tom, who was less convinced about being a parent, to return home to Melbourne. She explained that *it was the children thing … really what [she wanted] to do [was] to have children, so [she had to] … go home* [Australia]. Diana returned to *start … a new life* as she did not ***trust** [herself] to be capable of managing **older** children on [her] own*. Her self-doubt and emphasis on *older* children may reflect the difficulties she subsequently experienced raising adolescent children.

Diana's boyfriend Tom *changed his mind*, followed her home and shortly after they married. In early 1977, when Diana conceived at nearly 30 years old, she was older than many first-time mothers. At that time, nearly 60 per cent of first-time mothers were under the age of 25.[21] Pregnancy was clearly a welcome choice for Diana. She explained that she had had

19 Alistair Thomson, 'Memory and Remembering in Oral History', in *The Oxford Handbook of Oral History*, ed. Donald A. Ritchie (Oxford University Press, 2010), 90.

20 Carla Pascoe Leahy, *Becoming a Mother: An Australian History* (Manchester University Press, 2023), 2–4.

21 David de Vaus, *Diversity and Change in Australian Families: Statistical Profiles* (Australian Institute of Family Studies, 2004), 196, aifs.gov.au/all-research/research-reports/diversity-and-change-australian-families. For a discussion on maternal age, risk and pregnancy in New Zealand, see: Charlotte Greenhalgh, 'The Right Time: Women, Medicine and Maternal Age in 1980s Aotearoa New Zealand', *Medical Humanities* 50, no. 2 (2024), doi.org/10.1136/medhum-2023-012844.

access to the contraceptive pill *since the late sixties.*[22] Her pregnancy was *very straightforward,* and she remembered feeling *vigorous and well and* ***happy***. Seeing her baby on a screen during a prenatal scan strengthened her happiness as she imagined her future family. This hope became a reality and Diana recalled years of joy bringing up her two young daughters.

Diana's joy was intense but transitory. Adolescence brought complications after her younger daughter began a long struggle with anorexia nervosa. Diana recalled these difficult years with such overwhelming grief that she questioned happy memories of her daughters' early childhoods. For Diana, the grief is ongoing, challenging her conception of herself as a person and as a mother.

Mingled Memories

Diana's memories of pregnancies, births and motherhood are deeply interconnected. Her experience of motherhood spans a long period, yet connections emerge. Hospitals serve as crucial settings for key moments, from pregnancies and births in the 1970s to her younger daughter's medical treatments in the 1990s, providing a consistent backdrop where earlier and later experiences mingle.

Medical technology and expert opinions can powerfully shape maternal experiences and memories, especially in prenatal testing. This is evident in Diana's case. A month before her first baby was due, her general practitioner discovered that the baby was in a breech position. He sent her for a scan at the Royal Women's Hospital in Melbourne to confirm the baby's position. Prenatal scanning in situations like this was relatively unusual in 1977 in Melbourne; none of Diana's friends had been referred by a medical practitioner for a scan during their pregnancies.

22 The pill reached Australia in 1960 and the first major clinical trials began to be published in 1962. See: Janet McCalman, *Sex and Suffering: Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne, 1856–1996* (Melbourne University Press, 1998), 366.

Ultrasound technology, part of post–World War II electronic advancements, expanded into general obstetric care in the mid-1970s. In the late 1970s, real-time ultrasound was still not routinely used in Australia.[23] In 1979, British childbirth educator Sheila Kitzinger described the sonar scan as a 'new technique'.[24] By the late 1980s, ultrasound had become a standard part of pregnancy in Australia and other Western countries, transitioning from high-risk cases to an accepted part of most women's pregnancy experience. In 1982, the *Journal of the American Medical Association* noted that ultrasound had shifted from a research tool to a widely used diagnostic method in obstetrics.[25] And in 1987, Kitzinger observed: 'most pregnant women in the Western world are exposed to ultrasound in one form or another'. However, in 1977 in Australia, ultrasound was mostly reserved for high-risk pregnancies.[26] Diana's pregnancy was not in this risk category, so the use of ultrasound is surprising.[27]

Ultrasound can provide useful information about the developing foetus, such as the position of the placenta or the presence of twins. However, to diagnose malpresentation, such as in Diana's situation, it is less useful, as conditions present at one stage of the pregnancy often change by the time labour begins.[28] The doctor would not have needed a scan to determine whether Diana's baby was in a breech position, as he had already felt it.

Diana's ultrasound confirmed that her baby was in a breech position and could not be turned by the doctor. It also left an unexpected and enduring emotional impact on Diana:

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23 On 11 May 1962, the first Australian obstetrics examination by ultrasound was performed at the Royal Hospital for Women, Paddington, Sydney: George Kossoff, physicist; David E. Robinson, engineer; and William J. Garrett, obstetrician. Robert Gill, 'Medical Ultrasound in Australia: A Short History', *Australasian Journal of Ultrasound in Medicine* 21, no. 1 (2018): 97, doi.org/10.1002/ajum.12085. See also: M. B. McNay and J. E. Fleming, 'Forty Years of Obstetric Ultrasound 1957–1997: From a-Scope to Three Dimensions', *Ultrasound in Medicine & Biology* 25, no. 1 (1999): 3–56, doi.org/10.1016/S0301-5629(98)00129-X.

24 Sheila Kitziinger made several visits to Australia including in 1979 and her books were widely available and popular. See: Sheila Kitzinger, *The Good Birth Guide* (Fontana, 1979), 33.

25 Barbara Bolsen, 'Question of Risk Still Hovers over Routine Prenatal Use of Ultrasound', *JAMA* 247, no. 16 (1982): 2195, doi.org/10.1001/jama.1982.03320410003001.

26 A 1979 Australian study highlighted its use in reducing medical risks. See: M. G. Chapman, J. H. Sheat, E. T. Furness and W. R. Jones. 'Routine Ultrasound Screening in Early Pregnancy', *The Medical Journal of Australia* 2, no. 2 (1979): 63, doi.org/10.5694/j.1326-5377.1979.tb112704.x.

27 For more on risk in pregnancy and childbirth, see: Rachelle Chadwick, *Bodies That Birth: Vitalizing Birth Politics* (Routledge, 2018), doi.org/10.4324/9781315648910; Greenhalgh, 'The Right Time'.

28 Sheila Kitzinger, *Freedom and Choice in Childbirth: Making Pregnancy Decisions and Birth Plans* (Penguin, 1988), 132.

> Diana: I can remember that the scan was just a ***marvel***, because she was so close to full term, it was this ***perfect baby***, ***in*** there, all curled up, just like the ***pictures***, it was so—I was so moved, I had to go, I wanted to ***buy*** it something, you know it was something I had to do to ***acknowledge*** its—I had this ***new reality*** for me. Oh I, I knew it was there, it was moving, and there was, and, fantastic, but to ***see*** it, on the screen, was ***just*** something else, it was ***really exciting***. And I didn't have ***any*** money, not at all, I couldn't even ***buy*** it something, now that I knew that it was ***really*** real [relaxed laugh].
>
> Miranda: But you wanted to buy something?
>
> Diana: I ***wanted*** to buy something, somehow, oh, ***register*** this ***new*** reality, new understanding I had of this, well this baby's got a ***body***, and it's not just as, as amorphous feelings that ***I've*** got, it was a ***separateness***, that I hadn't—it was a new insight.

Diana's memories of her wonderment at seeing her baby for the first time on the screen convey her excitement at the prospect of her long-awaited first child. A machine created an ultrasonic image of her baby, and this image shifted the way she imagined her daughter and her life as a mother. Her emphasis on her baby's *separateness* highlights the way the foetus, imaged by the ultrasound scanner, becomes, as described by Nicolson and Fleming, 'a clinical entity, a patient in its own right'—and, for Diana, separate from her.[29]

Feminist historians and sociologists have noted the shift towards more medicalised maternity care in the latter twentieth century. Sociologist Ann Oakley critiqued how imaging technologies mechanised childbearing and childbirth.[30] However, historians like Angela Davis and Tania McIntosh argue that many women supported hospital births and technology such as ultrasound.[31] McIntosh, while noting this move to 'scientific birth', suggests focusing more on women's voices and experiences rather than

29 Malcolm Nicolson and J. E. E. Fleming, *Imaging and Imagining the Fetus: The Development of Obstetric Ultrasound* (Johns Hopkins University Press, 2013), 1.

30 Ann Oakley, *The Captured Womb: A History of the Medical Care of Pregnant Women* (Oxford B. Blackwell, 1984).

31 Angela Davis, 'Choice, Policy and Practice in Maternity Care since 1948', *History & Policy*, history andpolicy.org/policy-papers/papers/choice-policy-and-practice-in-maternity-care-since-1948; Oakley, *The Captured Womb*; Tania McIntosh, 'Changing Messages about Place of Birth in *Mother and Baby* Magazine between 1956 and 1992', *Midwifery* 54 (2017), doi.org/10.1016/j.midw.2017.07.017.

the technology.[32] Diana's oral history provides insight into a mother's positive emotional experience with new technology and how it shaped her connection to her unborn child.

We might see the use of the scan for Diana as the early stages of increasing technological intervention in women's reproductive lives. Technologies like amniocentesis and ultrasound are often seen as providing women with information and therefore choices.[33] However, as the history of obstetric ultrasounds and amniocentesis shows, such tests can quickly become routine.[34] By 1986, sociologist Barbara Rothman observed that prenatal testing in the United States was already as routinised as blood tests or urine analysis.[35] For Diana, ultrasound was presented as routine for a breech presentation, not as an informed choice. As Sheila Kitzinger notes, mothers' choices are often restricted by social context, even when they feel free to choose.[36]

For Diana at least, remembering at a time when ultrasounds have become an everyday part of pregnancy in Australia, visualising her first baby in 1977 was an external recognition that her emotions were not *just amorphous feelings*. Like most mothers in the 1970s, Diana had never seen a foetus.[37] However, she had carefully read the women's health manual *Everywoman* by the University of Sydney gynaecologist Derek Llewellyn-Jones and recalled picturing the size of her baby through the line-drawn illustrations of an embryo and foetus at various stages in development.[38]

Diana's remembered excitement at viewing the ultrasound hints at the complex relationship between emotions, expectations and technology. In enabling the visualisation of the foetus, the introduction of ultrasonic

32 Tania McIntosh, *A Social History of Maternity and Childbirth: Key Themes in Maternity Care* (Routledge, 2012), 101, doi.org/10.4324/9780203124222.

33 Medical technology has also been used by the anti-abortion lobby to argue for the 'personhood' of the foetus. See: Rosalind Pollack Petchesky, 'Fetal Images: The Power of Visual Culture in the Politics of Reproduction', *Feminist Studies* 13, no. 2 (1987): 263–92, doi.org/10.2307/3177802.

34 Meredith Nash, '3D Fetuses and Disappearing Mothers', in *Mother Knows Best: Talking Back to the 'Experts'*, ed. Jessica Ann Nathanson and Laura Camile Tuley (Demeter Press, 2008), 46–57.

35 Barbara Katz Rothman, *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood* (Viking, 1986), 51.

36 Kitzinger, *Freedom and Choice*, 10.

37 Sara Dubow notes the impact of a photograph of a foetus on jurors in the United States in the 1970s before the 1984 film *The Silent Scream*. See: Sara Dubow, *Ourselves Unborn: A History of the Fetus in Modern America* (Oxford University Press, 2010).

38 First published in 1971, *Everywoman* was followed that year by the first paperback edition. Chapter 9 ('A Most Wondrous Growth') features hand-drawn line illustrations of an embryo and foetus at various developmental stages.

technology changed the emotional relationship between mother and child, bringing forth a whole new set of expectations, fears and joys that women previously had not had a machine to verify or to feel or to name. This moment, in the late 1970s, captures a powerful maternal response to a medical technology that is now an almost unquestioned part of all women's prenatal care in Australia.

Oral historian Lynn Abrams suggests that it is difficult to recall emotions attached to a single event because we struggle with the recall of emotion itself over time.[39] While this is often the case, Diana's memories of seeing her older daughter on ultrasound are very well recalled and her intense joy is remembered with acuity. Her emotional recall can be located at the specific place and moment when she felt driven to buy clothes for her unborn baby. Abrams's argument focuses on recalling difficult memories, but Diana's memory was not distressing, so it did not require emotional protection.

The intensity of Diana's ultrasound memory highlights its importance in her life story.[40] The scan was a striking sensory event and the powerful emotions it generated were consolidated in Diana's visual and cognitive memory with the signpost of walking around the shops. There is also a sense of hope in her description of an intense drive to buy something for her unborn baby—even though she did not have any money. Buying or making material objects is a way for pregnant women to create a sense of themselves as mothers.[41] This drive reflects hope. Diana's experience was both intensely present and forward looking as she imagined her future family. Vivid memories tied to powerful emotions like Diana's show how oral history can illuminate historically embodied experiences such as pregnancy.[42]

39 Lynn Abrams, *Oral History Theory* (Routledge, 2016), 87–8.

40 Abrams references Sven-Åke Christianson and Martin A. Safer, 'Emotional Events and Emotions in Autobiographical Memories', in *Remembering Our Past: Studies in Autobiographical Memory*, ed. David C. Rubin (Cambridge University Press, 1996), doi.org/10.1017/CBO9780511527913.009.

41 Alison J. Clarke, 'Maternity and Materiality: Becoming a Mother in Consumer Culture', in *Consuming Motherhood*, ed. Janelle S. Taylor, Linda L. Layne and Danielle F. Wozniak (Rutgers University Press, 2004), 55–71.

42 Paula Hamilton, 'The Proust Effect: Oral History and the Senses', in *The Oxford Handbook of Oral History*, ed. Donald A. Ritchie (Oxford University Press, 2010).

Pregnancy and Childbirth: Intergenerational Maternal Memory

Diana was well prepared for childbirth, having read guidebooks, attended antenatal classes and spoken with friends who had children. Despite hearing *terrible birth tales*, Diana was not anxious about childbirth. However, her excitement was tempered by concerns that her baby was *going to be healthy*. She was acutely aware of pregnancy risks, as her mother had suffered from infected postnatal thrombosis and was advised against having more children. This experience deeply affected Diana, so much so that she began her interview discussing its lasting impact on her and her mother:

> Miranda: Could you give me a sense of your childhood?
>
> Diana: I'm an only child. I grew up in Belmont, in Geelong. I was born in 1947. I arrived on the day I was ***due***. Following my birth, my mother was very ill, she had a thrombosis, a ***postnatal*** thrombosis, which apparently runs in families. Her thrombosis became infected, she stayed in hospital for a while but then she spent the next eight months in bed, with her leg elevated, and so I spent the first eight months of my life with my parents living in my grandmother's house because my father had to work, my mother couldn't look after me, or herself … that's the beginning of ***my*** life.

Diana's recollections of the enduring physical impact of birth on her mother have a deep emotional undertow. Poignantly, this lifetime of physical incapacity also had long-term emotional effects on Diana. What she remembers particularly keenly was a sense of her mother's grief at being unable to care for her child, unable to lift her or play with her. Due to her mother's birth trauma, Diana had no siblings and spent much of her time at her grandmother's house, which forms her earliest memory. During both her pregnancies, Diana dreamed of moving through her grandmother's house, seemingly at *adult eye-level* but as if carried as a child. While Diana spoke, her embracing gesture reminded me of Jeff Friedman's argument that 'all embodied aspects of interviewing', such as posture, gestures and expressions provide, 'additional and important information'.[43] I asked Diana more about this dream and she replied that the *return to infancy* was only ever *intimations of the dream* post-pregnancy. Diana's dreams took her back to her infancy at her grandmother's house, not her mother's.

43 Jeff Friedman, '"Muscle Memory": Performing Oral History', *Oral History* 33, no. 2 (2005): 36.

Powerful emotional experiences like Diana's dream, re-enacted in an interview, reveal how intergenerational maternal memory influences a woman's embodied experience of mothering.[44] Diana fondly recalled her early childhood spent happily between her paternal and maternal grandmothers' homes. Despite her mother's physical incapacity, Diana felt emotionally close to her *gentle and devout* mother, who always *gave her **plenty** of time*. Diana explained that she *would never feel something had **actually** happened* until she had told her mother about it; she felt that life experiences were not *complete until [you'd] talked to your mother*. This insight might mirror how she viewed the interview process, in which unconscious intersubjective exchanges occur between interviewees and interviewers.[45] In today's confessional culture, particularly on social media, sharing mothering experiences is common. However, the women I interviewed had fewer opportunities to do so. For some, the interview provided an opportunity to discuss conflicted and painful memories as they reflected on their younger selves and changing cultural ideals around parenting.[46]

Happy Ordinary Years

Diana welcomed her pregnancy and her experience of ultrasound only increased her excitement about becoming a mother. Her first daughter, born in 1977, was joined by a second in 1981. She fondly described that period with her infant daughters as *probably the happiest time of my life, with them, when they were infants, oh, **little***. Diana repeated this memory of joy and contentment many times in her interview, linking her own joyful memories with those of her daughters:

> I was very happy at home with ***young*** children, I felt that was what I should be doing, and I was doing it well enough that they were ***happy***.

Diana found early childrearing a joyful experience. By prioritising play with her young daughters, she was able to offer them the experiences she had missed out on as a child due to her mother's ill-health, which had made even simple tasks like walking to the library a *chore* and prevented her mother from *playing any ball games in the backyard*. Diana's decision to resign from her teaching position after the birth of her first child was

44 Leahy, 'The Mother within'.
45 See, for instance: 'Subjectivity and Intersubjectivity', in Abrams, *Oral History Theory*.
46 Miranda Francis and Katie Holmes, 'Remembering the Family That I Thought We Would Be', *Oral History* 47, no. 1 (2019): 49–60.

a deliberate choice and one not open to all mothers in the 1970s.[47] She explained in her interview that she did not see *the point of having children, to give them to somebody else during most of their waking hours*. Instead, Diana and Tom took their 12-month-old first-born daughter, who was a ***joy*** to be with and a *very* ***easy*** *baby to manage*, around Europe for six months. The baby *attracted a lot of attention, because she was blonde, and smiley, she was* ***always*** *smiling at people*.

In my post-interview diary, I questioned whether Diana's joy may also have been heightened in its recall because of later experiences during her younger daughter's adolescence. However, I am conscious of what Michael Roper terms the 'subterranean' exchange of the interview and how it can shape both the interview and the oral historian's interpretation.[48] Diana's joy was certainly heightened at the time, and it became a positive memorable travel experience that was well signposted by being recorded and stored in her family photo albums.

Diana and Tom brought up their daughters in a comfortable inner-Melbourne suburb. Their life was busy, but Diana described it as *quite ordinary*, revolving mostly around work, school and children's sport. Aside from describing them as *happy* and *easy*, Diana did not recount many specific memories of these years when her daughters were young. She explained that she *really didn't have a lot of problems, nor I think was I anxious about my baby's development.* A local mother's group provided Diana with support and company, the members visiting each other's houses. And, if Diana had any concerns, she would talk to her local infant welfare nurse, who was ***marvellous***.

When I returned to these years of early parenthood later in the interview, Diana explained *I know I said I was happy, and I* ***was*** *but I think they were the most* ***settled*** *years* when her daughters' *behaviour was* ***relatively*** *predictable*. This changed with adolescence, which Diana described as *difficult for* ***everybody.*** Unexpectedly, their second daughter became seriously ill with the eating disorder anorexia nervosa around the age of 14 in the mid-1990s and has struggled with anorexia and depression ever since. Almost two

47 Although not a new phenomenon in Australia, working middle-class mothers were a social reality by the mid-1970s. In 1973, 50 per cent of mothers of school age children and 27 per cent of the mothers of pre-school children were working. See: *Royal Commission on Human Relationships*, vol. 4 (Australian Government Publishing Service, 1977), 35.

48 Michael Roper, 'Analysing the Analysed: Transference and Counter-Transference in the Oral History Encounter', *Oral History*, Autumn (2003): 21–2.

decades of worry, family therapy, lengthy hospitalisations and expensive medical treatments in Sweden have taken an enormous toll on the family. This emotional turmoil shaped the way Diana talked to me about her transition to motherhood and the *ordinary* years of her children's infancy. Parenting is lifelong. Although histories of parenting often focus on early parenthood, later experiences can be very different and significant at the time, as well as in our memory.[49] Diana's motherhood was experienced in two very different phases and, perhaps mirroring this, her narrative divided into two parts.

A 10-Year Gap in the Story

The strong focus in Diana's interview on her daughters' infancy and early childhood suppressed what she described off-recording as a *10-year gap in the story.* This gap was only revealed in the second part of the interview after her husband Tom, who had been *skulking upstairs*, left the house. His departure may have simply provided the opportunity to stop the audio recording and to raise this silence, or his earlier presence upstairs may have made it harder for Diana to introduce this difficult period in their lives. Tom did not feature prominently in Diana's narrative; when mentioned, he appears as quietly providing practical support. A father who was *always happy to look after the children, happy changing nappies and cleaning up beds that were vomited in*. When Diana spoke about her daughter's eating disorder for the last hour of her interview, after Tom had gone out, she only mentioned Tom directly twice: first that he attended family therapy sessions and later that the medical treatment in Sweden *cost us a lot of money, and the money really worried Tom*. Diana's narrative focus was on mothers providing care of children, not fathers.[50]

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49 A woman's current life stage, whether actively mothering young children or reflecting from later in life, influences how she recalls and interprets her mothering memories. See: Carla Pascoe Leahy, 'From the Little Wife to the Supermom? Maternographies of Feminism and Mothering in Australia since 1945', *Feminist Studies* 45, no. 1 (2019): 100–28, doi.org/10.1353/fem.2019.0004.

50 Ideas about mothering are intricately connected to ideas about fathering. The history of motherhood has been created in conversation with the history of fatherhood and childhood. See: Carla Pascoe Leahy and Petra Bueskens, 'Contextualizing Australian Mothering and Motherhood', in *Australian Mothering: Historical and Sociological Perspectives*, ed. Carla Pascoe Leahy and Petra Bueskens (Palgrave Macmillan, 2020), 14, doi.org/10.1007/978-3-030-20267-5. Jessica Weiss's analysis of postwar mothers highlights how their roles influenced subsequent fathering patterns. See: Jessica Weiss, '"A Drop-in Catering Job": Middle-Class Women and Fatherhood, 1950–1980', *Journal of Family History* 24, no. 3 (1999): 374, doi.org/10.1177/036319909902400308. On fathering, see: Alistair Thomson, *Fathering: An Australian History* (Melbourne University Press, 2025).

However, Diana ended her interview by reflecting on the impact *parenting* had had on both her and Tom's lives:

> So, in terms of parenting [long pause]. Aaah [sigh]. On objective grounds, I guess we were total failures [pause]. But we were always ***there*** [long pause]. Yes [whispered]. And we still are … I ***do*** hope that she is going to hang in. But, once a parent, always a parent. You don't walk away [long pause]. You can't [whispered].

Diana's deep sigh, long pauses and whispers indicate intense sadness and a sense of exhaustion. Her grief here is profound and sits alongside her hope that the love and joy of the early childhood years could shield her family and protect her daughter. While the expression 'once a parent, always a parent' was repeated in many interviews for this project, it was particularly poignant in this interview knowing that, even in retirement, Diana's and Tom's lives were still consumed with the practical, emotional and financial demands of parenting. This, as well as Diana's final, almost inaudible words *you can't* [walk away] point to the contrast between her early hopes and dreams for her life as a mother when she saw her first baby on the ultrasound, followed by the joyful early years of parenting, and her later reality, which she describes with such a sense of defeat as being a *total failure*. This sense of failure seems to encompass both daughters, although her first child did not have significant health problems.

The *objective grounds* for *failure* raised by Diana, and her defence that she and Tom *were always there*, echo a common instruction to parents in the late twentieth century about the importance of being there for your children. The development in the second half of the twentieth century of what sociologist Sharon Hays has identified as 'intensive mothering'—an ideology that holds individual mothers as primarily responsible for the emotional and physical wellbeing of their children—may explain, in part, why Diana describes their parenting as a *complete failure*.[51] Given Diana's use of 'we' not 'I', perhaps her experience tells us about intensive parenting, rather than just intensive mothering. Diana comforts herself with the fact

51 Sharon Hays, *The Cultural Contradictions of Motherhood* (Yale University Press, 1996). For more on the toll on mothers caring for ill children, see: Barbara Brookes, '"Cherishing Hopes of the Impossible": Mothers, Fathers, and Disability at Birth in Mid-Twentieth-Century New Zealand', in *Bodily Subjects: Essays on Gender and Health, 1800–2000*, ed. Barbara L. Brookes, Wendy Mitchinson and Tracy Penny Light (Montreal McGill-Queen's University Press, 2014), doi.org/10.1515/9780773596412-009.

that she and Tom were *always there*, but her emphasis on *failure* clearly shows that she does not think she was, to use British psychoanalyst Donald Winnicott's phrase, a 'good enough' mother to both children.[52]

Like many parents of adult children with mental illnesses, Diana's grief was complicated by a sense that she had failed in her parenting role.[53] A growing body of psychological literature on the experiences of parents of children diagnosed with mental illness shows a high level of grief associated with the loss of the previous relationship with their child and of the hopes parents might have had for their child.[54] Marion O'Brien describes the intense parental grief associated with accepting that the 'child they thought they had is not the child they must learn to live with'.[55] Parental grief is often complicated further by a 'profound guilt over having contributed or not prevented the disorder'.[56] Mothers tend to experience and cope with this stress and grief differently from fathers due to their different gender roles within the family.[57] Gendered familial arrangements mean that mothers are more likely to be caring for children and mediating between the family and medical practitioners.[58] Mothers are also more likely to blame themselves for their child's illness.[59] Serious mental illnesses like anorexia nervosa often begin in adolescence, complicating the relationship between the primary carer, usually the mother, and the child due to expectations of greater independence.[60]

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52 Donald Woods Winnicott, *The Child and the Family: First Relationship* (Tavistock Publications, 1957).

53 Anita Johansson, Agneta Anderzen-Carlsson, Arne Åhlin and Birgitta Andershed, 'Mothers' Everyday Experiences of Having an Adult Child Who Suffers from Long-Term Mental Illness', *Issues in Mental Health Nursing* 31, no. 11 (2010): 696, doi.org/10.3109/01612840.2010.515768.

54 Julia Godress, Salih Ozgul, Cathy Owen and Leanne Foley-Evans, 'Grief Experiences of Parents Whose Children Suffer from Mental Illness', *Australian and New Zealand Journal of Psychiatry* 39, no. 1–2 (2005): 88, doi.org/10.1111/j.1440-1614.2005.01518.x. This type of unresolved grief is also described as 'non-finite grief'. See: Jennifer Camille Rarity, *Nonfinite Grief in Families with Children on the Autism Spectrum* (St Mary's University, 2007).

55 Marion O'Brien, 'Ambiguous Loss in Families of Children with Autism Spectrum Disorders', *Family Relations* 56, no. 2 (2007): 135, doi.org/10.1111/j.1741-3729.2007.00447.x.

56 E. Darmi, T. Bellali, I. Papazoglou, I. Karamitri and D. Papadatou, 'Caring for an Intimate Stranger: Parenting a Child with Psychosis', *Journal of Psychiatric and Mental Health Nursing* 24, no. 4 (2017): 194, doi.org/10.1111/jpm.12367.

57 David E. Gray, 'Gender and Coping: The Parents of Children with High Functioning Autism', *Social Science & Medicine* 56, no. 3 (2003): 632, doi.org/10.1016/S0277-9536(02)00059-X.

58 Virginia Goldner, 'Feminism and Family Therapy', *Family Process* 24, no. 1 (1985): 31–47, doi.org/10.1111/j.1545-5300.1985.00031.x.

59 Joan M. Anderson and Helen Eifert, 'Managing Chronic Illness in the Family: Women as Caretakers', *Journal of Advanced Nursing* 14, no. 9 (1989): 735–43, doi.org/10.1111/j.1365-2648.1989.tb01638.x.

60 Williams-Wengerd and Solheim, 'Grief Experiences', 529.

You Don't Walk Away: Search for Medical Treatment

Although described in the nineteenth century, anorexia was systematically studied only from the late twentieth century onwards.[61] Psychiatrist Stewart Agras attributes this surge in research to the rise of eating disorder cases in the 1970s, especially in North American clinics.[62] During this time, public awareness increased, partly due to greater media coverage and broader recognition beyond the medical field. Popular feminist publications such as Naomi Wolf's *The Beauty Myth* began to link societal pressures with deliberate weight loss.[63] In *Fasting Girls* (1978), Joan Jacobs Brumberg described anorexia as the defining disorder of modern female adolescents.[64] In the late twentieth century, understandings of eating disorders evolved, often focusing on the family and implicating mothers. In 1978, Hilda Bruch's book *The Golden Cage* suggested that anorexia nervosa stemmed from affluent, controlling families, influencing perceptions for decades.[65] Similarly, Susie Orbach's *Hunger Strike* viewed anorexia as both a personal and public struggle.[66] While Orbach's feminist approach placed less blame on families, she still highlighted the disorder's connection with the mother–daughter relationship. By 1993, discourse had evolved to acknowledge male anorexia and the disorder's broader societal context.[67]

Anorexia nervosa often begins during early or late adolescence and is more prevalent in females.[68] Its causes are complex and the connection to family dynamics remains uncertain. During the 1990s, Australian media often depicted families, particularly mothers, as influential in the disorder's

61 A. D. Harvey, 'Anorexia Nervosa in the Nineteenth Century', *Historian*, no. 102 (2009): 19; Vasilija Simonovic, Dominik Gross and Jean-Philippe Ernst, 'The Historical Discourse on the Etiology of Anorexia Nervosa Results of a Literature Analysis', *Sudhoffs Archiv* 99, no. 1 (2015): 31–43, doi.org/10.25162/sudhoff-2015-0003.

62 W. Stewart Agras and Athena Hagler Robinson, *The Oxford Handbook of Eating Disorders*, 2nd ed. (Oxford University Press, 2017), doi.org/10.1093/oxfordhb/9780190620998.001.0001.

63 Naomi Wolf, *The Beauty Myth: How Images of Beauty Are Used against Women* (Vintage, 1991).

64 Joan Jacobs Brumberg, *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease* (Harvard University Press, 1988).

65 Hilde Bruch, *The Golden Cage: The Enigma of Anorexia Nervosa* (Open Books, 1978).

66 Susie Orbach, *Hunger Strike: The Anorectic's Struggle as a Metaphor for Our Age* (Faber & Faber, 1986).

67 Ibid., xxvii.

68 Agras and Robinson, *The Oxford Handbook of Eating Disorders*, 2.

onset.[69] A study by the Royal Melbourne Hospital, reported in newspapers in 1995, suggested that father–daughter relationships were a primary cause.[70] However, Lynne Lumsden from the Anorexia and Bulimia Nervosa Foundation of Victoria warned against oversimplification in 1997, stating there is 'no such thing as a classic case' and no single cause for anorexia nervosa.[71]

Uncertainty about the causes of eating disorders led to evolving treatment methods. In the 1970s, Salvador Minuchin's 'psychosomatic family model' suggested that anorexia nervosa stemmed from families that are 'rigid, enmeshed, overinvolved, and conflict avoidant'.[72] This view influenced treatment for years. In 1985, researchers in London shifted the focus, viewing the family as a treatment resource instead of the cause. The Maudsley Family-Based Treatment, formalised in 2001, emphasised that families should not be blamed for an eating disorder.[73] Diana's family found themselves caught between these contrasting approaches.

Towards the end of 1997, Diana's younger daughter, then aged 16, was, after many visits to doctors *who tiptoed around the words*, diagnosed with anorexia nervosa and referred to the paediatric unit of a large hospital in the north of Melbourne.[74] By that stage, she was so ill that she was kept at the hospital for six weeks and force-fed through a nasogastric tube. After she left hospital, she stopped eating again and was sent back to the hospital to be *force-fed* again in what became an agonising *yo-yo* pattern.

Over the next two years, Diana's daughter *spent more time **in** hospital than out of hospital* and did most of her final years of school by distance education. Inpatient treatment for adolescent anorexia nervosa involved a combination of force-feeding, medical stabilisation and family therapy. Diana remembered willingly taking part in family therapy as *we **wanted** to*

69 At the 1993 Australian Cultural History Conference, Melbourne academic Liz Eckermann stated that attributing self-starvation and binge-purging to overprotective mothers and media influence was seriously misleading. 'Anorexics Looking for the Perfect Body—and Sainthood, Says Academic', *Canberra Times*, 21 June 1993, 3.

70 Danielle Talbot, 'Bad Relationships Main Anorexia Cause—Study', *Age*, 11 October 1995, 7.

71 Rita Erlich, 'Weighing It up', *Age*, 5 August 1997, 8.

72 Daniel Le Grange and Renee Rienecke, 'Family Therapy', in Agras and Robinson, *The Oxford Handbook of Eating Disorders*, 319–20; James Lock, *Treatment Manual for Anorexia Nervosa: A Family-Based Approach* (Guilford Press, 2001).

73 Christopher Dare, 'The Family Therapy of Anorexia Nervosa', *Journal of Psychiatric Research* 19, no. 2–3 (1985): 435–43, doi.org/10.1016/0022-3956(85)90050-0.

74 This reluctance to diagnose anorexia nervosa was noted in 1996 by psychiatrist Dr Neil Coventry, Austin Hospital. See: Steve Dow, 'Ever-Younger Girls Join the Culture of Thinness', *Age*, 23 May 1996, 2.

go to family therapy, to see how we could best ***help*** *her … because* ***she*** *couldn't control it*. Diana's eldest daughter was at university at the time and Diana struggled with the impact the illness and the family therapy sessions had on both her daughters and on the cohesion of the family unit. She recalled the emotional toll on her older daughter who *alternated between anger and support* and eventually had a nervous breakdown herself before she could see that her sister was *actually out of control, that the malnourishment of the brain was what really caused her sister to be psychotic, that it wasn't her choice*.

Diana was dealing with a very ill daughter but also an irreconcilable grief around her imagined family unit. During our interview, she described her family and house both collapsing. While her husband Tom handled costly and complex house repairs, Diana tried to hold the family together, *how we worked day to day*. This division of labour may have reinforced her feeling that family care was her responsibility. As a mother, she carried the main burden, partly due to experts linking the mother–daughter relationship to anorexia nervosa and because, as Sara Ruddick argues, women are often seen as the family's emotional centre.[75]

These early family therapy sessions destabilised Diana's understanding of their family and her ability to understand and care for her daughter. She described her desperation and pain as both her daughters suffered, and the hospital took a treatment approach that was not working:

> We were just plain mystified, so we spent lots of time visiting her in hospital, or ringing her to see if she didn't ***want*** to be visited, in hospital, and the treatment that she had seemed to be ***no*** treatment at ***all***, because she'd be discharged, because she was ***medically*** stable, but when she was discharged she was supposed to see a psychiatrist, once a month, but between being discharged, and seeing a psychiatrist, she could lose five kilos, or all of that she'd put on, and there was no ***actual treatment***, the psychiatrists didn't seem to be able to do much. She would see dieticians, she would try new diets, newer ways of persuading herself to eat, ***we*** never tried to force her to eat … it was better to try and ***encourage*** her; to ***keep*** encouraging her, it certainly called on all our reserves of patience and understanding.

75 Sara Ruddick, *Maternal Thinking: Towards a Politics of Peace* (Women's Press, 1990).

Diana described these family therapy sessions as *very judgemental*. They called into question Diana's recollections of her daughter's childhood and directly challenged Diana's sense of herself as a mother and left her feeling *undermined* and *disbelieved* in what she describes as *a **terrible** time.* The practical and emotional impact of the family therapy also affected Diana's employment. She had moved from secondary teaching to working in an education role in a government department. Although her manager was accommodating, trying to work and care for her daughter had an enormous toll on Diana:

> Work was ***fantastic***, they understood that sometimes there were emergencies, where she'd have to be admitted straight away and I couldn't come in, or I'd have been sitting with her, on a trolley, overnight, in a hospital, waiting for a bed, work was ***extremely*** flexible. And there would be days following the family therapy where I couldn't, just couldn't go to work. I'd have ***cried*** so much, after family therapy, that I couldn't turn up the next day. It was an ***awful*** time.

Five years later, in 2002 at another Melbourne hospital, Diana was relieved when a different pair of family therapists *didn't make us feel that we'd failed, in every single aspect of parenting*. Another family at one of the group sessions suggested a Swedish treatment associated with the Karolinska Institute called the Mandometer method.[76] Diana's daughter ***knew** she had a problem, and she knew that no matter how hard **she** tried she couldn't **deal** with it.* She was *willing to give it a go*, so her parents agreed to finance the travel and treatment. To do that, they had to sell their house. Diana's daughter came home after a year of treatment and then had two follow-up treatments in Sweden.

In 2004, new treatment guidelines for anorexia nervosa in Australia and New Zealand recommended a more flexible approach that was less damaging to self-esteem. These guidelines indicated that no single therapeutic method was superior.[77] By 2010, Australian clinicians were endorsing a modified

76 On the Mandometer method in Australia, see: John Court, Cecilia E. K. Bergh and Per Södersten, 'Mandometer Treatment of Australian Patients with Eating Disorders', *The Medical Journal of Australia* 188, no. 2 (2008): 120, doi.org/10.5694/j.1326-5377.2008.tb01539.x. This article mentions public awareness in 2003 via ABC radio, although Diana attended seminars by Dr Cecilia Bergh (Karolinska Institute) in 1994.

77 'Australian and New Zealand Clinical Practice Guidelines for the Treatment of Anorexia Nervosa', *Australian and New Zealand Journal of Psychiatry* 38, no. 9 (2004): 659–70, doi.org/10.1080/j.1440-1614.2004.01449.x.

form of family therapy that emphasised that 'parents are not to blame' and focused on managing weight restoration.[78] In 2016, the Eating Disorders Families Australia was established as the first organisation dedicated solely to supporting families and carers of individuals with eating disorders.[79]

Such changes in perspective and support for families caring for people with eating disorders came too late to spare Diana and her family the huge financial and emotional costs they had suffered. In the last moments of her interview, Diana quietly stated: *I **don't** have any ambitions for her, I just hope that she can **make** her way*. This hope is a diluted echo of her more hopeful words earlier in her interview, when she spoke about her own move away from the confined world of her childhood to university: *when you're a parent, then you expect the same thing to happen with your children, that they will grow … off they'll go*. However, Diana's younger daughter has not been able to leave the family home to live independently for more than a few weeks at a time. Each time, her parents have had to *unpack her room … move her from boarding houses to student houses, to halls*.

Diana's whispered and exhausted final words *you don't walk **away**, well you **can't*** are heavy with a sense of resignation, highlighting what sociologist Arlie Hochschild terms 'emotion work'—the effort involved in managing feelings when there is a discrepancy between what one feels and what one wants to feel, prompting efforts to resolve this 'pinch'.[80] Bridging the gap between societal expectations that children grow up and make their own lives and the reality that this may never be possible for her younger daughter has left Diana simply with the hope that her younger daughter is able to *hang in*.

Diana would like to focus on being a grandparent; however, she finds herself revisiting her daughters' early childhood as she continues to care for her younger daughter. This appears to have constricted her narrative about her other daughter and two grandchildren, who bring her joy, but are almost subsumed by her sense of *total failure* as a mother. The ongoing emotional, practical and financial demands of parenting have led to a grief

78 Peter Bosanac, Richard Newton, Edwin Harari and David Castle, 'Mind the Evidence Gap: Do We Have Any Idea about How to Integrate the Treatment of Anorexia Nervosa into the Australian Mental Health Context?' *Australasian Psychiatry: Bulletin of the Royal Australian and New Zealand College of Psychiatrists* 18, no. 6 (2010): 518, doi.org/10.3109/10398562.2010.499433.

79 Eating Disorders Families Australia, 'Shared Eating Disorder Experiences', accessed 16 September 2025, edfa.org.au/about-index-edfa/our-history/.

80 Arlie Russell Hochschild, 'Emotion Work, Feeling Rules, and Social Structure', *American Journal of Sociology* 85, no. 3 (1979): 562, doi.org/10.1086/227049.

that is painful and endless. This grief was not something Diana could have anticipated when she announced to her grandmother at the age of four that she would have a family of six children. There is also a loss of hope as Diana reconciles what John Gillis terms 'the family she lives by' with the 'family she lives with'.[81] Diana is left grieving for her imagined family—one in which both her adult daughters live healthy and independent lives.

A Good Place to End

Diana's interview ended abruptly. Sensing her complete exhaustion, I asked, 'do you think that might be a good place to end?', and Diana replied simply *yes*. The narrative arc of the interview had mirrored her life. There could be no conventional ending in which her daughter flew the nest. Emotions were unresolved and the future looked bleak. Diana's journey through motherhood took her to very dark places, and she realised that she could not avoid them. Her quiet *yes* was a resigned accommodation to the reality of life with a daughter with a mental illness.

Diana's life story interview offers insight into how changing ideas and expectations about motherhood leave an emotional legacy that mothers carry throughout their lives. Her narrative also highlights the role of mothers as historical actors and agents who both respond to and shape historical change. Through Diana's intimate life, we see a mother resisting social pressures and pushing back against gender structures for her child's safety. By listening to mothers' voices, we gain a better understanding of their emotions and experiences in raising children, as well as the historical circumstances that have shaped—and continue to shape—their lives.

81 John R. Gillis, *A World of Their Own Making: A History of Myth and Ritual in Family Life* (Oxford University Press, 1997), xv.

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