MOTHERING & MENTAL ILLNESS

AN ETHNOGRAPHY OF ATTACHMENT
IN AN INSTITUTIONAL CONTEXT

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For my son

Ari Masciantonio King
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Abstract

This thesis entitled *Mothering and Mental illness: An Ethnography of Attachment in an Institutional Context*, explores mothering in the context of mental illness. It is based on ethnographic fieldwork conducted from November 2008 to October 2009 in Oliveto – an Australian, state-run, mother and baby unit that facilitates dual admission and treatment of mothers and babies. Psychiatric diagnosis was the primary criterion for admission; however it was the woman’s social role as mother that confirmed her entrance into the psychiatric unit which specifically offered dyadic treatments.

Oliveto was a six bed inpatient facility that admitted a total of 104 mother-baby dyads during the eleven month fieldwork period. Oliveto’s psychiatric practice followed a biopsychosocial model of treatment, facilitated by a multidisciplinary team. The team was led by female psychiatrists and supported by psychologists, psychiatric nurses, midwives, occupational therapists and social workers who were predominantly female. As Oliveto was an acute unit, admission periods were relatively short, with an average of three weeks. Therefore the most useful ethnographic data were collected through participant observation and in-depth interviewing with Oliveto’s multidisciplinary team, whose daily focus was the observation and treatment of mothers and babies during their period of admission. Such focus on the multidisciplinary team enabled the research to explore taken for granted assumptions embedded in the theoretical underpinnings that guided Oliveto’s psychiatric practice. This resulted in a more critical understanding of the interplay of psychiatric and attachment treatments offered in this context, and the consequences of such an approach.
Oliveto’s psychiatric practice followed a medical model for treatment of symptoms of mental illness. Facilitated through the Diagnostic and Statistical Manual of Mental Disorders (DSM), women’s behaviour was translated, and intrinsically linked, to symptoms of mental illness. Consistent with the medical model approach, symptoms were matched with a checklist of medical criteria to treat with biological interventions. Despite offering a biopsychosocial treatment model, a clear bias towards pharmacological treatments for mental illness was observed. The research also uncovered that psychiatric knowledge was further used to justify hierarchical disciplinary power through observation, surveillance and control.

In Oliveto, psychiatric knowledge intersected with the assumptions put forward by Attachment Theory, and wider cultural understandings of normative mothering, promoting an intense dyadic relationship. Oliveto’s application of the theory meant that mothers were considered primarily responsible for the physical, psychological and developmental health of their child because of their biological link. Attachment principles were also used to explain, define, and pathologise the mother-infant relationships and interactions. This was exemplified through Oliveto’s use of the psychotherapeutic tool known as the Circle of Security (COS) which diagrammatically depicted the main tenets of Attachment Theory. In this institutional context, such a focus on the attachment paradigm was observed to highlight dysfunction in the mother-infant relationship. In addition, underlying beliefs about the transgenerational transmission of pathological attachment templates meant that therapeutic investigations crossed temporal boundaries. This implicitly linked the mothers’ early attachment relationships to a potential for risk in her child’s future developmental and mental health.
This thesis observes that the biomedical assumptions about mothering in the context of mental illness were considered through the interplay of psychiatric and attachment theories. Within this interplay, tensions and contradictions between biological and behavioural models were observed, and filtered into Oliveto’s treatment practices. Despite this, the woman’s biology remained central to understandings of mental illness symptoms and the attachment relationship. In such a way, treatment processes in Oliveto reinforced the gendered assumptions inherent in childrearing by positioning biological mothers as both primarily responsible for their child’s physical and psychological health, whilst simultaneously viewing mothers as a risk to their child’s mental health.
Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

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Sonia Masciantonio
INTRODUCTION

MOTHERING & THE PSYCHIATRIC CONTEXT

This thesis is based on anthropological fieldwork carried out between November 2008-October 2009 in Oliveto,¹ an Australian Mother and Baby Psychiatric Unit. It is an ethnographic study of the psychiatric context for treating women diagnosed with a severe or acute psychiatric mental illness. What set their psychiatric treatment apart from other women diagnosed with a mental illness was that these women were mothers to young children (birth to three years). Due to this, treatment practices in Oliveto had a specific focus; Oliveto’s psychiatric admissions included both the mother and her child, viewing the woman’s mental illness in the context of her mother-infant relationship.

Oliveto was an acute public psychiatric unit, admitting up to six women and their babies at one time. On rare occasions,² fathers also stayed with the dyad throughout the treatment process, however this was not common practice. Fathers with a psychiatric diagnosis were never admitted into this mental health facility: the relationship between the mother and her child was given primacy. This relationship, I will argue, served as the foundation for psychiatric and psychological treatment choices for the mother and her child in Oliveto.

¹ Pseudonyms are used throughout this thesis to protect anonymity.
² Although fathers were promoted as being welcome, throughout the time of my fieldwork, only a handful of fathers slept in the unit with their partners and child.
Women were admitted into Oliveto through a diagnosis of mental illness and referral from a medical practitioner. In doing so, the women became both patients of the institution and a psychiatric case, the primary focus of Oliveto’s multidisciplinary team’s daily work. As a case, women as mothers became the central object of Oliveto’s multidisciplinary team’s every day work, uniting those working within the unit with a common goal — treating the mother’s mental illness. However, by viewing a mother’s mental illness in the context of the mother-child relationship, the interactions that the mother had with her child were also under observation, judgment, and subject to treatment. The unifying work of Oliveto’s team therefore was the construction, management and treatment of the mother-infant dyad as psychiatric cases.

Throughout this thesis, the mundane everyday practices that occurred in Oliveto’s psychiatric context are brought into focus, exploring the relationship between biomedical constructions of mothering and mental illness, the people who those ideas affected, and the setting in which they were used (Barrett 1996:4-5). The complexities of postnatal mental illness in Oliveto’s psychiatric context were understood and interpreted through perspectives informed by psychiatric and attachment theories. It was within the boundaries of these perspectives that knowledge about the patient was constructed, thereby setting the parameters for how mother-infant dyads could be understood and treated.

Given the anthropological lens, the socio-cultural aspects and understandings of mothering, along with critiques of psychiatry, have particular significance to my analysis. As such, this thesis occupies a space between these two key bodies of literature: Critical Psychiatry and the Anthropology of Mothering. In setting the
context for my ethnographic project, I have drawn largely on anthropological literature; however there is also a significant amount of work deriving from Critical Psychiatry, Critical Psychology and Sociology which underpin the theoretical framework.

Critical Psychiatry

Critiques concerning the theory, practice and profession of psychiatry have appeared in abundance since the Second World War, when the conditions of the mentally ill in psychiatric institutions raised questions about patient health and well-being (Barrett 1987:7). In particular, criticisms of psychiatric practice as a project of social control through the custodial and repressive treatment of the mentally ill have shaped the landscape of community and hospital mental health treatment (Miller & Rose 1986). Medical ethnographies (Bloor 2001) deriving from various disciplinary backgrounds have brought new insights into the complexities produced within the psychiatric paradigm through in-depth understandings about mental health communities. Ethnographic research has the benefit of bringing the context of mental health experiences into focus by the researchers' intimate association with the field site and therefore access to information from field informants through engagement rather than anonymity and distance (Barrett 1996:5). As such, medical ethnographies have offered insights that have informed critical psychiatric texts as well as changes in policy and practice.
Medical Ethnographies

Earlier critical studies of psychiatry from around the 1950s onwards focused on the psychiatric institution: illuminating the social context where psychiatric practice, experiences of patienthood and professional training played out. Many of these studies addressed the social world within the institutional space, and the power relations within this space. These texts largely viewed the institution as an apparatus for social control, emphasising the imbalance in power dynamics, ideological values and tensions, and the organisation of psychiatric professionals (see Belknap 1956; Caudill 1958; Devereux 1949; Rushing 1964; Stanton & Schwartz 1954). The most influential of these studies was Goffman’s ‘Asylums’ (1961) in which he referred to the psychiatric hospital (in addition to other institutional spaces) as a ‘total institution’ that was ‘impermeable’ by the outside world. Admission into these spaces occurred with little regulation, and, he argued, began the ‘moral career’ of the patient in which they were socialized into the social identity of chronic mental illness. Goffman’s critique of the social world within the institution emphasised the cruel treatment of psychiatric patients, observing a great social divide between patients and staff, reinforcing the already marginal status of the patient.

The social world of psychiatric patients described by early medical ethnographies highlighted the function of the institution as an apparatus of social control resulting in the oppression of patients within them. These were central themes in the ethnographic works of this period (see for examples Belknap 1956; Caudill 1958; Goffman 1961; Rosenhan 1973). The imbalance of power in these contexts was recognised as a significant contributor to the oppressive treatment of patients,
a factor identified by others as inherent in the socialisation process of students into the medical profession (Becker 1961; Light 1980; Luhrmann 2000).

The institutional context of my fieldwork bears little physical resemblance to those described by Goffman and other theorists of this period due to a loosening of visible restraints upon the patient. However the social control aspect of the psychiatric space remains germane and is explored throughout this thesis. It is also significant to note that these works were written in the context of the anti-psychiatry movement (Basaglia 1987; Cooper 1967; Laing 1960; Szasz 1961) which had begun to question the core values of psychiatric practice and its application of the medical model for the understanding and treatment of mental disorders. Anti-psychiatrists argued that mental illnesses, unlike other medical conditions, could not be visually identified, so therefore there was no scientific evidence of their existence. Identifying mental pathology relied purely on the subjective judgment of psychiatrists who were trained to look for pathological behaviour. Therefore behaviours viewed through a psychiatric lens, particularly when observed within a psychiatric context, could potentially be misinterpreted as pathological (Rosenhan 1973; see also Goldman, Bohr & Steinberg 1970). These critiques of psychiatry in the context of anti-psychiatry debates bolstered the push toward deinstitutionalisation and the humane treatment of the mentally ill.

**New Psychiatric Contexts: The ‘Community’**

The deinstitutionalisation movement saw a shift in mental health treatment practices. Individuals, who had previously received long-term psychiatric treatment in the institutional context, began receiving treatment in community settings aided with the assistance of pharmaceutical interventions for the
management of symptoms. Post-deinstitutionalisation, the shift to community based care created a new psychiatric context— the mental health 'community'. With this, the boundaries between the psychiatric hospital and the external world became blurred (see Basaglia 1987; Cohen 1985; Prior 1993). A ‘social/institutional context’ (Quirk, Lelliott & Seale 2006:2114) began to emerge where the treatment of mentally ill patients occurs largely in community settings, leaving the hospitalised treatment of mentally ill for only the most severe or acute cases. As such, psychiatric practice now also incorporates the psychiatric surveillance of individuals identified as ‘at risk’ of developing mental health problems, providing interventions to begin identifying and treating these problems in the community before they reach admission stage (Quirk, Lelliott & Seale 2006). Oliveto was a psychiatric unit facilitating the admission and treatment of acute and severe mentally ill mothers along with their child. The institution also offered outpatient treatments to mothers living with mental illness in the community; however the focus of this thesis was on the institutional setting, a rare ethnographic example in an era of deinstitutionalised psychiatric care.

Anthropological critiques emerging after the deinstitutionalisation movement also challenged the notion of whether the ‘community’ was a supportive environment as it was promoted to be (Estroff 1981; Lovell & Scheper-Hughes 1986; Lucas 1999; Newton 1999). Research in this area demonstrated how the concept of community in relation to mental health is multi-faceted and holds different meanings and values that are dependent on the perspective that is taken; that of the mentally ill individual or the people who work with them. Ethnographic studies of the subjective experiences of chronically ill patients living in the
community gave different expressions to the challenges and dilemmas encountered daily by the mentally ill. For many chronically ill patients, the community was not an inclusive, supportive environment, but an isolating and lonely place. Many patients living in a post-deinstitutionalised era experienced ‘community’ isolated within their suburban home (Lucas 1999), or formed their own community with those who shared their experiences of living with mental illness in an unsupportive environment (Estroff 1981).

Ethnographic investigations have also explored the meaning of ‘community’ from the perspective of mental health workers. For mental health workers, the term ‘community’ was used as a means for both establishing symbolic boundaries from the hospital setting (Barrett & Parker 2006a) and within the psychiatric professions (Parker & Barrett 2006b). When used in relation to patients, the term ‘community’ established and maintained symbolic boundaries between the inside and outside of the hospital: discharging patients into the community was viewed as a departure from the constraints of the hospital, thereby invoking the values of integration, autonomy and freedom from the institutional setting (Barrett & Parker 2006a). However Barrett and Parker (2006a:315) brought attention to a counter-narrative that existed for community clients, who described their experiences of living with mental illness in the community as feeling confined by their illness, with ‘no quality of life’ and little social interaction; experiences also similarly identified by Estroff (1981) and Lucas (1999) in their ethnographies of clients with chronic mental illness. Indeed, even mental health professionals working in the community were prohibited from social engagement with their clients, informed by an ethical imperative to not form interpersonal relationships.
with those under their care (Parker & Barrett 2006b). At Oliveto similar relationships were observed between Oliveto’s staff and the patients they treated, remaining bound to the therapeutic space. Therapeutic relationships that extended beyond the institutional walls were expected to remain therapeutic.

**Contemporary Institutional Ethnographies**

Only a handful of psychiatric institutional critiques employing an ethnographic lens have emerged to date. Those produced in recent years have considered the importation of psychiatry into non-Western contexts, questioning the applicability of a medical model for understanding and treating ‘unusual’ behaviour as pathological, in favour of local understanding (Goddard 2011). In one ethnographic study, Addlakha (2008) illuminated the intertwining of illness and culture observed in an Indian psychiatric hospital. In this context, the manipulation and adjustment of psychiatric knowledge was appropriated to correspond with local and cultural understandings.

Ethnographies of psychiatric institutions have largely been conducted in developed countries where hospitalisation of the mentally ill is still considered the best treatment for those severely affected despite the deinstitutionalisation movement. For those who are admitted now, hospitalisations are generally short and viewed as a ‘transitory spell’ in a longer management plan which continues in community settings (Quirk, Lelliott & Seale 2006:2110). One of the difficulties of the new psychiatric context, highlighted by Rhodes (1991) in her study of an emergency psychiatric ward, is delivering effective psychiatric treatment whilst also balancing this with the pressure of hospital mandates to keep beds free.
In contemporary psychiatric wards, Quirk, Lelliott and Seale (2006) argue there is far more ‘permeability’ than the asylums of Goffman’s day, with a high fluidity of movement of individuals within the wards, short-stay admissions, regular staff changes, and daily visitors (family, friends, and patients from other wards, case workers and service providers). Quirk and his colleagues argue that although permeability levels the social playing field for patients, it also has consequences for institutional functioning. The regulation of patient behaviour continues in ways that are transparent (for example with the use of Close Circuit Television (CCTV), locking doors and special observations), but also in more discreet ways (planning around patient discharge or leave) (Quirk, Lelliott & Seale 2006:2111-2116). Oliveto’s surveillance practices will be explored in Chapter Three.

Diagnosis & the Diagnostic and Statistical Manual of Mental Disorders

Critical psychiatry debates have seen a shift in focus over the years. The institutional psychiatric setting was central to early critiques as it was the site where psychiatric power and social control was first recognised (Belknap 1956; Caudill 1958; Goffman 1961; Stanton & Schwartz 1954; Strauss et al. 1964). However the emergence of these critiques in an era when the biological focus of psychiatric practice was also being brought into question saw the push to remove inpatients from the institutional setting to ‘community’ settings where the experiences of those with chronic mental illness continued to be linked to institutional restraints. These social reforms brought new challenges within the psychiatric paradigm. However the focus of critique has shifted from the psychiatric setting to issues of diagnosis, labelling and treatment of mental illness.
through the medical model. Drawing on contemporary Foucauldian theory, Rose (2007:187) demonstrates how during any historical period, human beings try to improve or reform themselves in reference to particular knowledges and beliefs held. Throughout the twentieth century these knowledges have changed significantly; in the early part of the century, advanced industrial societies understood themselves as ‘inhabited by a deep psychological space’ but by the last half of the twentieth century there was a shift whereby human beings began to view themselves more as ‘somatic individuals’ (Rose 2007:188). This refers to how people have increasingly come to understand themselves as being shaped by their biology (ibid). As Rose (ibid) explains:

> This somatization ...extend[s] to the way in which we understand variations in thoughts, wishes, emotions, and behaviour, that is to say, our minds. While our desires, moods and discontents might previously have been mapped onto a psychological space, they are now mapped onto the body itself, or one particular organ of the body — the brain.

The most significant influence on this shift was during the 1950s when biological theories of mental pathologies were tested and clinically observed to be effective with the use of chlorpromazine for patients with psychosis and other psychopharmacological discoveries (Rose 2007:189). With these new findings psychiatric practice began to view mental pathologies previously understood as a result of psychological dysfunction or ‘maladjustment’ as a physiological disturbance (ibid). From this point, psychopathology began to be viewed as a somatic illness (Rose 2007:190). With this new focus on the brain and its
functioning the distinction between organic and functional disorder was dissolved. Mental pathology could be identified in the brain and potentially corrected through physical means (for example ECT or medication). The symptoms of mental pathology were viewed as the behavioural consequences of the anomaly of the brain (Rose 2007:192). By targeting treatment options to specific areas of the brain, the symptoms of mental illness could be ameliorated and the individual’s condition improved.

With a shift in psychiatric power from the institution to the community, psychiatric diagnosis became the new agent of social control. Diagnoses formulated through the Diagnostic and Statistical Manual of Mental Disorders (DSM) provided a checklist of symptoms for the identification and treatment of psychiatric illness. In particular, the introduction of the DSM—III in 1980 served to further psychiatry’s medical legitimacy by categorising behaviour as pathological and therefore treatable with medication (Horwitz 2007; Mayes & Horwitz 2005). The DSM—III also introduced a multi-axial system, which included the diagnostic category of personality disorders (Manning 2000:622). Since their introduction into the DSM, the category of personality disorders has been disputed. It has been argued that personality disorders rely too heavily on the moral evaluation of clinicians to diagnose them (see also Bjorklund 2006b; Charland 2006; Parker & Barrett 2006a; Zachar & Potter 2010), because they ‘do not include obvious psychological or organic functioning’ and instead are ‘detected through their interpersonal effects’ (Manning 2000:622). Luhrmann (2000) gave an example of how diagnosing personality disorders occurs in clinical practice in her ethnographic study of American psychiatry. Here she described the process where
students were taught to put aside DSM criteria when diagnosing personality disorders in favour of an interaction model; that is, their response to how the patient made them ‘feel’ (2000:112). This mimics the process by which women described as *borderline* in Oliveto were identified (referring to borderline personality disorder (BPD), see Chapter Eight). Indeed, there is a significant amount of literature dedicated to the ‘uncomfortableness’ individuals ‘feel’ when interacting with personality disordered patients in clinical contexts, raising questions about the moral evaluations inherent in the diagnosis of BPD (Charland 2006; Luhrmann 2000; Parker & Barrett 2006a); the gender bias associated with the label (Bjorklund 2006a; Sargent 2003; Shaw & Proctor 2005); and the historical and sociocultural factors (Paris 2004; Paris, Chenard-Poirier & Biskin 2013; Paris & Lis 2012) that reflect gendered expectations about women (Nuckolls 1992; Potter 2006); and about behaviour that contradicts femininity (Wirth-Cauchon 2001). These texts give rise to the tensions between behavioural and biological aetiologies surrounding personality disorders also often observed in Oliveto — a distinction between ‘are these women really sick’ or ‘are they choosing to behave this way?’ Such tensions were therefore related to the ideological constructions of illness behaviour and are recognised as a contradiction arising within the ‘psy’³ professions, as well as in Oliveto.

**Ideologies and Illness behaviour: Tensions and Contradictions**

Ideological tensions within the psychiatric space have also been the focus of key critiques in institutional ethnographies (see for examples Barrett 1996; Reynolds

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³Rose used the term ‘psy’ to collectively refer to the ‘psychosciences and disciplines—psychology, psychiatry and their cognates’ (1996:2).
& Farberow 1976; Strauss et al. 1964). Of particular relevance for this thesis was Barrett’s (1996) exploration of the ideological tensions inherent in the nature of mental illness (also recognised by Strauss et al. 1964). Barrett believed that the tensions were located in the taken-for-granted assumptions inherent in psychiatric terminology. Through ethnography he demonstrated the ‘dynamic tension between ‘scientific’ and ‘moral’ domains, two opposing assumptions concerning the nature of mental illness’ (Barrett 1987:12). Barrett argued that the scientific assumption of mental illness generated through the medical model constructs patients as passive objects of their illness. Yet at the same time, the symptoms of a patient’s mental illness were discussed by psychiatric staff as being consciously motivated and therefore within the patient’s capacity to control. Barrett demonstrated how these competing frameworks informed ideologies that were negotiated and managed by mental health professionals, and how these tensions filtered down to the treatment of patients.

For Barrett, tensions were viewed as part of the challenge of psychiatric practice, creating a context where ideologies were able to be improved and perfected, making the institutional environment ‘both a recipient of and a crucible for the production of the ideologies’, and having significant influence over patient treatments (Barrett 1996:9). The impact of ideological tensions on patient treatment within a psychiatric space has also been illuminated in other ethnographic studies, both at a therapeutic level (Reynolds & Farberow 1976; Young 1995) and an operational/functional level (Rhodes 1991).

In today’s psychiatric context, only acute mental illness is considered to require inpatient hospital treatment and generally admission times are short. Currently,
chronic mental illnesses (in particular schizophrenia), are seen to require short stay admissions as part of longer-term treatment plans. As such, schizophrenia has been the focus of almost all psychiatric ethnographies, with some recognition of the subjective realities experienced outside of hospital settings. My ethnography in Oliveto draws on many of the themes highlighted above, following in the tradition of medical ethnography and the critical exploration of people’s experiences with psychiatry. However it differs from many of the existing texts in a number of ways. Schizophrenia was only one of a number of acute mental illnesses treated in Oliveto. In addition, although admission into this psychiatric ward was facilitated by psychiatric diagnosis, it was the mother’s relationship with her child that shaped much of the treatment. The hospitalisation and psychiatric treatment of mothers with their babies is a reflection of the particular social, cultural and historical context in which this thesis was written.

**Anthropology of Mothering:**

**Parenting, Mothering, Child Socialisation & Enculturation**

As a psychiatric institution, Oliveto was founded on a number of fundamental beliefs. First, as a mother and baby unit, Oliveto was created to facilitate the admission of mentally ill women who were also mothers to young babies. In the Oliveto context, being a mother meant that these women had physically given birth to the child they were admitted with up to three years previously. Mothering in this context therefore assumed a biological link, both through the process of childbirth, but also through blood kinship. In addition to this, the fact that babies were admitted with their mothers (not fathers or other carers) also highlighted the assumption that as the child’s biological mother, she was the individual
responsible for the primary care of that infant in everyday life, and thus they should remain together. These two significant assumptions made about mothers and the care of young infants were used as primary justification for the dual psychiatric hospitalisation and treatment of mothers who experienced mental health difficulties in the postpartum period and were admitted into Oliveto.

In the anthropological literature, there has been a significant amount of research conducted in the area of mothering, childrearing, child socialisation and enculturation. The majority of ethnographic research has been conducted in cultures outside of industrialised societies, highlighting the multiple and varied child rearing configurations and practices that occur in diverse settings. However few anthropological studies have given attention to the everyday practices carried out by biological mothers in societies such as Australia where biomedical knowledge dominates. While there are a handful of studies that consider mothering in relation to human biological functions (for example breastfeeding or sleeping), or mothering in the context of assisted reproductive technologies, to date no ethnographic research has explored mothering and maternal-infant relationships in a biomedical context. This thesis aims to expand the anthropological literature of mothering by providing an ethnographic account of mothering in a context dominated by biomedical logic.

Parenting & Mothering

As an infant, the human child is dependent on others for survival. In the cultural anthropological literature, the practices used for child rearing and socialisation are by and large referred to as ‘mothering’. Throughout this thesis I consider mothering as a practice used to promote child well-being and care, through an
engagement in a range of activities, including child nutrition, education, health, language development, spiritual growth and appropriate discipline and care (see Walks 2011:3-4). Enculturation and socialisation occur through mothering processes, whereby the child is taught core values and beliefs of the cultural system including emotional and motivational components (Barlow 2010:339).

Mothering has generally been characterised as a responsibility for promoting a child’s well-being and development through physical care and nurturance (Barlow & Chapin 2010:333). However, anthropological literature demonstrates that ‘well-being’ and ‘development’ are terms that are locally defined and show vast variance across, as well as within, cultures (ibid).

Western assumptions about mothering predominantly focus on biological mothering (Hays 1996; Margolis 1984), a point made evident through the underlying assumption guiding Oliveto’s admission and treatment practices. However anthropological, sociological and feminist literature has repeatedly emphasised that mothering is not always carried out by biological mothers; it can be carried out by other people and may not have a dyadic but a multiple focus (see for example Crittenden & Marlowe 2013; Hewlett 1991; Hrdy 2009; Mead 1939; Meehan & Hawks 2013; Middleton 2000; Pelka 2010; Seymour 2013; Seymour 1983, 1999, 2004; Stack 1974; Tronik, Morelli & Winn 1987). Despite this, mothering in Western societies tends to imply an ‘intensely emotional dyadic bond’ (Seymour 2010:450). The cultural emphasis on this primary relationship was made evident in Oliveto where the focus of treatment practices was to nurture this culturally revered relationship defined in biomedical terms as the attachment relationship. In industrialised societies such as Australia, and other contexts
dominated by biomedical beliefs, the promotion of the mother-infant dyadic relationship is largely responsive to the widespread acceptance of ideas arising from the psychological paradigm. Most significant to this research is the psychological construct of Attachment Theory which promoted the importance of an infant forming a significant relationship with one person — almost always referred to as ‘mother’. Yet anthropological research demonstrates that dyadic bonds are de-emphasised in much of the world; promoting dyadic relationships is even considered dangerous at times as they diminish the child’s ability to learn the value of multiple bonds and independent kin ties (Seymour 2010:450). Cross-cultural researchers highlight the significance of multiple bonds for child development, recognising that the mother-infant dyad does not exist in isolation, but rather that mothers and children are located in a wider context of social networks (Meehan & Hawks 2013:85). Through ethnographic exploration, primary caregiver attachment models have been challenged, as attachment models cross-culturally demonstrate that protective caregiving can be multiple, co-operative (Crittenden & Marlowe 2013; Gaskins 2013; Meehan & Hawks 2013:108) and diffuse (Barlow 2013; Seymour 1983). This is best demonstrated in Hrdy’s (1999) concept of allo-parenting, where individuals other than the biological parent assume parental roles. Female kin in particular have been shown to have significant involvement in child care, including, although not exclusively limited to grandmothers, sisters, friends and siblings (Ochs 1988; Stack 1974), and alternative forms of child care such as nannies and baby sitters (Gathorne-Hardy 1972). Males, specifically biological fathers, have also been shown to play a

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4 First used in reference to primate communities, but also used to describe human societies.
significant role in child rearing in societies such as the Aka pygmies in the Central African Republic (Hewlett 1987; see also Lewis & Lamb 2003). Despite these examples, the anthropological literature on mothering and childrearing practices demonstrates there is a clear skew towards women being assumed to be responsible for this social role of mothering. This viewpoint was strongly emphasised in Oliveto, as I will demonstrate in this thesis.

Attachment, Mothering & Anthropology

The biological view of mothering favoured in industrial societies has helped support the assumption that the practice of mothering is instinctive for women (see Badinter 1981; Hrdy 1999; Kitzinger 1978; Ruddick 1989) and an act considered inherently feminine despite evidence demonstrating both genders engage in mothering. Oliveto’s admission practices were reflective of these widespread beliefs whereby all patients admitted into the unit were biological mothers to the child they were admitted with. Mothering in Oliveto was demonstrated to require both the emotional and physical care of the child, with the biological mother being primarily responsible for providing this. Mothering therefore required two distinctly different demands, yet these were viewed as indivisible and treatment practices in Oliveto worked towards improving a mother’s provision of both to her young children. In Oliveto, the physical act of mothering, referred to as mothercraft (see Chapter Seven for a detailed discussion) was viewed as an instinctive act for women. Despite this, in Oliveto mothercraft was also understood as a craft or skill, learnt through a socialisation or transmission process that was assumed to be passed down from one generation to the next. Therefore it was assumed that in order for a woman to be a good mother
she had to have been the recipient of good mothercraft herself. These inherent contradictions played out in Oliveto’s everyday practices, where the instinctive and the learned were confounded.

During my time in Oliveto, the tensions between the biological/instinctual and learned/behavioural were observed in everyday mundane practices. For mothers diagnosed with a postpartum mental illness, an integral part of the treatment they received was to be taught and receive training interventions to improve their mothering skills, such as regulating babies’ eating and sleeping patterns to fit within predictable time frames and encouraging child development through culturally specific ‘play’ interactions. Teaching women how to mother contradicts the widely held assumption that mothering is biological and instinctive; the view of mothering predominantly assumed in Western societies. In addition to this, mothering, also considered to be inherently feminine, was taught by individuals who were often not mothers themselves, and in some instances, not women but men.

The importance of viewing mothercraft as an integral form of mothering practice used in Oliveto was significant for my fieldwork, as it was believed that through good mothercraft a mother demonstrated a healthy relationship or ‘attachment’ with her child. The term attachment derives from Attachment Theory, a theoretical construct based on primate models (see for example Harlow 1958) and the work of John Bowlby (1958) and Mary Ainsworth (Ainsworth & Bell 1970; 1979) which is used to define a mother’s sensitivity and responsiveness to her child’s needs. Attachment Theory uses scientific principles to demonstrate the influence of a child’s first significant relationship as a prototype for future relationships. The
promotion of a dyadic relationship between mother and child, above all other relationships, both reflects and emphasises the dyadic focus of childrearing arrangements in industrialised societies such as Australia. In Oliveto’s biomedical setting, Attachment Theory provided a template for determining whether a mother was ‘good-enough’ (a term first used by Donald Winnicott (1950), discussed in detail in Chapter Seven). According to the theory, a mother who is not responsive to her child’s needs may threaten the survival of her child — a ‘bad’ mother may physically harm or even kill her child. Attachment, it was believed, was the foundation for all psychological, emotional and cognitive development. Thus, a mother becomes the prime influencer of the fate of the child’s life. Consistent with the transgenerational model, then, a poor attachment would damage the child, who would then be impaired as an adult and would thus be impaired as a future partner and parent.

Anthropological research is clear that this biomedical and psychological thinking, although supposedly holding universal applicability, does not hold relevance in all cultural settings. Indeed, critiques of Attachment Theory and its ethnocentricity began last century (see LeVine & Miller 1990; LeVine & Norman 2001; Rothbaum et al. 2000) and have since been supported by numerous ethnographic studies that challenge the main tenets of the theory. Through ethnographic observation in diverse cultures, anthropologists have highlighted the profound differences in beliefs, values, practices and institutions that surround attachment (Quinn & Mageo 2013:6). These studies provide evidence of childrearing that does not conform to Bowlby’s assumption of intense mother-infant bonding in the first years of life for the child’s physical protection and long term psychological health.
Instead anthropology has offered examples of childrearing that integrate contextualised models of attachment, taking into account cultural beliefs, values and practices in childrearing objectives (Gaskins 2013); recognise the impact of environmental conditions (Meehan & Hawks 2013; Scheper-Hughes 1985, 1993); and respond to localised notions of personhood (Gottlieb 2004; Scheper-Hughes 1993). Although these studies demonstrate far less emphasis on the dyadic bond, they do not dispute the primacy of the mother to the child’s well-being (Morelli & Henry 2013:244; Quinn & Mageo 2013:19). Instead this research illuminates the multiple and varied configurations of attachment patterning that include infant interactions with others, not just mothers, as a defining quality of infant security.

In addition, the qualities of independence and autonomy believed to be fostered through a healthy attachment relationship do not translate to all cultural models of secure personhood (Barlow 2013; Chapin 2013; Mageo 2013). Ethnographic studies have challenged the applicability of measurable categories of attachment behaviours; proximity seeking (Takahashi 1990); maternal availability (Crittenden & Marlowe 2013); and sensitivity to the child’s needs (Mageo 2013; Seymour 2013) as suitable categories for assessing cross-cultural attachment patterning.

A further discovery made possible through ethnographic research is that attachment bonding is not always immediate, but can be delayed. This was demonstrated by Scheper-Hughes (1993) in her study of infant death in a Brazilian shanty town; Weiss’ (1994) study of handicapped children in Israel; LeVine’s (2004) study of the Guisii of Kenya; and Gottlieb’s (2004) study of the Beng people in West Africa. Lancy (2013) argues that across the anthropological and historical literature, the psychological concept of attachment between a caregiver and infant
is often delayed until cultural models of infancy and the beginnings of personhood are achieved. For example, in Western models of infancy, personhood begins from conception, and sometimes even before, and childhood in industrialised societies is highly culturally valued (Lancy 2013:15). In contrast, infants in non-Western cultures have been demonstrated to have what Lancy (2013:7) describes as ‘delayed personhood’; a state where infants are considered to be in a liminal state or ‘not fully human’ (see also Balikci 1970; Castle 1994; Eickelkamp 2011; Fabian 1992; Gorer 1938; Gottlieb 2004; LeVine & LeVine 1981; Martin 2001; Scheper-Hughes 1993; Yanagisawa 2009 for examples). Lancy argues that the primacy of the child in contemporary Western societies has been in response to social, political and economic changes which have meant that children stay in education longer to gain well-paid employment. This has changed family demographics in contemporary industrialised societies whereby children are no longer viewed as economic assets but personal ‘projects’ (Lancy 2008:24-25). In addition to this, the medicalisation of mothering and the mother-infant relationship as seen through Attachment Theory strengthened the primacy of childhood in industrialised contexts (see Kanieski 2010). From an anthropological perspective, Attachment Theory therefore can be viewed as a cultural artefact, or as Quinn and Mageo (2013:5-7) suggest, ‘folklore’ that exemplifies cultural values embedded in everyday assumptions about mothering for white, middle-class mothers in industrialised (particularly biomedical) contexts.

Medicalisation of Mothering

Feminist research has argued that mothers have increasingly become the focus of intense medicalisation due to their biological functioning (Lupton 2003),
particularly in the areas of reproduction, pregnancy, and childbirth (see Davis-Floyd 1990, 1994, 2004; Fox & Worts 1999; Ginsburg & Rapp 1995; Lee 2003; Lupton 1999; Oakley 1979, 1980, 1984; Rapp 1999; Rothman 1982; Teman 2003). Through the medicalisation process, bodily functioning and human behaviours previously considered natural now have medical definitions and frameworks applied to them (Conrad 1992; Kanieski 2009). Human conditions are now viewed as medical conditions, placing them within the jurisdiction of the medical professions (Clarke 2013). As such, medicalisation is also linked to social control, a process linked to institutions and governmentality, and also recognised in the critical psychiatry literature (Conrad 1979, 1992; Foucault 1973a, 1977; Lupton 1994).

Women and the female body have been particularly vulnerable to projects of medicalisation (Kanieski 2009:4). As mothers, women became linked to a number of growing social problems, including infant mortality and juvenile delinquency, and are often held accountable for their child’s general health (Hays 1996). As such, medical anthropological critiques in relation to mothering in urban, contemporary settings have also examined infant feeding, infant sleep, breastfeeding and child nutrition (Faircloth 2009; Faircloth 2010; Gottschang 2007; McKenna, Ball & Gettler 2007; Merrill 1987; Moffat 2002); and the role that mothers play in their child’s health and healing (Griffith 2010; Schwartz 2004). As such, mothers who are commonly positioned as responsible for their child’s health are held accountable for recognising and attending to medical concerns promptly and in a manner that adheres with acceptable cultural practices.
Defining issues or problems in mothering through medicalisation renders them amenable to medical interventions and treatments by those with medical authority. For example, the medical reframing of maternal emotion and distress after the birth of a child as postnatal mental illness through psychiatric practice (see Chapter Four for a detailed discussion) facilitated the admission of mothers into Oliveto. In addition, the mother-infant relationship, also medicalised through attachment theorising, was believed to pose a risk to a child’s safety and developmental growth if the mother was diagnosed with a mental illness.

**Mothering & Child Development**

In Oliveto attachment was viewed as the embodiment of a mother’s love for her infant, and the foundation for all psychological, emotional and cognitive progress — referred to in psychological terms as ‘development’ (Piaget 1964). Attachment was considered the most influential factor for measuring a child’s future development, the first of a list of developmental achievements thought to measure physical, cognitive, social, emotional and communicative growth. In the sub-discipline of developmental psychology, a list of developmental standards identifies age-related behavioural changes. These stages, commonly referred to as ‘milestones’, are argued to show universal similarities across cultures, and have been used for assessing a child’s behavioural changes according to their age (see Porter et al. 2002). Through the production of a list of developmental milestones, psychology has offered an optimal script for human development, supported by scientific principles verifying their validity in the biomedical paradigm. However, as Super and Harkness argue, these scripts have evolved from the assumption of a ‘universal decontextualised child’ (1982:545). A handful of anthropological
accounts question the validity of a universal developmental trajectory in children (DeLoache & Gottlieb 2000; Gottlieb 2004; Whiting & Edwards 1988). It is argued that these milestones are judged in accordance with Western assumptions of childrearing, and disregard the cultural practices and beliefs about child rearing in other cultures. Super and Harkness offer an alternative developmental framework that takes into account the cultural structuring of child development — what they term as the ‘developmental niche’ (1986:545). The developmental niche takes into account the physical and social setting of the child; the customs of child care and childrearing of the child’s culture; and the psychology of the caretaker (Super & Harkness 1986:565). Such an alternative view of child development was not taken up in Oliveto. Instead developmental milestones were a guide for assessing a child's developmental growth, and were used to question the quality of the mother-infant relationship.

Anthropology demonstrates how culture influences which developmental behaviours are given emphasis (if they are recognised at all). For example in some African cultures, weaning from child-wearing on the back is considered a developmental milestone (Lancy 1996:25; citing Whiting & Edwards 1988:88), yet in countries where child-wearing is not practiced, this has very little cultural relevance. The appearance of molars and children’s feet touching the ground are also given cultural elaboration yet hold little significance in Western societies (Gottlieb 2004:220). Gottlieb argues that ‘even when the same milestones are celebrated as critical in a variety of societies, the reason for highlighting those particular milestones and not others are sometimes surprisingly dissimilar’ (2004:221). It is therefore critical to give recognition to the underlying beliefs
justifying celebrated milestones before assuming universal relevance. While there have been ethnographic examples that discredit universalist claims, critical psychology has further questioned their collective applicability (see Bornstein 2012; Schulze et al. 2002).

In Oliveto, a child’s developmental milestones were intrinsically tied to mothering. If a child missed a milestone, or was delayed in reaching the prescribed timeframe for achieving it, concerns were raised about the child’s future cognitive, emotional and physical well-being. The linking of a child’s future outcomes to the mother’s caregiving was a recurrent theme in Oliveto.

**Mothering & Mental Illness in Oliveto**

Oliveto was a psychiatric treatment institution specifically designed for treating mental illness in the context of the mother-infant relationship. This thesis is an ethnographic project that explores the assumptions around biological mothering as they are played out in a biomedical setting whereby mental health symptoms were understood and treated with a biological focus, with mothering assumed to be the most significant, yet also the most precarious relationship for a child.

This ethnography adds to the literature of critical psychiatry by offering a contemporary reading of psychiatric practice in a context specific to a biomedical culture — the mother and infant psychiatric unit. This ethnography contributes to the medical ethnography literature that explores the biological focus of psychiatric treatments as well as the critical studies of institutions. As Oliveto is an institution that facilitates psychiatric admission for mothers, the research contributes to the anthropology of mothering in an industrialised context, with a specific focus on
biomedical settings. It explores the assumptions of biological mothering as they are played out in a biomedical setting and draws attention to the contradictions that the biomedical models of mothering generate. As the women admitted into Oliveto received medical treatment for the mental illness and issues related to their mothering (attachment and mothercraft mothering practices), the assumption was that these women were defective in their ability to be good-enough mothers.

The first chapter of this thesis orients the reader to the ethical processes and boundaries that shaped my fieldwork participation. This chapter offers insight into the negotiation processes that were necessary for conducting ethnography in a biomedical setting where the vulnerability of patients raised concerns over patients’ privacy and safety. While these concerns are consistent with medical ethical boards, they sat in tension with the ethnographic method. Within this chapter, a reflexive approach was also undertaken to acknowledge my own biases, and more effectively position myself in relation to the fieldwork.

The second chapter uses a case study of the admission of one patient and her child, Helen and Javier, in order to describe the processes of Oliveto admissions whereby the mother’s psychiatric diagnosis, along with her attachment relationship with her child, are the fundamental prerequisites for admission. The analysis of Helen and Javier’s admission when placed in a historical context explains how the dual hospitalisation of mothers and infants for psychiatric treatment had become an accepted biomedical practice.

Chapter Three explores how observation and surveillance practices shaped maternal subjectivities in Oliveto. Through a contemporary Foucauldian lens, I
examine the institution as a space of social control, an institution aiming to transform deviant maternal subjectivity through ‘technologies of power’ — namely surveillance and observation. Here, I also introduce the reader to Oliveto’s multidisciplinary team, and consider the roles of staff in being agents of social control in this institutional context. The chapters that follow (Chapters Four and Five) are dedicated to an in-depth description of the theoretical orientations that underpinned Oliveto’s biomedical practices, those of psychiatric and attachment theories. As both of these theoretical orientations were used to facilitate dual patient admission (psychiatry through a DSM diagnosis and attachment through defining the mother-infant relationship as pathological), one chapter is dedicated to each. Chapter Four draws on participant observation to describe Oliveto’s psychiatric practice and its relationship to biological theories of mental illness behaviour. In particular, I situate ethnographic examples alongside critiques of psychiatry to describe the significance of the Diagnostic Statistical Manual (DSM) in this contemporary psychiatric context, and the imbalanced power dynamics inherent in the medical model. Chapter Five then describes the history and practices surrounding the medicalisation of maternal-infant interactions. This chapter focuses on the influence of Attachment Theory in contemporary understandings of the mother-infant relationship in biomedical contexts through examples observed in the Oliveto context. The following chapter (Chapter Six) draws heavily on ethnographic data to demonstrate and analyse the application of Attachment Theory as it was observed in Oliveto’s everyday context. I focus specifically on the psychotherapeutic tool known as The Circle of Security (Cooper, Hoffman Kent & Powell 1998) which describes the main tenets of Attachment
Theory in diagrammatical form. In this chapter I consider how the Circle of Security was a metaphor for Oliveto’s psychiatric practice which promoted the mother-infant dyadic relationship above all others, while simultaneously providing a template for identifying pathology within that relationship.

Chapter Seven is a detailed exploration of daily practices that occurred in Oliveto in the public spaces of the unit. It was here that mothers and their babies spent most of their time while admitted, and where nursing staff (in particular) guided and trained mothers to fit within the ideals and social norms of ‘good-enough’ mothering promoted by Oliveto, particularly in terms of mothercraft. This is followed by Chapter Eight which focuses on a specific diagnostic category viewed as problematic in the Oliveto context — the borderline, a term used to described patients with behaviours synonymous with borderline personality disorder (BPD). Ethnographic exploration of the borderline category allows for critical analysis of the relationship between mental illness and attachment models that were practiced in Oliveto. These tensions became most clearly apparent in the staff responses of discomfort and difficulty in appropriately treating borderline women.

The concluding chapter considers the core arguments of this thesis through revisiting the trajectory from patient admissions through to discharge outcomes. I raise questions about the nature of parenting expectations in Australia’s contemporary biomedical practices where gendered assumptions about parenting remain strongly skewed towards dyadic mother-child configurations. This was particularly made evident in the context of parenting with a mental illness, where biomedical assumptions about mothering were considered through the interplay
of psychiatric and attachment theories created tensions and contractions between the biological.

This thesis offers a new contribution to the literature of Institutional and Medical ethnographies, Critical Psychiatry, and the Anthropology of Mothering by offering original insights about the biomedical treatment of mothers with mental illness. Illuminating these practices informs understandings of what biomedical culture recognises as abnormal, and in need of transformation. Ultimately, this thesis offers an in-depth understanding of what Australian biomedical practices of this time expect as necessary for women to be deemed ‘good-enough’ mothers for their children to remain in their care.
NEGOTIATIONS AND CHALLENGES: SHAPING THE FIELD

My interest in researching biomedical understandings and experiences of postnatal mental illness stemmed from experiences in my personal life. Several of my close family and friends had given birth and were struggling with the challenges that the interdependency of caring for a new-born brought into their life. For some, these challenges became so difficult that they consulted their medical practitioner or shared with the visiting nurse about the challenges they were facing. In these brief medical encounters, they were asked to complete a screening questionnaire about how they were feeling at the time. Based on the answers they gave, they were told they had postnatal depression (PND). Their responses to receiving this diagnosis varied from relief to complete rejection. One of the women was pleased to receive a diagnosis to explain the difficulties she was having. She was glad to know that she was not alone in her experiences, and even more pleased that there was a medication she could take that would make her feel better.

At the other end of the spectrum, another friend felt that the PND was a misdiagnosis. She was caring for a toddler, as well as an infant, her partner was

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5 At the time of this thesis, the government in the state concerned here scheduled one meeting with a mother and her newborn in her home after the birth of her child. A nurse attended this appointment and observed and documented the health and growth of the baby while also assessing the living environment for the child. The mother and other caregivers present at the appointment were asked a range of questions about how they were managing with the child. Questions related to mental health were included in the assessment.
working away from home and she was also living away from family support structures. She attributed the difficulties she had to sleep deprivation and lack of support, rather than a psychiatric condition. Although prescribed medication, she refused to take it. She felt that what was needed was a few nights to catch up on sleep and her symptoms would improve — in essence, she rejected the diagnosis. The disparity in their responses made me wonder about how women who were given the same diagnosis could understand and experience their situation in such different ways.

In the early planning stages of my research, I had the opportunity to meet with the Oliveto’s Medical Unit Head, Dr Margaret, to talk with her briefly about her understanding of postnatal mental illness. After that meeting, I realised that Oliveto would be an ideal ethnographic location to research biomedical understandings of postnatal mental illness in context. Oliveto Mother and Baby Unit (MBU) was a psychiatric facility within an architecturally bounded space. As such, it provided a ‘controlled and limited spatial arena for observation’ (Estroff 1981:23). It was also within this space that knowledge about postnatal mental illness was developed, treated and experienced, and as such could be viewed as a microcosm of both medical and mainstream ideas.

I had expected (perhaps naively) that women diagnosed with postnatal mental illness and their experiences and stories would become the central focus of my thesis. I had not anticipated how the mother’s relationship with her child, referred to in Oliveto as attachment, would feature so significantly in biomedical understandings of postnatal mental illness. After my first week in the field however, it became very apparent that the role of the child was significant in this
context. The participant observation conducted in Oliveto largely fell into two parts; participant observation in the public areas of the unit, involving women/mothers who were patients in the unit, their babies, family, friends and staff (predominantly nursing), and observation in the areas of the unit where members of Oliveto’s multidisciplinary team interacted to discuss patients in formal and informal contexts. Although a large amount of my time in the field was spent involved in participant observation with patients in the public area of Oliveto’s space, Oliveto’s staff informed the majority of my ethnographic data. There were two main reasons for this: Oliveto’s policy of short stay admission (averaging approximately three weeks), and the ethical restrictions set by Oliveto’s governing body, referred to here as Healthy Women and Children (HWC) (discussed in more detail below).

It is well recognised in the anthropological literature that the ability to establish a good rapport with field informants facilitates successful ethnographic fieldwork (Powdermaker 1966; Schensul, Schensul & LeCompte 1998; Sluka 2007). Building rapport with Oliveto’s inpatients was limited by the amount of time spent with them. However, the interactions and involvement I had with Oliveto’s staff was more consistent. This was particularly the case with nursing staff, who worked twelve hour shifts. Therefore, the time spent with them allowed me to build stronger relations. As such, the most fruitful ethnographic material was informed by Oliveto’s multidisciplinary team, or what Landy (1958) refers to as the ‘professional community’.

The mothers admitted into Oliveto were significant for this thesis, but not in the manner I had originally anticipated before my data collection began. Their
admissions were the central focus of Oliveto’s multidisciplinary team work, which through a biomedical lens interpreted and assessed each mother’s ability to manage her relationship with her child in a manner consistent with biomedical assumptions of good mothering. As such, this thesis critically explores biomedical understandings of the mother-infant relationship and their relevance to postnatal mental illness.

Methodology

This thesis has engaged with traditional ethnographic methods: primarily participant observation, collections of documents and materials from the environment, and in-depth interviewing. In the initial stages of rapport-building with my informants, interviewing was informal and unstructured. Conversations largely centred on the main themes of mothering, and mental illness. When areas of interest arose, I began to ask more direct questions in order to seek clarity. As the primary tool for data collection, ‘[t]he anthropological fieldworker customarily attempts to learn and to reach understanding through asking, doing, watching, testing, and experiencing for herself in the same activities, rituals, rules, and meaning as the subjects’ (Estroff 1981:20). Conducting ethnography in a medical setting however, meant that the degree of participation in my informant’s daily lives was structured by a number of external factors. Traditional anthropological ethnography assumes that by participating in their informants’ daily lives and immersing themselves in their daily ongoing activities, the ethnographer can understand that social world in terms of what is meaningful to the people who inhabit it — ‘from the native’s point of view’ (Geertz, 1974:27). However, fieldwork in specialised healthcare systems does not fit with these assumptions.
This was certainly true of my fieldwork, where I encountered a number of obstacles which prohibited me from engaging in what I had come to understand in my previous studies as ‘proper’ ethnographic fieldwork. Through identifying the external factors that shaped my data collection, I situate my work so that the reader can understand my justification for the chosen methodological approach.

**Negotiating Participant Observation in Oliveto**

From the outset, fieldwork in Oliveto was a negotiation process: the first obstacle encountered was entry into the field. I formulated the concept for my research project in consultation with my supervisors, and it was through this academic relationship that my entry into Oliveto was facilitated. As a PhD candidate, across the Disciplines of Psychiatry and Anthropology, my affiliation with the School of Medicine meant that access was legitimated through someone inside the organisation, as Oliveto was a tertiary training institution as well as a treatment facility (Pope 2005:1180).

**Ethics**

Ethics approval was sought from two ethics committees: the university and the medical body governing Oliveto, referred to here as Healthy Women and Children (HWC). Ethics approval from the university was accepted without question. Ethical clearance from HWC however, required a series of negotiations spanning several months, delaying the fieldwork process until both parties were satisfied with the

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6 When I began my PhD candidature, my primary academic supervisor belonged to the Discipline of Psychiatry, however towards the end of my dissertation writing, my supervisor transferred to the School of Psychology within the same academic institution. I chose to also transfer with her.
conditions. The concerns raised by the HWC ethics committee predominantly centred around ideas pertaining to the vulnerability and privacy of psychiatric patients (see Oeye, Bjelland & Skorpen 2007), and the issues around obtaining informed consent. As Oeye, Bjelland & Skorpen (2007:2304) note:

Participant observation creates a problem for obtaining informed consent, because informed consent is an individual-based ethical guideline and participant observation is based on observing interaction between participants, which makes it a collective approach.

The logistics of adhering to informed consent in a manner consistent with medical ethics, created barriers to more naturalist forms of participant observation which I had come to understand as characteristic of anthropological fieldwork. I was requested to obtain signed consent from each person in the unit before engaging in participant observation. For staff informants, this was addressed by approaching the staff as a whole, describing my project to them and their involvement in my research. All staff members (except one)\(^7\) gave consent for their involvement. The consent process with patients was far more convoluted. The procedure of asking for consent was never direct, but instead followed several processes before I was able to invite patients to be involved: the vulnerability of patients resulting from their mental health was the institution’s primary concern.

The process for requesting consent from patients began during their admission interview and was initiated by a third party — one of Oliveto’s consultant or

\(^7\) The staff member who did not consent to participate in the research did not offer an explanation.
registrar psychiatrists. Before formally addressing mothers for consent, a
psychiatrist assessed the woman’s ability to make decisions. In biomedical
reasoning, decision making was considered to be potentially impaired by the
woman’s mental health status. For the most part, patients in this context were
considered well enough to give consent. After this, the psychiatrist advised the
patient of my presence in the unit and asked if they were happy for me — I was
referred to as ‘the PhD student’ — to approach them to discuss potential
involvement in my research. I then had to wait for the psychiatrist to inform me
that that both of these processes had occurred (screened for decision making
ability and me approaching them) before I was able to approach patients for
recruitment. Many times, this process was delayed, particularly in the early stages
of fieldwork when the importance of advising me of this primary step was not
made clear to the consulting psychiatrist and registrar. This three step consent
process was considered necessary because of the patient's psychiatric condition,
which was deemed a possible interference in the woman’s ability to provide
informed consent (see Oeye, Bjelland & Skorpen 2007).

As mentioned earlier, Oliveto’s acute psychiatric setting had admission times
averaging approximately three weeks, so the admission and discharge of patients
occurred regularly. As such, the turnover of new people in the psychiatric space
was high and requesting consent occurred frequently. The flux of patients had
repercussions for my data collection in two significant ways. First, the ethical
guidelines set meant that quite often I would be in a room with several patients at

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8 Those with mental health conditions that were viewed as particularly challenging would not be
admitted into a unit such as Oliveto. Severe mental health problems were considered a risk to their
child so a joint admission would not be deemed appropriate. This is discussed in more detail in the
following chapter.
one time, some whom had been screened and given consent for their involvement in my research, and others who had not. My position at these times was difficult, because in the natural flow of everyday life in the unit, many of the women would engage in conversation with me, or engage in a group conversation with each other, including myself. Leaving this space to accommodate ethical considerations worked against the ‘methodological “habitus”’ of participant observation’ (Oeye, Bjelland & Skorpen 2007:2297). In the early weeks of fieldwork, I found that the best way to manage this was to continue with participant observation and refrain from including any information from informants until consent had been given.

The ethics committee also decided that because I did not have any clinical training, access to patients’ medical case notes, or observation of individual, couples, or dyadic therapies was not appropriate. Even when consent was granted by the patient, ethical concerns for protecting patients’ privacy and anonymity were paramount. As such, my engagement with psychiatric case construction was primarily through the observation and detailed note taking of formal and informal discussion by Oliveto’s professional community, as well as through general admission and statistical data. There were two formalised staff meetings that occurred regularly in Oliveto: handover meetings and ward rounds. Handovers occurred twice daily at the exchange from day to night staff, and ward rounds, a more formalised group meeting, occurred once a week and were longer in duration. In the beginning I attended both meetings; however, I found that in handover meetings, discussions would jump from one patient to another without warning, frequently placing me in an awkward ethical position. For this reason I chose to focus my time on ward round meetings where patients were discussed by
the whole team in a systematic manner, allowing me to remove myself from the conversation when I knew time was dedicated to speak about a patient who had not given consent.

Ethical boards across biomedical fields often have been recognised as having little experience with participant observation and ethnographic methods, instead dealing primarily with clinical models of research, experiments and hypothesis testing (Angrosino & Mays de Perez 2000). The suggestions put forward by HWC were therefore consistent with research ethics concerns familiar to their committee members. As an anthropologist conducting participant observation in a clinical setting, I was caught between two ethical ideals which methodologically shaped my fieldwork. Similar challenges when conducting ethnographic research in medical settings have also been recognised by a number of scholars (see for example Angrosino & Mays de Perez 2000; Atkinson 1992; Colen 1995; Hoeyer, Dahlager & Lynöe 2005; Johnson 2009; Li 2008; Merrill 1987; Murphy & Dingwall 2007; Oeye, Bjelland & Skorpen 2007; Pope 2005; Wind 2008).

Where & When

Although there were limits placed on my participant observation, Oliveto still proved a rich fieldsite with plenty of opportunity for ethnographic engagement. From the outset, I had decided to be flexible with my research hours so as to work with the ebbs and flows of the institutional environment. I conducted fieldwork in Oliveto for approximately four to six hours per day, predominantly during the working week (Monday to Friday) for approximately one year (mid November 2008 to late October 2009). I occasionally conducted fieldwork on weekends or at night, however, as the data collection progressed, it became clear that I had
sufficient data for analysis without needing to extend my research hours. Also, as I became particularly interested in biomedical constructions of mothering and mental distress, it made sense to conduct fieldwork at these times as this was when the majority of staff occupied the space.

The design of Oliveto’s space was such that the entry point was a dining area that extended into a lounge area (see Chapter Two for a detailed description of Oliveto’s design and layout). This space was also the main thoroughfare for staff and visitors entering the unit. I spent the majority of my fieldwork here, engaged in the ‘classic ethnographic tactic of informal "hanging out"’ (Gottlieb 2000:23). This involved interacting with mothers as they cared for their babies and were assisted by Oliveto’s staff. Many of my informal interactions with Oliveto’s professional community (particularly nursing staff) also occurred in this space, both on an individual basis and when they interacted with patients. Patients often formed relationships with other patients during their admissions and used this space to interact. They would sometimes include me in their conversation, meal times, craft making and colouring.\(^9\) Time was also spent with mothers outside the boundaries of the facility. On occasions, I would walk with mothers (sometimes in groups) around the hospital grounds as they pushed their babies in pushers to encourage sleep. I also went to the local shopping area with mothers, or accompanied them to a designated outside area when they had a cigarette.

Once consent issues were clarified, my participation with patients and their children occurred quite easily. As many of the mothers spent the majority of their

\(^9\) A cupboard full of craft supplies and magazines were available for patients to use to help pass the time. The assumption was that as women/mothers they would find this interesting or stimulating. Magazines were generally those directed at women: local magazines or celebrity news.
time in the public areas of the unit, where staff and visitors also interacted, it made 
sense that I too spent the majority of my time there. During my time in the field, 
numerous students from the university's medical school, as well as nursing 
students and occupational therapy students, spent time at the unit as part of their 
tertiary training. Volunteers from the Anglican Mother’s Union and various other 
visitors also frequented the unit on a regular basis. Due to the constant flow of new 
faces in the unit, patients rarely explicitly asked who I was and why I was there, 
many explaining to me when I introduced myself and my position in the unit that 
they had thought that I worked there. This was not surprising to me as I kept many 
of the same hours as Oliveto’s psychiatric and allied health staff members (9am-
5pm).

Due to the sensitivity of many of the women’s situations, and the recognised 
vulnerability of mental health patients, I was cautious with overt note taking in the 
presence of patients. Instead, I would find a quiet place to write scratch notes, 
which were then elaborated on in more detail when I returned from the field at the end of the day. When I was not in the public areas of the unit, I would often sit in 
the nurses’ station and interact with the nursing staff and other staff who entered 
that space. Patients understood this to be a space reserved for Oliveto staff; a 
sliding door separating the two spaces was often closed when discussions about 
patients ensued. From the patients’ perspective, it may have appeared that I was somehow aligned with staff; unlike them, I was permitted to be in the same shared 
spaces with staff, which distinguished their hierarchy in this context.

My participation with Oliveto’s professional community was varied. I spent a 
significant amount of time with nursing staff as I shared their work space. My
interactions with psychiatric staff however were less frequent, and occurred largely in formalised staff settings where I predominantly adopted an observational status. The same also applied with my observations of Oliveto’s allied health staff (psychologist, occupational therapist and social workers). My understanding about staff perspectives were derived predominantly from ward round discussions and informal conversations they engaged me in at various times. It was in these group discussions about patients where differing disciplinary beliefs became most obvious. It was rare that I was able to spend time directly with the psychiatrists or allied health team members, as their busy workloads meant that they were engaged in therapeutic work to which I was denied access. I was, however, able to participate in group therapy sessions held by the psychologist (when all patients attending had consented), and watch video recordings of mother-infant therapy sessions (again when the patients concerned had agreed to this).

Finding My Place in the Field — The ‘PhD Researcher’

For many, the ethnographer’s work routine may appear quite unnatural because we spend a lot of time hanging around, asking strange questions and taking notes about what many informants would consider mundane phenomena. To many this does not seem like academic research (see Van Maanen 1982). My role as an anthropologist, an observer, participant and note taker, was not a familiar role recognised in a psychiatric setting.
As a researcher in the polarised field of a psychiatric unit (Estroff 1981; Landy 1958), two distinct groups\(^{10}\) of field informants existed: staff and patients. I had to establish a place for myself as an anthropological ethnographer, aligned with neither group. Over my time in the field, I became known as the ‘PhD researcher’, a title I also used to refer to myself in this context. My ethnographic work involved both groups: mothers diagnosed with postnatal mental illness and Oliveto’s professional community. Within the boundaries of my ethical guidelines, observation of both of these groups was conducted without problems, however I was never able to fully participate in either of the groups. Within anthropology it is recognised that the level of participation in any fieldsite is dependent on the chosen field, the area of investigation and the researcher’s willingness to be involved (Wind 2008:80). When I entered the field, I was not a mother, I did not have a baby, nor had I had experienced any severe mental health problems. In the academic literature, only a couple of medical ethnographies from decades ago have allowed a deep level of participant observation from the researcher, where their presence was covert and practice in the unit was able to function uninterrupted by the knowledge of a researcher’s presence (see for example Caudill et al. 1952; Rosenhan 1973). Current ethical codes prohibit full immersion to this extent, so my ability to fully participate in the experience of the women admitted was limited. At times, I questioned how this would restrict my ability to truly understanding my informants’ perspectives, but felt confident that it would also afford me a level of objectivity that would allow me to view things critically.

\(^{10}\) Within these two groups there still existed a number of sub-groups; however the power dynamics inherent in the medical model meant that each of the broader two groups held different social positions in relation to the other.
My participation with many of Oliveto’s professional community was also restricted due to my lack of clinical training. I have not studied medicine, psychology, nursing, occupational therapy or social work, or any other health care profession. However, I found that participant observation with the nursing staff was more easily facilitated than with other members of the multidisciplinary team because I spent much of my time sharing their work space. I would assist them with the care of babies, for example giving them bottles of milk, rocking them in a stroller until they fell asleep and engaging babies in play (see Chapter Seven for a discussion about the physical care of babies). Nursing staff came to accept me in this role, and would ask me to help them if no other staff member was available. Oliveto’s staff began to engage me more deeply with their practical work, particularly in the area of mothering practices, when I became pregnant. This occurred midway through the fieldwork process, and fundamentally changed the dynamics of my research.

**Becoming a Mother...and a PhD Graduate:**

**A Reflection on the Fieldwork Process**

Participant observation performs the dual purpose of placing the researcher both inside – that is participation – and outside – that is observation of the social world of the host community.

Gitte Wind (2008:79)

Perhaps the biggest obstacle I faced in my research was myself! I entered the field as a member of the broader culture that I was studying. I conducted my research ‘at home’, that is, in my own home town surrounded by a living environment and
cultural practices that were in many ways familiar to me. However, my research focused on the sub-cultural practices of maternal, Perinatal and Infant mental health. Conducting my research in a mother and baby psychiatric unit, I was aware that many of the practices that I would encounter would be highly influenced by biomedical culture and cultural beliefs. Growing up and living in Australia, exposure to medicalisation is an integral part of my everyday life. Conducting fieldwork ‘at home’ made me both an insider and outsider to the field (Peirano 1998). While there were areas of my fieldwork that were familiar to me, I was also required to learn the language of psychiatry and mental health as it was articulated in Oliveto’s setting. I knew from the outset that it would be a challenge to see past my own beliefs and question long held cultural assumptions, however I had not anticipated to what extent my own personal beliefs about mothering and family would also challenge my ability to view my field site critically.

In qualitative research, the researcher’s positionality (Alcoff 1988) or place in the field is recognised as having an integral role in the data that are collected and the direction that analysis takes (McCorkel & Myers 2003; Moore 1988). The researcher’s gender, past history, sexual orientation, and/or ethnicity all have the capacity to shape how the researcher interacts with their field informants and gains access to data. It is also influential in the focus and direction of research topics chosen. In anthropology, as with other forms of qualitative research, being reflexive about the researcher’s position in the field and its impact on data collection, aims to reveal any biases that may appear in their analyses and writing.

As mentioned earlier, my main motivation for researching postnatal mental illness was driven by the experiences of many of my friends and family who were having
children around me. As a newly married woman, I also felt I was ready to have a child but had told myself that my studies would need to come first. I now realised that I combined these dual desires by choosing a field site that allowed me to conduct ethnographic research, while still being involved with an area that was close to my personal interests—motherhood and babies. Being a young woman of child bearing age (I was thirty five at the time), my presence in Oliveto did not seem out of place. As Oliveto was a fieldsite dominated by women, my gender helped facilitate access to information from my informants that I believe would have been more difficult to gain if I was male (McCorkel & Myers 2003). Becoming pregnant further aided my acceptance by field informants, both patients and Oliveto’s staff. Many patients were eager to share their positive stories about becoming mothers, as well as their negative ones. Several tried to prepare me for all of the unknown experiences they encountered through becoming a mother. Some even questioned how I could possibly want to continue with having a child after hearing their difficult experiences. Staff too shared information with me on a different level. Many of their discussions with me became focused on what to expect when I became a mother and what being a good mother was from their biomedically informed perspective. I was instructed in the best ways to hold, settle, wind and even gaze at my child when he was born. I was not only offered practical advice but also shown both physically and through videos. Much of the advice given to me, particularly by Oliveto’s nursing staff, made practical and common sense to me. Although there were a few techniques that I had not encountered before, the underlying logic behind them resonated with my own beliefs and values. As an anthropologist in this field, this became a considerable challenge.
I am the youngest of four daughters in an Italo-Australian family. I was raised in a traditional nuclear family; my mother stayed at home to raise myself and my three sisters until we were all at school and my father worked long hours to provide for us financially. I belong to a large extended family with many aunts, uncles and cousins. There is a very strong matriarchal structure on my mother’s side of the family and I have spent a lot of my time among the women in my family. Growing up, I was always surrounded by children, not only children my own age, but also younger children who myself and other cousins would help care for. It was not unusual for me as a child and young teenager to be given the responsibility for my younger cousins. When my sisters had their own children it seemed quite natural for me to assume certain care taking responsibilities, for example feeding, changing nappies, putting babies to sleep and playing, in my relationship with my nieces and nephews. People had always told me I was ‘good with babies’ or had a strong ‘maternal instinct’, and I agreed that caring for babies felt like it came ‘naturally’ to me, especially since I had had a lot of opportunities to experience caring for young children. My familiarity with caregiving young children served as a good introductory tool in my fieldwork, as it was often through interacting with a woman’s child that rapport was built. I had not realised however, that this would also render it more difficult to see the inherent assumptions that underpinned my fieldwork setting. Analysing my ethnographic data confronted me with just how powerful the cultural beliefs imparted by my family around motherhood and childrearing were. Many of the beliefs that informed the practices I observed in my field site corresponded to what I already knew and understood to be true, explained in a more formalised, prescribed way. As an anthropologist it was my role to question these practices and underlying beliefs, however, my own taken for
granted assumptions meant that I found it difficult to recognise them for the assumptions that they were.

On reflection, the most significant challenge I faced during the PhD process was my struggle to critically analyse a fieldsite that was too ‘experience near’. This became most apparent more than a year after I left the field, when I took my son to his first day of child care. When I left him at the centre in the care of strangers, he was content and showed no distress. I felt a little saddened leaving him for the first time and rang my mother to share my experience with her. Her response was ‘if he was happy when you left, it means you have been doing a good job....If he was clinging to you I’d be worried’. My mother’s words immediately reminded me of Mary Ainsworth’s *Strange Situation Procedure* (Ainsworth, Blehar & Waters 1978) conducted in Oliveto where the measure of a child’s attachment to its mother (caregiver) was assessed through their response to their mother leaving them in a strange situation (discussed in detail in Chapter Five). Without any prior exposure to Ainsworth’s psychological theorising, my mother was able to articulate precisely the assumptions underpinning attachment in lay terms. To my mother, the primary person who socialised me in my maternal role, this was just ‘common sense’. It became clear to me at this juncture that the pervasiveness of understandings of attachment and good mothering were deeply ingrained in me: many of the underlying assumptions that staff informants in Oliveto described as constituting good mothering also resonated with my personal beliefs.

I found it confronting to put aside my assumptions that a mother and child ‘naturally’ form some type of special ‘bond’ or ‘attachment’ as it is theoretically referred to. These beliefs were (and still are) deeply ingrained in me, and
recognising them as culturally constructed concepts was challenging. As an anthropologist, I am acutely aware that science is a product of Western culture and therefore reflects the core cultural values and beliefs that drive practices connected with it. The relationship that an infant forms with its primary caregiver is an element of the human behaviour that has been scrutinised by science and placed in the domain of developmental psychology. Realising just how deeply my own beliefs have been influenced by this has been confronting, and in many ways blinded me for a period of time. Furthermore, I believe that my experiences in the field, and the knowledge my informants imparted to me, decisively shaped my own experiences of mothering (Gottlieb 2004:5). I was fortunate to never have experienced a mental illness in early motherhood like my patient informants, however, the mothercraft practices I observed mothers being taught during their psychiatric treatment, and the underlying assumptions behind why these practices were beneficial to the mother-infant relationship and a mother’s mental health have remained with me. Despite this, I simultaneously understood that it was essential for me to suspend my own views to function successfully as an ethnographer.

The next chapter will introduce the reader to Oliveto mother and baby unit. It locates the unit within a socio-historical context, and gives recognition to the influences that justify the dual admission of mothers and babies for psychiatric treatment.
When I first met Helen, she was sitting on the floor jiggling a toy in front of her son’s face as he lay propped-up in a ‘bouncy chair’. *Javier, Javier* \(^{11}\) she repeated with an encouraging but flat tone. I smiled at her and went over to join her and her son on the floor. She explained to me that she was trying to get him to look at and grab the toy in front of him. I too picked up a toy and tried to get Javier to look at it, but he was not interested. He did however, look past the toy and smile at me. I turned to Helen, happy that he was able to respond to me. I understood this to be a good thing: he was obviously aware that I was there and was able to reflect this with his response. Helen explained that her reason for trying to get him to grab an object was because after an evaluation by the Oliveto team, she was told he was considered to be *delayed or a bit behind* in his development. Javier did not try to grab or show any interest in objects in front of his face, nor did he respond to his name or any other sounds.

Helen was very concerned for her son. She feared Javier was deaf, blind or perhaps even autistic. Javier was six months old when Helen was admitted into Oliveto. Before her admission into Oliveto, she had never considered having his development checked nor had she considered doing things to encourage his developmental growth. She had treated her son in exactly the same way that she

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\(^{11}\) Thought this thesis, words deriving from ethnographic data will be distinguished from other writing or quotations with *italics.*
had treated her daughter when she was a baby, and she had never had problems with her daughter’s developmental growth.

Helen was a psychiatric inpatient at Oliveto, and like all of the 104 women who were admitted into Oliveto during the period of my fieldwork, she had been diagnosed with a mental illness and was receiving psychiatric treatment by Oliveto’s multidisciplinary team. The women admitted as inpatients into Oliveto had two things in common: they had experienced symptoms of their psychiatric mental illness after the birth of their child(ren) who were under the age of three, and they were all biological mothers to the infants they were admitted with.

At the time of this research, Oliveto was one of the few public psychiatric services offered for postpartum women and their babies in Australia. The psychiatric unit was located in the same 1980s red brick building where it first opened. Situated in the far right hand corner of Hopton Hospital grounds, the unit was surrounded by grass, trees and an area for car parking. It adjoined another psychiatric unit, a closed ward that housed patients who were detained under the Mental Health Act (2009) because it was believed that their mental health condition could lead them to harm themselves or others. Helen was one of twenty-four women

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12 The term ‘patient’ is used to refer to women receiving treatment in Oliveto. At the time of this research the term ‘client’ was the preferable label for a person receiving treatment as it implied agency in the woman’s choice to be treated in the unit making her an active contributor, as opposed to a passive recipient, in the therapeutic process. I have chosen to continue using the term ‘patient’ because I felt it better described the relationship between mothers and the staff at Oliveto, reflecting the hierarchy of medical dominance.

13 Oliveto MBU no longer exists in the same physical space, however the newly built unit exists with the same underlying principles and on the same hospital ground.

14 Under state law, the Mental Health Act stated, at the time of this research, that any individual with a mental illness who is at risk to their own/or another person’s health and or safety and because of their mental health condition, and who is not willing to accept treatment voluntarily for that condition, could be detained under the Mental Health Act. In order for that person to be detained, treatment must also be available for them in the place they have been detained to. The detainment must then be reviewed by a psychiatrist within 24 hours, then three days, then 21 days if necessary.
admitted as inpatients\textsuperscript{15} in Oliveto, who consented to participate as informants in my ethnographic research. Twenty-six of Oliveto’s staff members also gave consent to be involved.

Before being admitted into Oliveto, Helen was given a psychiatric diagnosis of postnatal depression\textsuperscript{16} by her General Practitioner (GP) when her son Javier was six months old. In the early months after Javier’s birth, Helen had attempted to manage breastfeeding difficulties, a home business, and family life with her husband and three year old daughter. As a result Helen suffered severe sleep deprivation which then began leading to anxious thoughts. Helen, like many women in Australia who experience unexplained health symptoms, consulted her doctor for advice. Her GP diagnosed her with PND and began treating her depression with antidepressants. Despite being on medication, her symptoms continued to worsen; her GP therefore referred her to Oliveto where she was accepted for admission on the same day.\textsuperscript{17} Helen was told she would receive inpatient treatment while remaining with her son, but would not be able to be admitted with her three-year-old daughter Sophie, or her husband.

In our conversations, Helen rarely talked about her emotions and was unable to describe her diagnosis of ‘postnatal depression’ in language that matched the criteria of her diagnosis. All that she could tell me was that she was \textit{tired}, \textit{worried} and \textit{sad}. When Helen spoke about her sadness, she often framed it as concern for

\begin{footnotesize}
\begin{itemize}
  \item Oliveto also has an outpatient service, however, this was not the focus of the research.
  \item Postnatal depression is a biomedical label given to women suffering depressive symptoms in the year(s) following the birth of their child.
  \item There is a long waiting list for admissions into Oliveto, so Helen’s admission on the same day was not usual practice unless there was already a spare bed available and/or her case was considered significant enough that the dyad needed to receive psychiatric treatment as soon as possible.
\end{itemize}
\end{footnotesize}
her son. I asked her if her experiences with her son were much different to when she had her daughter. Helen said that she would not have recognised any of the things that Oliveto staff had told her were wrong with her son, because she treated Sophie in the same way and had never experienced any problems with her. Helen’s recognition that both of her children received the same treatment from her but responded in different ways might be understood in a number of ways. However within the biomedical model which dominated beliefs in Oliveto, Javier’s inability to reach these milestones was seen as problematic and in need of repair. As a patient in Oliveto, Helen was eager to follow the direction of medical authorities (see Conrad 1979) and their suggestions to help improve her son’s developmental delay. For many of the times Helen and I spent together, we were sitting with Javier in front of us, propped up by pillows. Helen would jiggle an array of colourful, musical toys in front of his face, hoping his eyes would latch on to them. This rarely happened as he was more fixated on objects in the distance, primarily faces.

Using the case of Helen & Javier as an example, I will introduce the reader to some of the key themes that will be explored throughout the thesis, as well as highlighting some of the primary areas of concern recognised by staff in Oliveto when treating mother-infant dyads. This chapter will also sketch the socio-historical landscape of mental health treatments, in order to contextualise the biomedical rationale, recognised anthropologically as distinctly cultural, for the dual admission and treatment of mothers and babies in Oliveto.

Helen and Javier were an example of the therapeutic work that occurred in Oliveto. After Helen sought help for her mental health condition and was admitted for
treatment in Oliveto, the multidisciplinary team also began to identify abnormalities in her son’s behaviour. As will be demonstrated later in this thesis, Javier’s developmental delay was attributed to problems within the mother-child relationship, referred to throughout thesis as the attachment relationship. In the Oliveto context, it was the mother-infant relationship that was brought into focus. Understanding the significance and primacy of this relationship to my fieldsite is fundamental to this thesis (see Chapter Five for a detailed discussion).

For the multidisciplinary team working in Oliveto, each admission into the unit was viewed as a psychiatric case — the central and unifying object of the psychiatric team’s every day work. Barrett describes a psychiatric case as a ‘fragmented structure’ that is built through ‘layers of clinical assessments and professional definitions in and around the person until he or she is made into a case’ (n.d.:3). In Oliveto, case work concerned mother-child dyads, as a mother’s mental illness was always viewed in the context of her relationship with her child. The central focus of Oliveto’s work therefore was not simply a case of a woman with psychiatric illness, but the assessment and treatment of the woman as a mother to her young child. As the child’s mother, Oliveto viewed her as primarily responsible for her child’s health and well-being. Implicit in case work of this description therefore, was the observation, surveillance and treatment of the mother’s mental illness, with a focus on how her mental illness impacted on her relationship with her child. The primacy of the child in the mother-infant relationship was significant to staff’s shared daily work, as was demonstrated in Helen and Javier’s case and the attention given to his developmental progress.
Oliveto’s Mental Health Landscape

Oliveto mother and baby psychiatric unit was a contemporary institution for the hospitalisation and treatment of mothers diagnosed with mental illness and their babies. This psychiatric unit had two functions: as a space where women could receive psychiatric treatment while their child(ren) remained with them, and also as a space where new knowledge about maternal mental illness and its association with the mother’s relationship with her child was developed and taught in an Australian context. The languages and techniques used within Oliveto at the time of this fieldwork can be historically traced to political and social changes and concerns. These will be briefly illustrated to give context to the underlying beliefs and practices in Oliveto’s contemporary psychiatric practice (Miller & Rose 1988).

Australia’s mental health system developed primarily through its relationship with England. Recognising this relationship is particularly important for this thesis, as this is where many of the ideas promoted in Oliveto find their origin. Following closely the English mental health system, Australia also built psychiatric asylums throughout the new settlement in the early 1800s, to accommodate the growing number of men and women declared as ‘lunatics’. The first lunatic asylum in the Australian state where this research was conducted was opened in 1852 (Australia’s third), followed several years later by what is known today as Hopton Hospital in 1870 (Singh et al. 2012:71). Oliveto mother and baby unit (MBU), the focus of this ethnography, was situated on the grounds of the same Hopton Hospital. Evidence of Hopton Hospital’s history was still visible throughout the
hospital grounds, with a variety of stately historic nineteenth century buildings remaining, and a smattering of additional twentieth century buildings.

Australia’s original lunatic asylums imported both their architecture and their treatment system, referred to as ‘moral treatment’, from England (Meadows et al. 2012:71; Piddock 2004). Moral treatment meant that the patient was rarely physically restrained; instead patients were housed in a built environment that was thought to manage the patient and bring about a cure. This environment had what was discussed at the time as key features of: classification and separation of illness categories, kindness towards patients, religious support, a clean environment, designated areas for exercise and activity to occupy the mind (Piddock 2007; Singh et al. 2012:71). The concept of moral treatment placed emphasis on moral values and humane care, however, with the increase of patient numbers, particularly those considered chronic, a custodial approach often overrode moral ideals (Meadows et al. 2012:71). The design of these buildings therefore, was such that patients, once classified by their psychiatric diagnosis, could be segregated according to their illness category and were visible for constant surveillance by hospital staff. The original Hopton Hospital did not have a MBU; in fact, there was no unit at all for women. The first women’s wards were opened in 1880 when mental health patients with a variety of diagnoses were housed in the same building, without the separation and classification of diagnoses that are evident in modern day psychiatric facilities (Piddock 2004:174). Significantly, the role of women as mothers was not acknowledged in the spaces provided in the State’s asylums, with no accommodation for nurseries, or sleeping facilities for children in the room of parents. Similarly, both men and women in
Australian asylums were denied their role as family members by the apparent lack of visiting rooms for family and friends (Meadows et al. 2012).

In the early 1900s, psychiatric practice only treated psychotic disorders. The psychiatric perspective of these pathologies assumed an organic cause, and thus those affected received physical treatments (Pilgrim & Rogers 2005:141). The treatment of psychological disturbances or non-psychotic disorders did not occur until the early decades of the twentieth century. At this time a new conceptual framework was beginning to emerge for the treatment of minor (in relation to psychotic illness) disorders in children and adults. In England, a number of ‘clinics’ (most notably The Tavistock Square Clinic) were established independently from the asylum for treatment of these minor mental health problems (Miller & Rose 1988:176): minor mental disorders were viewed as disorders of the ‘nervous system’ as opposed to the organic aetiologies of psychiatric illness that were dominant at the time (Rose 1986:46). This new conceptual framework came to be known as the ‘new psychology’, whereby mental pathologies were no longer viewed as organic, but as ‘functional’, that is, a condition not related to brain pathology but psychological dysfunction (Rose 2007:189). Minor disorders were classified in terms of ‘adjustment’ and ‘maladjustment’ (Miller & Rose 1988:176). With this, ‘[t]he boundary between normality and pathology was now blurred — each was the possible outcome of the same fundamental processes’ (Miller & Rose 1988:177). The treatment for minor disturbances was based loosely in psychodynamic principals and was practiced predominantly by those outside of the psychiatric profession (Miller & Rose 1988:176). Within this model, the individual’s unconscious ‘instincts’, believed to be moulded by their early
childhood experiences within the family, were thought to control pathological behaviour. Furthermore it was believed that early treatment of these disorders could prevent the manifestation of problems (ranging from insanity to criminality) later in the individual's life (ibid).

Childrearing then became therapeutically significant, not only for understanding illness causation, but also in the implementation of preventative measures. The assumption that early intervention could prevent maladjustment in children drove the public health strategies of the mental health hygiene movement in the 1920s and 1930s (Miller & Rose 1988:177; Rose 1986:47; Rose 1985). In this socio-political context, the mother's role in the household and her childrearing became central; mothers were compelled to raise their children in a manner that adhered to the advice of experts as a means of seeking desirable social and personal fulfilment (Miller & Rose 1988:177 -178). John Bowlby (1944, 1965) and Donald Winnicott (1955), two psychoanalytic theorists whose work featured significantly in Oliveto’s contemporary therapeutic practices, ‘drew heavily upon their early experiences in child guidance and mental hygiene in their writings and talks on child rearing and its vicissitudes’ (Miller & Rose 1988:178) (See Chapters Five and Seven for more detailed discussion about Bowlby’s and Winnicott’s work).

War time brought about significant changes in psychiatric practice; particularly with the emergence of ‘shell-shock’ after World War One, that could not be clearly defined by organic theories. At this time, psychiatry was becoming more eclectic, however there was still a discernible difference in treatments depending on the symptoms displayed: neurosis was being treated psychoanalytically and psychotic illness was being treated with physical means (Pilgrim & Rogers 2005:142).
Psychiatric asylums then became reserved for those who had psychiatric conditions that were considered organic or beyond hope (Rose 1986:50).

Before the 1960s, psychiatry in Australia was practised predominantly in an institutional setting, however, the anti-psychiatry movement taking place in Europe and the United States of America (see Chapter Four for a full discussion), placed greater emphasis community treatment and psychosocial intervention in Australian mental health services (Ash 2001:136). As a result, a number of Community Mental Health Centres were established along with supported accommodation in the community for people with mental illness. At this time the introduction of inpatient psychiatric units, where patients were housed and treated, also began at a number of the general hospitals throughout the state, thereby alleviating the demand on beds in psychiatric hospitals. Medical staff training programs were also significantly improved and a greater emphasis was placed on multidisciplinary teams (ibid). The number of beds in psychiatric hospitals began to decline in the 1970s as patient treatment focused more on rehabilitation and preparation of patients for community living (ibid). In a significant restructuring of the mental health system referred to as ‘deinstitutionalisation’, mental health services also began to include the provision of community support and outpatient programs for mentally ill patients after they had been discharged from hospital (ibid). Rose argues that the de-institutionalisation movement created a ‘proliferation of sites for the practice of psychiatry’ and therefore a ‘psychiatrization of new problems and the differentiation of the psychiatric population’ (1986:83 author’s emphasis removed). In the 1980s a process referred to as ‘diagnostic streaming’ meant that
specialised services were developed for different groups of patients, along with the further development of inpatient and community services (Ash 2001:137).

Around the same time (1960s and 1970s) the Women’s Health movement began to question the sexist practices in women’s health care (Munch 2006:17). Throughout biomedical history, a woman’s reproductive body had been thought to predispose her to madness, with her reproductive organs viewed as the source of problems related to psyche and physical well-being (Ussher 2011:18). It was after the Women’s Health Movement that the State’s first psychiatric unit for the treatment of women with postpartum disorders and their families was opened.

History of Mother & Baby Units

It has only been since 1981 that women in Australia have been receiving specialised psychiatric treatment that allowed them to be hospitalised with their children. Australian psychiatric hospitals started this practice several years after it was first trialled in hospitals in the United Kingdom. Before this time, women with mental illness were removed from their children and in some cases were even cut off from contact with their children completely (Main 1958:845). Up until the late 1950s, it was commonly thought that children (especially young children) should not bother their mother (whether she wanted to see them or not) if she was ill. It was also thought that children were too noisy and disturbed other patients.

However, there were counter arguments to the separation of mothers and children. During the mental hygiene movement of the early 1900s where the emphasis on correct childrearing was given prominence for the prevention of future mental pathologies in children, paediatricians began raising suggestions
that separating the child from its mother could be problematic. In response to this, Sir James Spence founded the first babies’ Hospital in the United Kingdom in 1925 which allowed mothers to stay in hospital and help nurse their child back to health (Howard 2000; Main 1958). Spence believed there were ‘twin dangers’ in separating mother and child ‘first and more obvious to the child’s physical and emotional health, and second...to the mother’s confidence in her future capacities’ (Main 1958:845). During the 1940s and 1950s, influenced by beliefs espoused by Spence, René Spitz (1945), Anna Freud and John Bowlby (1965) concerning the significance of the mother-child relationship to child well-being, the rationale about this dyadic relationship began to change. These ideas also began to filter into the treatment of maternal mental health.

In 1948 under the direction of T.F. Main, the first child was admitted into Cassel Hospital (UK) with its mentally ill mother (Howard 2000; Main 1958). This first mother and baby psychiatric admission came about after a mother requested to have her child with her as there was no one else to care for it (Main 1958:845). Main commented at the time: ‘Just as it seemed important to keep a man patient in touch with his job and to treat him for the difficulties he might meet there, so it seemed important that a mother should be in touch with her job, and the children who were part of it’ (ibid). His comment reflected the growing cultural belief at that time, that children must have one devoted caretaker who was ideally the biological mother.

Establishment of Mother-Baby Units in Australia

Within this sociocultural environment, the first MBU was established in Australia in 1981, followed soon after by what is known here as Oliveto in 1983 (Buist et al.
There are no formal records about the foundations of the state’s first Mother and Baby Unit, however when enquiring about its origins, I was told that a nurse conducting electroconvulsive therapy (ETC) at Hopton Hospital on women with postpartum disorders, recognised that these women had no facility to be able to care for their children while receiving treatment. As a result, Hopton Hospital opened their first family unit\(^{18}\) which allowed for joint admission of mothers with their child(ren) (up to the age of five).\(^{19}\) As the demand for the services that the family unit offered increased, so too did the need for a bigger premise. With this change, the family unit was able to expand its services from four-beds with a lounge and small play area to the six-bed facility that it was at the time of this research. It was also at this time that the unit was given the name *Oliveto*.

At that time, restructuring within the mental health services of the State left the unit in a position of uncertainty. Although located on the grounds of a psychiatric hospital assisting adult mental health, this MBU also admitted and provided treatment for babies. Oliveto’s management was given the choice of whether the psychiatric treatment facility would belong to the parent body for adult healthcare, or with the service which provided public health care for women and children of the state (HWC). It was decided that Oliveto should remain on the adult mental health hospital grounds but become part of the mental health division for the State’s women’s and children’s health care service. With this change also came further changes that established Oliveto as the unit that it was at the time of this research.

\(^{18}\) Although named a ‘family unit’, the majority of admissions were mothers and their babies.

\(^{19}\) The age range of children admitted changed from birth to five years to birth to three years with the establishment of the new Mother and Baby Unit.
research. It was decided that a name was needed that reflected the therapeutic focus of the unit. After much discussion, the name Oliveto was chosen in memory of Louise Oliveto\(^2\) an influential female doctor and a pioneer in women’s and children’s health. It was thought that naming the unit after a woman, particularly one who had contributed so greatly to women’s and children’s health was an appropriate choice.

Oliveto’s Mother & Baby Admissions

As Oliveto was only a six-bed psychiatric unit at the time of fieldwork, waiting lists for admissions were long. Patient admissions were sometimes discussed by the multidisciplinary team, however, the Consulting Psychiatrist made final decisions on the priority of admissions including preferences of who could be admitted first, if at all. Once referred, admissions were organised into three categories: a) psychotic or severe mental illness, especially when they were younger babies b) mothers with less severe mental illnesses (such as depression and anxiety) along with psychosocial problems (for example domestic violence, drug addiction, financial difficulties and such) and usually slightly older babies and toddlers and c) admissions that were for parenting assessments which had been requested by the State for mothers who had pre-existing mental illnesses and had had their child(ren) placed in the temporary care custody of another carer. These women often had chronic problems but their situations were not considered acute, so were given the lowest priority on the waiting list.

\(^2\) The Louise Oliveto is a pseudonym, however, the circumstances behind why the name Oliveto was chosen still remain the same.
The classification of patients’ admissions reflected the cultural assumption that the maternal-infant relationship is most critical in the early stages of life. Admissions with young infants were given preference, particularly if the mother was still breastfeeding. Biomedical beliefs concerning breastfeeding recommend it as the best form of child nutrition. Oliveto’s governing body (HWC) also advocated continual breastfeeding for infants up to the age of two whenever possible. Apart from the nutritional benefits found in breast-milk, the act of breastfeeding was also understood as a significant facilitator for the establishment of the mother-infant relationship or bond, an underlying assumption central to Oliveto’s therapeutic practices. The psychiatric unit offered a service for these mothers and their child(ren) with the possibility for admission of further family members or support people when deemed necessary.

The average age of women admitted into Oliveto was 29 years. A large majority of the mothers were of Anglo-Saxon appearance and represented a working class or lower socio-economic demographic. Almost all women (97%) identified as being born in Australia. These statistic are based on information generated by Oliveto in 2009. Nearly half (48%) of the admissions during this time identified as being married or defacto.

Women as Mothers

A precondition for all admissions into Oliveto was that the person admitted with a mental illness, must be admitted with their infant (zero-six months), baby (six to eighteen months), or toddler (up to the age of three). There was some flexibility with the age range of child being admitted, depending on the particular circumstances of the patient.

21 These statistic are based on information generated by Oliveto in 2009.
22 There was some flexibility with the age range of child being admitted, depending on the particular circumstances of the patient.
were the primary caregiver—in all instances throughout the time of my fieldwork this was the biological mother. Oliveto admissions were reflective of the widespread cultural assumption in Australia that mothers are best suited to provide primary care for an infant, baby or young child. The beliefs surrounding the maternal roles of women in Oliveto’s context cannot be understood in isolation from the social and cultural contexts that have informed them. The assumption that because women give birth, and their bodies produce the most suitable (and highly favoured) nutrition for feeding an infant, then the ‘natural’ and most obvious choice for providing care in the early years is the biological mother.

Current childrearing configurations in Australia are characterised as ‘an exclusive, one-to-one relationship within patriarchal public and familial contexts’ (Barlow 2004:515). The practice of exclusive one-to-one mothering in Australia is considered the norm, and is promoted as the most ideal situation for raising emotionally healthy children. In Australia, the nuclear family is considered a ‘natural’ family—husband, wife and children with the (usually biological) mother taking primary responsibility for the physical and emotional care through nurturing children while the father assumes the role of provider (Seymour 2004:540). Although there are many families who do not conform to this model, it is considered the norm; anything outside of this is considered a deviation. Oliveto’s daily therapeutic work reflected and reproduced these norms by focussing on the mother-infant relationship above all others.

In the Oliveto context, the mother-infant relationship was highly revered. Although fathers were considered, their involvement was generally cursory to the role of the mother (Walzer 1996). The assumption that the mother-child relationship is the
most significant relationship in an individual’s life is a reflection of cultural values that uphold individualistic ideals. The mother-child relationship as it was constructed and reproduced in Oliveto, promotes the notion that infants form an intense, dependant relationship with primarily one other individual, namely its mother. The child’s needs are given primacy in this dyadic relationship, while the mother is assumed to want to devote herself to her helpless infant because of her natural and instinctual love for them.

Naturalist assumptions about the role of women as mothers have dominated Western beliefs, values and practices around child rearing and child care since the nineteenth century. During the Industrial Revolution women were separated from the public work sphere into the private sphere of the home and the specialised occupation known as 'motherhood' (Büskens 2001; Smart 1996). The shift of women into the private sphere of the household also isolated women from social support networks and external involvement in childrearing practices making child care the exclusive role of mothers. By the end of the nineteenth century, public health measures were put in place to improve the care of children in working class homes; mothers were the primary focus of this public health education (Davin 1978; Smart 1996). Women were advised on the best ways to manage their children and given advice from ‘experts’ (often men) outside of the family context. Recognition of the changes in child care practices demonstrate that mothering is in fact not ‘natural’ but deeply influenced by culture, including the social, economic and political conditions that shape that culture. The rules guiding ‘good’ and ‘bad’ mothering were (and still are) set by expert recommendations that become fixed into policies (for example best feeding practices) and have changed over time.
The ideas of 'experts' set the standards by which 'good' and 'bad' mothering was, and continues to be, judged.

The influences of biomedical reasoning and psychological theorising into the domain of parenting and the dyadic mother-infant relationship, are fundamental to the concept of exclusive biological mothering (Barlow & Chapin 2010:326). More specifically, the assumptions made about appropriate maternal roles and 'good' mothering practice derive from theories developed in the psychological paradigm. These assumptions will be explored further throughout the thesis.

What about Male Parents?

During the fieldwork period, fathers were only ever admitted as 'boarders' (for example, the mother was admitted for her mental health and the father was there to support her). Women's partners were only allowed to room-in with them if the multidisciplinary team agreed it was the best decision for the therapeutic environment. The appropriateness of male boarders was determined by the stability and supportiveness of the relationship between the women and her partner and the receptiveness of other female patients to having a male in the unit at the time. Oliveto staff explained that if a partner was believed to exacerbate the patient's mental health condition, or hinder her progress in treatment, he would be asked not to board in the unit. In many cases, having men in Oliveto was also thought to be disruptive to the therapeutic environment for women, particularly because many women had experienced domestic violence, physical or sexual assault by a male perpetrator and, it was argued, having men in the unit made them uncomfortable. When justifying why men should not stay in the unit, several members of Oliveto's staff referred to Oliveto as a therapeutic environment that
need to be a space where female patients could feel ‘safe’, ‘secure’, ‘comfortable’ and ‘at home’. Interestingly, the language used to describe Oliveto’s therapeutic milieu in many ways echoed the language staff used when describing the ideal mother-infant relationship as described within an attachment framework (see Chapter Six for a more detailed discussion).

Men were notably absent in the Oliveto context. Fathers of the babies in the unit were either not a regular presence in the woman and child’s life (there were several single or unsupported mothers), or the fathers were working and fulfilling the traditional gendered role recognised in Australian society of providing financially for the family unit. They were therefore unable to spend a great deal of time with their partner and child in the unit. In only a handful of cases, fathers stayed in the unit with their partner and child. Fathers more commonly spent time in the unit at weekends, or after their working day was complete. These visits were generally only brief (one to three hours) and the time spent with the child was comparatively less than what was expected from the mother. When a father visited after work, it was often to share a meal with the family, or spend some time together before the mother and child went to sleep. Weekend visits however were lengthier, as the absence of work commitments permitted them to stay longer. On Sundays, Oliveto would provide a barbecue lunch for inpatients and their family or visitors. This was generally a popular day for the people in Oliveto, as the therapeutic environment was more relaxed; there were (usually) no psychiatrists or allied health workers in the unit at this time, only mental health nurses. The one male nurse that was employed by Oliveto often worked on Sundays and enjoyed being responsible for cooking the weekly barbecue. Several staff also referred to
this day as an opportunity for the male nurse to talk with fathers about their relationships with their child and the child’s mother (not always their partner), in a setting that was less formal and therefore less intimidating. It also worked to reinforce stereotypical Australian roles of masculinity.

During my fieldwork experience, the occurrence of men boarding with their partners only happened three times. There were two bedrooms with double beds, which facilitated this. Only two of these partners were involved in my research, interestingly both of these men were in the unit at the same time. The two men who were research informants were never formally diagnosed with a mental illness by Oliveto staff, nor did they receive any individualised treatment, however they were involved in couples and family therapies. Surprisingly though, despite not formally diagnosed or treated while in Oliveto, both of these fathers were spoken about by staff as having mental health problems. However, staff concerns about their mental health condition impacting on the child’s development were not given as much focus as the influence of the mothers’ mental health. There were several other fathers of the children admitted into Oliveto that were referred to as having mental health diagnoses, problems with anger or substance abuse (both legal and illicit). Although treatment options were occasionally offered, their admission into a psychiatric unit along with their child was never suggested. The risk to the child through the father-infant relationship was not ever given the same priority as the mother’s relationship. In biomedical terms, both biological parents contribute equal amounts of genetic material in the production of a human child, however in Oliveto, the father’s contribution was seemingly less important once the child is born. This was one of the many contradictions at play in Oliveto’s
psychiatric space, centred on the underlying assumption that women as mothers were primarily liable for any potential threat to their child’s psychological well-being.

In Oliveto, postnatal mental illness was ethnographically observed to be treated primarily as a biological illness: following a medical model for diagnosis and treatment, and made further evident through the use of pharmaceutical treatments (discussed in more detail in Chapter Four). Following this logic, should the child’s biological father not equally be considered a threat to the child’s well-being? This contradiction in Oliveto treatment approach remained relatively unquestioned by research informants, whether staff or patients, as a taken for granted practice. The underlying logic that facilitates this was complex and is explored throughout this thesis.

So, why was the absence of men, in particular fathers but also male staff, so notable in Oliveto? I repeatedly struggled with this question, as did my research informants when asked. Many of the responses given were that an infant needs to be with its mother, or mothers are the ones who look after kids, or looking after babies is ‘women’s work’. I began my fieldwork with the same taken for granted assumption that men would not be admitted into a unit of this description because they were not mothers and had not recently given birth to a child. At the time, I also believed that as biological mothers, the women admitted into Oliveto were remaining with their child as they were best suited to provide care for their infant in the early months of life, particularly if they were breastfeeding. However, it soon became apparent that breastfeeding was not given as much primacy in Oliveto’s context as managing the symptoms of the mother’s mental illness (more often than
not with psychopharmaceutical treatments) and building her attachment
relationship with her child. If there was no immediate functional reason why the
mother and child should remain together, then why did this practice still occur?
Why weren't these women admitted into a psychiatric unit to receive
individualised treatment while their child was cared for by another person, for
example the child's biological father? Or why wasn't the family admitted as a
whole?

As an individual living in a society dominated by biomedical reasoning, and where
societal norms positioned mothers as primary caregivers, I also shared the
assumptions about the social role of women as mothers as my fieldsite informants.
To me, it made complete sense for an infant or young child to remain with its
mother while she received medical care because I also believed that a young child
needed its mother to care for it. For this reason, the dual admission of mothers and
babies for me was a taken for granted assumption that was challenging to
overcome. The questions to ask were not only “Where were the men?” in this
context, but more importantly, “Why do women, (and not men) receive psychiatric
treatment with their children?” The social construction of women in Australian
society, with the influence of science promoting a biological basis to the gendered
division of parenting is pervasive. This thinking particularly extended to the
Oliveto context where the mother-infant relationship was the focus of therapeutic
practices.

Social Construction of Fathers

During my time in the field, the observed involvement that fathers had with their
children and the child's mother corresponded with biomedical constructions of
fatherhood recognised in academic literature. In many Western contexts a father's involvement in childrearing has often been limited in relation to a mother's involvement with her child (Lamb 1987; Lamb 2000). The amount of parental involvement has also been believed to equate to the extent of influence that the parent has in the child's life and developmental well-being (Lamb 1987). Cultures in industrialised nations have seen shifts in this in recent years, with paternal involvement sometimes approaching similar time investments as mothers, however for the majority of circumstances, women remain the primary caregivers (Bornstein 2002). The changes in father involvement have altered in emphasis over time, from moral guidance (in the colonial period), to sex-role modelling in the mid-twentieth century, and in more recent years marital support, and finally, nurturance (Hewlett 2000; Marsiglio et al. 2000; Winnicott 1987b). Throughout history, the main motif for father involvement has been the role of provider (Lamb 2000:23), with a strong focus on men's responsibility in providing the family's income or 'breadwinning' (Marsiglio & Cohan 2000:80) whether they reside within or external to the family home (Hewlett 2000). It is through a man's provision of economic support that he has been constructed as contributing to his child's growth and development, as financial support predominantly helps facilitate good nutrition, health, better academic achievement and school retention rates, and improved emotional health and behaviour in children (Marsiglio et al. 2000:1182). The father's role as 'provider' has become a hallmark of responsible fathering (Lamb 2000:25). 'Men's ability to provide materially for their children is related in complex ways to [the] fathers' level and type of involvement with their children as well as their influence on them' (Marsiglio & Cohan 2000:78).
As first noted by Mead (1949), fathering roles are socially constructed, made evident through the varieties of practices and expectations in relation to paternal behaviour and involvement around the globe. The diverse range of fathering practices is too large to explore here, however, the anthropological examples I have chosen aim to demonstrate this variability. Fathering practices are generally assessed by the involvement that the father has with his child. Across cultures this can range from no or minimal involvement, to active engagement in the child’s everyday childrearing. Paternal involvement can be dependent on the father’s ability to be close to his children. ‘In large parts of the world, males are absent from the household for lengthy periods herding livestock, fulfilling military service or earning money as migrant workers’ (Lancy 2008:137). Other factors that influence paternal involvement include: gendered living arrangements as observed in parts of Papua New Guinea (Lancy 2008:136) or fathers who live distantly from their wives and children, and therefore have very little contact with them as observed in southern India (Menon 2001:354). Although some fathers may live with their children, the level of parental involvement can still be minimal. An example of this is seen among the Bofi, a group of Central African farmers, who spent most of their time in the village, and were rarely involved in the care of their children (Fouts 2005:358). In other parts of the world, prohibitions and taboos around father's involvement in childbirth and early postpartum contact prevent early paternal contact with children (see for example Gegeo & Watson-Gegeo 1985; Harkness & Super 1991; Thompson 1940). While in traditional patriarchal Chinese and Muslim societies and others, biological fatherhood denotes ownership of the child (Lancy 2008:140). In these instances, mothers are viewed as ‘incubators’, as opposed to caretakers for their children. After the child is born,
fathers have the right to remove the child and place him/her with his family (Fernea 1991:450).

Of the anthropological examples on fatherhood, perhaps the most heavily discussed example is Hewlett’s (1991) study of the Aka pygmies in Africa. Aka fathers have been described as playing a critical role in their child’s growth, a phenomena Hewlett (1991) attributed to ‘a community ethos of gender equity’ (Lancy 2008:140), particularly in relation to the local practice of net-hunting. According to Hewlett, fathers of Aka pygmies are ‘active infant caregivers when they are not engaged in economic activity and the mother could use some assistance’ (Hewlett 1992:159). Despite this example, anthropological literature demonstrates that childrearing and parenting practices remain overwhelmingly in the female domain and are highly influenced by socio-cultural as well as economic, political and environmental factors. ‘While ethnographers of the !Kung, Hadza and Ache among others, note the occasional direct involvement in childcare by men, there is greater evidence of indirect care or provisioning’ (Lancy 2008:140). When fathers are involved, a consistent theme in anthropological literature is of the disciplinarian or authoritarian role that fathers play in a child’s upbringing (Davis & Davis 1989; Harris 2006; Howard 1970; Kagitcibasi & Sunar 1992). Overall, paternal involvement in childrearing is demonstrated to be minor in comparison to female involvement (Lancy 2008). Oliveto admission and treatment policies reflect gender-based assumptions about the appropriate roles of mothers and fathers in childrearing. It was for this reason that the admission of mothers, and not fathers, with their children into Oliveto was rarely questioned.
Admission Criteria

To be eligible for admission, mothers had to be deemed as ‘suitable’ to receive treatment. A diagnosis of acute to severe mental illness was necessary and the woman was usually in a state of ‘crisis’ when she was admitted. Oliveto’s consulting psychiatrist explained to me that when patients were sent to Oliveto they were generally in the worst mental health condition that they could be in and for this reason were more receptive to treatment. The high demand for admission into Oliveto meant that the patients that were admitted were usually the most severe. The unit did not have the space or resources to deal with patients who were not in extreme need of help. The mother’s relationship with her child was also an important criterion for admission. Assessing the needs of the child in the context of his or her relationship with its mother and the risk of harm were of high importance.

Staff at Oliveto explained that there was a period of time after women were admitted that they began to see their time there as ‘respite’. They started to take advantage of the possibility of staff looking after their child; they would relax and let staff take responsibility for their child’s care. This practice was discouraged in Oliveto and mothers were expected to provide care whenever possible. For the same reasons, a woman who was diagnosed with postnatal depression (PND) but who appeared to be coping at home was rarely granted admission. Instead they were offered one of the services that Oliveto provided.23 Similarly, if patients had been in Oliveto for a period of time deemed too long by the staff, they were

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23 It was explained to me by one of Oliveto’s staff, that many years ago, the majority of patients admitted into Oliveto were PND sufferers; however the types of admissions throughout the years have changed. As education and knowledge around PND has grown, support for their condition could be sought from the wide range of services available in the community.
required to leave. The majority of staff felt that it was important to encourage mothers to go home and try to parent on their own. Most patients were given weekend leave as a ‘trial’, before they were sent home more permanently to care for their child on their own. Weekend leave was believed to give patients the confidence to experience caring for their child without the support of staff: if they coped well and wanted to be discharged then they were, but if they felt they needed more time, this could also be negotiated with psychiatric staff. Ultimately, it was the staff at Oliveto who made the final decision. If a patient wanted to be discharged and made efforts to leave, and staff at Oliveto felt strongly that this was not in the best interest of the mother and/or child, a detention order could be made. While for the most part the negotiated discharge system worked well, it became slightly more problematic for patients diagnosed with borderline personality disorder (BPD) (see Chapter Eight for a detailed discussion). The majority of patients admitted into Oliveto were voluntary patients, except in cases where a medical practitioner deemed the mother’s mental health condition was so severe that the mother and/or child’s health or safety was at risk. In these circumstances the detaining psychiatrist would discuss options with the patient and if they did not display an ‘awareness’ or ‘insight’ about the risk to themselves or their child, they would be detained under the Mental Health Act.

Patients could also be considered too unwell for admission. If their mental health state was so severe that they were not able to function at a level where they could provide any care for their child, or if their behaviour was viewed as so ‘erratic’ (for example inpatients who were psychotic) that it would disrupt the treatment of other patients, an alternative mental health service was identified. In addition to
this, there were also admissions that were not primarily facilitated through a psychiatric diagnosis for hospitalised treatment. During my fieldwork there were a few mothers admitted for what was referred to as ‘parenting assessments’. These mothers admitted for parenting assessments did not necessarily display symptoms of mental illness at the time, however, through a previous psychiatric admission, their child had temporarily been removed from their care. Parenting assessment admissions were an opportunity for these mothers to demonstrate through the observation and surveillance of the interactions with her child, that she was capable of providing a home environment where the child would not be considered at risk—thereby facilitating the child’s return to her care. In this context, being a biological mother was not enough to give her the role as primary caregiver for her child. Through Oliveto’s parenting assessments, mothers were expected to achieve biomedical yardsticks of identified ‘good mothering’ to be able to leave the facility with custody of their child (see Chapter Seven for a detailed discussion on Oliveto’s construction of ‘good-enough’ mothers). If these were not able to be achieved according to Oliveto staff and external child protection service’s standards, the child would be placed with another carer(s).

Oliveto was an acute psychiatric ward so the principal function of the unit, and funding provided, was to deal with patients ‘in crisis’. The average length of stay for patients was three weeks (this of course varied depending of the severity of the patient’s illness). Within that time, the team worked out a management plan to

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24 According to staff informants, crisis was used to refer to the severity of a woman’s mental health state when it had reached a point where she was no longer able to function in daily activity with her child without medical intervention. Patient informants never used this term with me; instead they said they were ‘not coping’ at home without help.
stabilise\textsuperscript{25} the patient’s mental health situation, while also nurturing the relationship between the mother and child. Before a patient and her child were discharged, a discharge plan was devised so that the client could be discharged back into their community with what they believed to be the most appropriate care. Each member of the multidisciplinary team brought specialised skills and individual personalities, imbued with their own attachment histories to the team. The therapeutic service that each patient received was tailored to suit individual needs. For the multidisciplinary team, a patient’s history, particularly their childhood and their attachment to their own primary caregiver, were of utmost importance.

\textbf{Becoming a Psychiatric Case: Helen & Javier}

Members of Oliveto’s multidisciplinary team would meet daily to discuss the progress of patients and discuss details of each case at handover meetings and more formally in ward rounds (held once a week). In a ward round meeting that discussed Helen’s case, Helen was described as \textit{needy}, \textit{anxious}, and there were \textit{concerns of her mental health deteriorating}. There were also concerns for Javier’s mental health, particularly because members of the team believed both parents were depressed and therefore Javier was \textit{not receiving anything from either}.

Despite recognition of Javier’s father experiencing mental health problems, he was not (to my knowledge) offered any intervention from the Unit. According to biomedical beliefs, Javier was not meeting the normal expected milestones for his age and for this reason there were concerns for his developmental growth. He

\textsuperscript{25} The term stabilise was used in this biomedical context to explain treating the symptoms of psychiatric dysfunction with medication.
showed a lack of interest in the world around him and was described as a Bali baby. In Balinese culture, infants are viewed as celestial beings and are therefore treated with the utmost respect. For this reason, babies in Bali do not touch the floor for the first 210 days (or 105 days, depending on region) of life as it is considered too profane for a being of this status (DeLoache & Gottlieb 2000:105). Therefore, what I understood by the staff member’s comment was that Javier was carried for much of his early life and had not really learnt to separate and form an independence from his mother as a result — attributes highly valued in individualistic cultures such as Australia. This form of handling was considered problematic by the multidisciplinary team: constant physical contact was considered excessive and interfered with the baby’s autonomy and ability to separate from its caregiver (See Chapter Seven for ethnographic examples of alternate cultures’ childrearing practices).

Over a weekend, concerns from Oliveto staff over Javier’s development escalated; Helen’s anxiety over her son’s development began to dominate her thinking. It was ultimately decided that Javier should be sent to the Child Development Unit (CDU), another branch of the HWC service (although on a different campus), that was used to assess and treat childhood developmental issues. Javier was admitted into the CDU for an evaluation to rule out any developmental issues. I was not there at that time, however, I was told that the decision to send Javier to the unit divided staff. Some of the team felt that an evaluation of his development was important for his future, while other staff members felt that sending Javier to the CDU was the wrong decision for two reasons. First, they did not see his behaviour as necessarily a developmental problem, but rather a problem of poor attachment to
his mother. In addition to this, his stay at the CDU would mean Javier would be separated from his mother and perpetuate what was recognised by some as an attachment problem even further. In addition to concerns over Javier's development, Helen and Javier were also involved in Mother Infant Therapy to address perceived difficulties in the mother-infant relationship (discussed in detail in Chapter Six). Although Helen had entered the unit to address her own personal mental health concerns, Oliveto's team also believed that Javier had problems as a result of his relationship with his mother that needed addressing. Although his father was described as also being depressed, he was never discussed in relation to his son's perceived developmental delays.

The way that Helen and her son Javier were constructed as a psychiatric case and the ways in which they were treated in Oliveto, highlighted a number of themes that will be explored throughout this thesis. Helen’s diagnosis of postnatal depression appeared relatively unproblematic, however in Oliveto’s context (and in the wider biomedical community), the inherent risk to Helen’s son through their poor attachment relationship justified a psychiatric admission and treatment. It was also through Helen’s diagnosis of postnatal depression that her admission was primarily facilitated. The process of giving diagnoses, and how these are then received, understood and in some instances challenged, is dealt with in Chapter Four which considers diagnosis as a significant part of Oliveto’s contemporary psychiatric discourse. Helen’s relationship to Javier was understood as problematic in terms of her attachment to him. Attachment, as a psychological construct, biomedically defines how a mother should love her child. The theory of attachment is explored in detail in Chapter Five, highlighting the dyadic between a
mother and child, and the sometimes contradictory cultural belief that the two should be intensely attached and yet also separate. In Chapter Six, I analyse how the focus on infant mental health is used as a prevention template for treatment in Oliveto. Though the psychotherapeutic tool the Circle of Security, attachment principles were used to identify difficulties in the mother's attachment relationship to her child. Drawing on fieldnotes from Helen and Javier's mother-infant therapy sessions, I analyse the use of the Circle of Security template to explore the influence of a mother's own early attachment relationship with her primary caregiver on subsequent attachment relationships.

In the following chapter I describe the roles of Oliveto's multidisciplinary team in shaping the subjectivities of women admitted in this mother-infant psychiatric unit, a critical step in analysis this context. Through a Foucauldian lens, the everyday practices that occurred in the Oliveto space are considered analytically as operating through 'psy' disciplinary knowledges: namely Psychiatry and the psychological construct of Attachment Theory. The chapter ethnographically explores the power relationships among staff through the concept of medical dominance, and between staff and patients particularly in terms of surveillance.
I sat with Emma in the dining area as she began eating her lunch of fish fingers and vegetables. Her four-month-old infant Jack was placed in a reclined high chair beside her, allowing her hands to remain free while she ate. Shortly after, her newly made friend Kate joined her. Kate also placed her daughter in an identical reclining high chair that was provided by the unit. Emma jokingly reminded Kate: You better strap Sally in... just in case there’s an earthquake!’ Bemused by this comment, I asked Emma to explain. She told me she had been warned by one of the nursing staff that she had to strap her son into the high chair at all times. Emma questioned the necessity of strapping in a four month old baby who was not able to move yet. The nurse cautioned that even if the child was not able to move, he must always be strapped in; he could not move but the ground may move if there was an earthquake. Although Emma thought this was ridiculous reasoning, she complied and strapped her son in. Kate also followed Oliveto’s rules and strapped her daughter securely into the high chair.

The women spoke quietly to each other so that others around them could not hear, but loud enough so that I was included in the conversation. Both women had been warned by staff at Oliveto about their ‘unsafe’ behaviour towards their children and had notifications made to the state’s child protection service for what staff in Oliveto had perceived as unsafe
behaviour towards their child.\textsuperscript{26} In Emma’s case, this was ultimately used to form part of a body of evidence justifying the temporary removal of her children from her care. Emma and Kate spoke about how they needed to be cautious of the things they were doing while in Oliveto because they felt they were being constantly watched by nursing staff.

This brief interaction I had with Emma and Kate signified one of the many ways women, as mothers, were made subjects of disciplinary power in Oliveto’s institutional context. Through ethnographic description, this chapter will discuss how Oliveto operated as a ‘mechanism of power’ (Foucault 1980) engaging with psychiatric knowledge and the moral discourse\textsuperscript{27} of attachment to shape the subjectivities of mothers in the psychiatric context. In particular, I focus on the various ‘technologies of power’ (Foucault 1976), that is, techniques specific to the institution used to reshape maternal subjectivities to fit within acceptable social and cultural norms of good mothering. Mothers with mental illness were intentionally admitted with their child(ren) to observe and normalise their mental health state, but also to modify maternal behaviours toward their children, training them to become what was considered socially and culturally acceptable. Through disciplinary techniques of surveillance and observation, an extensive range of events was brought into focus, ranging from the psychological to the physical: emotions, relationships (with child, partner, family and friends), nutrition (infant and mother), habits, finances and personality. This chapter will

\textsuperscript{26} In a process referred to as ‘mandatory reporting’ individuals working with children are required by law to report any incidences they feel may compromise the safety and well-being of the child.

\textsuperscript{27} I engage discourse in the Foucauldian sense, (1972) to describe what can be said, known and acted upon within specific bounded areas of social knowledge often referred to as scholarly disciplines (for human sciences example psychiatry, medicine, anthropology and so forth) (McHoul & Grace 1993:26).
explore Oliveto’s processes of governmentality (Rose, O’Malley & Valverde 2006) and the multidisciplinary teams’ involvement in disciplinary techniques.

**Governmentality**

Social institutions such as hospitals, schools and prisons, have long been an area of interest for social theorists, particularly in relation to their function as an apparatus for social regulation and management of agents within them (Armstrong 1995; Foucault 1977; Goffman 1961). Social control in these spaces has been described as operating through a complex ‘machinery of power’ that served to keep individuals’ actions within acceptable socio-cultural boundaries, defined by the historical and political agenda of that period (Foucault 1977). Foucault’s early work on the role of institutions in the late eighteenth and early nineteenth centuries (hospitals, asylums, prisons) as spaces of social control and regulation through discipline and surveillance, has been influential in the analysis of power and knowledge in sociological and anthropological literature. These works inform a ‘tradition which emphasises the importance of regulation and administration as key features of ‘modern society’’ (Turner 1997:xvii; see also Goffman 1961). As such, they can be viewed as sites which reflect or contain societal problems (Rhodes 1992:53). In his writing, Foucault discussed how the management and operation of individuals within institutions made them both objects of disciplinary knowledge and subjects of disciplinary practices (Foucault 1973a, 1973b, 1977). Foucault used the term ‘biopower’ to define the disciplining of human bodies to behave in particular ways that served to improve the health and productivity of the population.
Foucault’s work on the function of ‘discipline’ in institutional sites (Foucault 1976, 1977) offers a rich source of grounding and comparison into the analysis of power in Oliveto’s contemporary institutional setting. In his earlier work, Foucault explored the relationship between institutions and the people within the space. Tracing historical and political changes, he drew attention to how the control of societies shifted away from techniques of control involving physical punishment, to the situation in modern societies where control is exercised through dominant social discourses (Davies & Allen 2007). Through specific discourses linked to the emergence of the human and social sciences (for example medicine, psychology and psychiatry), new knowledge evolved, providing new ways for talking about and acting upon or ‘disciplining’ individuals. Norms of behaviour were created within the discourse, thereby also making it possible for the identification of deviancy in relation to these norms. From a Foucauldian perspective, knowledge produced within such disciplinary discourse can be used to regulate human conduct and therefore is inextricably related to power (Foucault 1977:27). Foucault explains: ‘...there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations’ (1977:27). His analysis of power, knowledge and discipline were an important feature in his later work on governmentality (Foucault 1991), which emphasised the management of populations through disciplinary institutions in addition to the education of citizens to regulate their own behaviour in line with disciplinary discourse in a process referred to as ‘self-governing’ (Danaher, Schirato & Webb 2000:xii).
Nikolas Rose offers a contemporary reading of Foucauldian insights, particularly in relation to the ‘psy’ disciplines. He suggests that through the ‘psy’ disciplines (psychiatry and psychology), ‘the government of human subjects has become bound up with innovations and developments... that have rendered knowable the normal and the pathological functioning of humans’ (Rose 1996:ix). As such the ‘psy’ professions could be classified as the medicalisation of social control and therefore have specific roles in the control of human behaviour (Rose 1986:44). Rose views the ‘psy’ disciplines as significant in the contemporary analysis of social regulation. Diverting from Foucauldian analyses which emphasised the subject as an ‘isolated automaton to be dominated and controlled’, psy disciplines offer individuals the freedom to enhance their own subjectivity through self-inspection and self-rectification (Rose 1990:ix-x). Psy disciplines therefore conceal their disciplinary function by providing the dominant language and ideas about the self and self-improvement, and are therefore justified in the intervention relating to human behaviour (Rose 1986:185; Rose & Miller 1992).

Throughout this chapter, I consider contemporary practices of neoliberal governmentality as they were observed ethnographically in Oliveto and the power relations that resulted. Psy knowledge played a dominant role in providing the intellectual framework and language for speaking about and acting upon maternal subjectivities in Oliveto: specifically the knowledge of psychiatry and psychology. Psychiatry provided the language for describing, classifying and treating deviant behaviour as ‘illness’, with the underlying assumption of biological dysfunction (Chapter Four). As mentioned, all women admitted into Oliveto had received a diagnosis of mental illness which required a medical practitioner to draw on their
authoritative knowledge to label the woman’s experience as a pathological. With that diagnosis each patient was classified as deviant in relation to cultural norms. The women in Oliveto were considered particularly deviant, because not only was their mental health impacting on their life functioning, but also on their child and family’s future psychological stability. The mother’s relationship with their child, understood in this biomedical context through the psychological theory of Attachment (discussed in more detail in Chapter Five), justified the dual admission into Oliveto. Therefore, both psychiatry and psychological reasoning was used to define, explain and then act upon the women admitted into Oliveto: the body of knowledge may also be referred to as Perinatal and Infant Psychiatry. The authoritative knowledge these discourses produced, determined what could be said, who had the authority to make decisions over others (based on disciplinary knowledge), and what disciplinary techniques could be applied to coerce mothers to conform to cultural norms, thereby facilitating the production of ‘good-enough’ mothers (See Chapter Seven).

In Oliveto, the overwhelming majority of mothers who were admitted went voluntarily, but did this on the recommendation and referral of a medical practitioner. The literature on governmentality (Foucault 1991), in relation to the ‘psy’ disciplines (Miller & Rose 1986, 1994; Rose 1996, 2007; Rose, O’Malley & Valverde 2006) is useful for understanding how the strategic use of language can act as a form of social control, encouraging individuals to self-regulate according to social norms. Through governmentality, individuals learn to self-regulate their behaviour in accordance with the dominant institutional discourse. Therefore, when an individual experiences unusual symptoms, it is common cultural practice
in Australia to visit a medical institution for answers. Mothers admitted into Oliveto spoke about seeking help for not only their own mental health, but also for their relationship with their child. In some cases, it was the woman’s family member who urged her to seek help from a medical practitioner, or a referral by one of the visiting midwives as part of a government home visiting scheme. These were often the first steps towards the woman being diagnosed with a mental illness, and her subsequent admission into Oliveto. Rose argues that through the ‘psy’ disciplines, not only were new languages developed for speaking about subjectivity but also new techniques for inscribing it, measuring it, acting upon it; the self was able to be calculated and managed in new ways (Rose 1990:x).

Seeking medical help was therefore a form of self-governance. These mothers treated themselves as subjects to be examined by deferring to the expert status of biomedicine and ultimately the disciplines of psychiatry and psychology (through Attachment Theory) (Miller & Rose 1994).

Since deinstitutionalisation, psychiatric institutions such as Oliveto now favour short-term admissions over long-term hospital stays. The power of the 'psy' disciplines has become diffused into the everyday through our contemporary understandings of the self — serving a self-regulating function. The analysis of the regulating function of Oliveto psychiatric unit is therefore unique in that it provides a Foucauldian analysis in a contemporary context where many of Oliveto’s patients deferred to the dominant discourse by agreeing to an admission.28 It highlights the concealed disciplinary function of 'psy' disciplines in

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28 Robert Barrett offered useful insights into the psychiatric context through his ethnography *The psychiatric team and the social definition of schizophrenia* (Barrett 1996), however his Foucauldian analysis of the institution structure did not include the insights offered by Rose, Miller and other which
the context of an institutional space. I argue that the disciplinary function of the 'psy' discourses and the new reconfiguration of self, became amplified in Oliveto’s institutional context, employing disciplinary techniques (Foucault 1977) which resulted in self-governing behaviours among many (though not all) of the women admitted who deferred to the dominant psy knowledge.

The Space of Everyday Surveillance

Foucault’s philosophical and historical writings on the function of power have been particularly useful for exploring the power dynamics in Oliveto. His interest in social control as a means to maximise the capacity of individuals through the production, regulation and representation of bodies were major themes in Foucault’s earlier historical writing (Foucault 1976, 1977). He saw power existing ‘...through disciplinary practices which produced particular individuals, institutions and cultural arrangements’ (Turner 1997:xii). Foucault stressed that power was not oppressive or unidirectional, instead arguing that power relations were diffused through a system of power expanding beyond the institutional space into society at large. He referred to Bentham’s Panopticon design as a metaphor for describing institutional spaces as a site where disciplinary power became institutionalised through their everyday mundane practices (Foucault 1977). He saw the panoptic design as a 'mechanism of power'; a space created to house deviant individuals in need of disciplinary action in order to reshape them into docile or compliant bodies (ibid). The power of the panoptic design was through surveillance. Foucault (1977) believed that disciplinary power was created

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explore the subjectivity of individuals through a new reconfiguration of self promoted through the 'psy' disciplines.
through observing others: when an individual is under constant supervision, all of their actions are recorded, and individuals within that system accept the regulation.

This chapter will demonstrate that Oliveto operated under the same principles. Mothers were coerced to achieve suitable maternal behaviours by panoptic discipline. Surveillance in this sense thus worked in two ways. Those in authority were able to observe those confined at all times, while those confined did not have the same view back. The power of this surveillance technique was such that even when individuals were not being observed, the awareness of being watched was enough to coerce individuals to reform their behaviour to fit within the expected norms of the institution, and avoid disciplinary action towards them. I observed such disciplinary power when Emma and Kate both dutifully strapped their young babies into their high chairs. Even though they both believed that the logic behind the reasoning was overcautious, they accepted that as patients admitted in Oliveto they had to surrender to disciplinary power or face disciplinary action, such as a notification to Child Protection Services. Staff therefore played a significant role in maintaining the effectiveness of surveillance techniques. As individuals working in the fields of expert knowledge that operated in Oliveto, they acted as agents of social control (see Goffman 1961) and were socialised into the role through their professional training (Becker 1961; Luhrmann 2000). In accordance with Foucault’s ideas on surveillance, awareness of their potential constant observation acted as a control mechanism; these mothers internalized a consciousness of constant surveillance.
Oliveto's Multidisciplinary Team: Agents of Social Control

Oliveto was a site of disciplinary knowledge of Perinatal and Infant Psychiatry. It was an institutional space where knowledge and power was generated through the constant observation (twenty-four hours a day, seven days a week, 365 days a year) and treatment of mothers with mental illness. Through the technology of observation and surveillance, maternal subjectivities were reshaped in accordance with Perinatal and Infant Psychiatric knowledge and beliefs.

Surveillance in Oliveto operated through its multidisciplinary team. Each profession within Oliveto’s team played a different role in the technological mechanism of disciplinary surveillance, individually contributing to the objectification of mothers as a psychiatric case through their intercommunication (see for example Barrett n.d.; White 2002). There was a distinct hierarchy in the team structure based on academic education, training and technical expertise. This hierarchy was reflected in the level of responsibility and autonomy in decision making around patient treatment, however not in their direct physical contact and length of time with patients (Willis 2006). Psychiatrists were at the top of the hierarchy and in the greatest position to make decisions about patients’ treatment, yet generally had very little direct contact with patients. They relied on the surveillance and monitoring of normalisation from those lower in the hierarchy (particularly nursing staff, allied health, and even kitchen staff) to inform them of what these other staff had observed about patients and their interactions with others, and particularly with their infants. Staff members who had recognised training in ‘psy’ disciplinary knowledge, had more power to wield within the system.
Loosely defined, panoptic practices were enabled through the use of Oliveto's space. It was organised in such a way that patients were rarely out of staff's view, except in their bedrooms. Patients in Oliveto spent the majority of their time in the dining and lounge/play areas. As a common area of the unit, it was a popular space for patients to inhabit because it provided them with a number of activities such as crafts, reading magazines, and talking with other patients and staff members. Such a phenomenon is recognised also by Due, Connellan and Riggs (2012:297) in their study of a psychiatric unit.

In Oliveto the dining area was the first space encountered when entering the building. With glass windows looking out (and in), this room also adjoined a kitchen area for cooking and preparing infant formula and sterilising bottles and breast pumps. The kitchen was separated from the dining area by glass windows and a childproof door used to keep children out of harm's way. On the opposite side was a walk-through lounge area where mothers would often sit to feed their children or watch them as they played on the floor or in bouncing chairs. Immediately next to this was the nurses' station attached to a structured play pen that was constructed into the space.

Mental health nursing staff had a strong and visible presence in the common space of Oliveto. During my ethnographic fieldwork, there were sixteen mental health nurses, many of whom had worked there for a long time. All of the nursing staff were women, apart from one man, who played an important role in staff dynamics and as a role model and confidant for male visitors to the unit. For the majority of
my fieldwork, he was also the only male staff member. Nurses worked closely with mothers and infants in Oliveto with one staff member allocated to two patients (and their children) per shift. Nursing staff worked ‘at the coalface’, interacting with patients and assisting them in a number of ways. Surveillance, more commonly referred to as ‘observation’ in nursing, has been described as an important function of the profession (Holmes 2001:8; see for example Benner 1984; Nightingale 1980). Their primary concern was to observe and report on the stability of the mother’s mental health condition, and to ensure that the safety of the child was maintained through the instruction of biomedically and culturally informed mothering and childrearing practices (referred to as mothercraft in Oliveto: see Chapter Seven for discussion). As such, mental health nurses acted as both models and advocates for normative mothering. As individuals who had not had their behaviour pathologised within the context of the unit, nursing staff were granted the authority to survey and discipline women who had been pathologised.

The close proximity of nursing staff to the day-to-day interactions of patients meant they were at the forefront of observational surveillance. Each nurse differed in their interaction with patients: some took a more involved and practical approach and conducted surveillance while interacting with their patient, while others waited in the nurses’ station until their help was requested, observing how mothers interacted with their child from a distance, and how they managed themselves in their day-to-day life during admission. Although seemingly different approaches, both still ultimately achieved the same disciplinary function.

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29 In the very early stages of fieldwork, there was a male registrar and a male social worker who was also a music therapist.
Despite having the most direct contact with patients, nurses’ contributions to formal staff communication and decision making was generally through a nominated representative who spoke on their behalf. Nurses had the least formalised academic membership into the technical knowledge of psychiatry which dealt with the internal workings of the patient. Instead, the nature of nursing work was in relation to the body’s surface (Barrett n.d.:13): administering medication, instructing in the care of infants, making sure that patients were clean, fed and comfortable.\textsuperscript{30} In terms of discipline and control, nursing staff held the least formalised power within the unit.\textsuperscript{31} However, nursing staff were able to recognise deviant behaviours according to psychiatric assumptions, which would sometimes be noted, and then passed on to the psychiatric staff to theorise and make decisions on the patient’s treatment. The following field extract is indicative of this.

\textit{Jen was visibly flatter than the previous day. I asked her how she was feeling and she said she was feeling very tired and quite anxious about going home. She was particularly worried about her partner who had severely injured his neck. Her friend Emma suggested to her that she shouldn’t be going home in that state. She was already unwell; going home could make her more unwell. Jen didn’t really want to be going home either if she had to deal with her partner being sick, but was too scared to ask Dr Sophie, the psychiatric registrar, for fear of rejection. Her anxiety about going home had started when she was first advised about her discharge from Oliveto,}

\textsuperscript{30} For this reason the work of nursing has often been linked to the ‘nurturing bond between parent and infant’ (Barrett n.d.:10).

\textsuperscript{31} The only other people working within the institutional space who held less authoritative power were the kitchen and cleaning staff, however were able assert their power in other ways.
however, she was determined to try to make it work. She felt that she and Harry had to go home sometime.

The day prior to this had been a particularly difficult day for Jen. During a conversation with social worker, April, which Jen described as just general, practical stuff, she broke down into tears and had a panic attack. She was really worried that she would do this again when she went home with Harry. Even though her partner was willing to help her, she knew that he would not be able to because of his neck injury. She was worried.

She describes herself as feeling weird and strange that day. She felt outside of her body; she didn’t feel like herself. The occupational therapy student was concerned about her going home also — she spoke to Jen’s nurse about this. Justine, who was her nurse for the day, was also concerned about her going home for the weekend. Justine decided that she would speak to Dr Sophie, Oliveto’s psychiatric registrar, about it.

In the meantime, Jen had accepted that she would have to go home — she knew that the decision would not be reversed. However, Jen’s nurse, Justine, offered to speak with Dr Sophie on her behalf. Despite this, the nurse still exclaimed that the decision was above her head and they would have to see what Dr Sophie said. Justine agreed that it was a good decision for her to stay in Oliveto over the weekend with support from staff until her mother arrived the following Monday.

After speaking with Dr Sophie, Justine returned with an ambiguous answer. She told Jen that she would still have a bed left for her on Monday and that
Dr Sophie would call her on Monday to see how she was. Nothing had changed. Despite several other people in the unit believing that Jen was not ready to go home, the ultimate decisions could not be made, or even advised, by any other staff member.

This particular event was chosen to demonstrate the hierarchy of decision making in relation to patient treatment in Oliveto. This is a clear example of the dominance of psychiatric knowledge in this context. The patient’s distress was noted by another patient as well a number of staff members. Jen and her patient friend held the least authority in decision making in this context, a reality recognised by both of them, hence their deferral to staff members whom were in a greater position of authority to make decisions. Interestingly, one of those people was a student who was also much younger than Jen, yet her position in Oliveto was advanced through her academic training in the knowledge of Perinatal and Infant Psychiatry. The nurse who had been working at Oliveto for over a decade was seen to hold more power in this encounter, yet it was ultimately the decision of the psychiatric registrar that determined Jen’s discharge that day. Decisions about patient treatments and discharge could only be finalised by psychiatrists, no other individuals within the unit had equal authority.

Nursing roles within Oliveto were thus paradoxical: not only were they watching and surveying the action of mothers, but they too were subjects of Oliveto’s hierarchical disciplinary functioning. Nurses had little authority in this context, and any suggestions they may have for the benefit of clients’ progress were often over ruled. Although in this context nursing staff appear to hold little authority with regards to decision making within the multidisciplinary team, they were able
to exert power in more subtle and diffuse ways. Power could also be understood in observing what nurses did not say or do. Withholding information from those higher in authority or not adhering to institutional guidelines was also an assertion of power.

Observations of behaviour that nursing staff consider problematic or risky were reported back to other members of the team. Much of the reporting happened informally through talk (staff handover, between staff members).\textsuperscript{32} Because of their continuous contact with patients, they were in a position to observe all of the day-to-day interactions and behaviours of patients, which they then reported back to the multidisciplinary team in staff handover meetings. Despite being at the forefront of surveillance, their involvement in group decisions about patients appeared to often be rejected and their advice ignored. As there were only three nursing staff on at one time (one staff member for two mothers and their child(ren), they could not leave the hospital area to attend multidisciplinary ward rounds. Only one nursing member represented the nursing team at meetings where decisions were made about patients, and it appeared very little recognition was given to the nurse's opinion. The most significant disciplinary involvement they had in shaping the treatment of patients was through talking and exchanging information between each other, and withholding information when they saw fit (see also Lukes 2005:479-480).

Nursing staff were also responsible for administering medication and maintaining pharmacological discipline through compliance to drug administration. It was

\textsuperscript{32} I am unable to comment what was contributed in written form because I did not have access to this information. Refer to Chapter One describing my limitations to data collection due to ethical restrictions.
their job to ensure that correct dosages were given to patients at the correct time, and to record each administration of medication as it was given. The surveillance of this activity was twofold: nursing staff were being surveilled by having to keep records of the interactions they had with patients.

Nursing authority was also reflected in their use of space, and their autonomy of working within the system. The nurses’ station was a shared space in the centre of the unit, accessible to all staff members at all time. It was also the most commonly used surveillance point for observing a patient’s behaviours and interactions with others (especially their child). Half encased with glass windows, the nurse’s station was designed so that surveillance was possible in a number of ways. The glass windows allowed staff to observe a mother’s behaviour and interactions with her infant (and others), and often without the patient being explicitly aware of the panoptic function.

There were two doors for the nurses’ station: one of which was the main entrance and exit, which had a sliding door. This door was pulled closed when staff wanted to discuss patients. The door made a distinct noise as it was dragged along the track, and so therefore was never discreet. A built-in childproof gate was also used to keep children, particularly toddlers, out of the staff space. This door was in frequent use and drew attention to the fact that patients were being talked about inside the ‘staff space’. Adjoining the nurse’s station and in front on the lounge/walk through area was a built-in play area: the second door to the nurses’ station was also an entrance into this play area. This door allowed staff to intervene quickly if they saw an incident with a child that they felt required immediate attention. This door also had a small window so that staff could look
through and observe a child’s developmental behaviour and interactions with its mother and/or others.

The nurses’ station was fitted with sound monitors that connected to each of the patients’ rooms. The intention of this was to allow staff to hear when a baby or a patient was in distress, particularly in the evening. Patients were able to control the monitor themselves to allow them some privacy, but they often forgot to turn them off, providing an opportunity to further surveil patients.

*Emma often forgot to turn her sound monitor off, particularly in the evening. I learnt this one morning in a handover meeting where night nursing staff spoke about intervening in Emma’s night care for Jack when they heard her raising her voice. Frustrated at not being able to settle her colicky child, she screamed at him, questioning what she had to do to make him happy, then sobbed loudly. Upon hearing this interaction, nursing staff immediately intervened to assist Emma, and remove Jack from what was understood to be a potentially harmful situation for the child. Emma’s response to her son’s cries was defined through the dominant Perinatal and Infant Psychiatric knowledge. In this situation, the fear of ‘risk’ to the child was used as justification for surveillance. This resulted in another notification to State’s child protection service, which was included in the statement used to remove the child from his mother. In order to be constructed as a ‘good mother’, she needed to learn how to manage to her emotions in response to his distress. Intervention by staff at this point operated as a disciplinary function to demonstrate that her behaviour did not correspond with expected norms.*
However, there were tensions within Oliveto’s disciplinary functioning. Around the corner from the nurses’ station, in an area that was closed off from visiting family and friends, a baby room was used to sleep babies throughout the day. It was also used in the evening when a decision was made that having the child sleep away from its mother would be the best option. Sound monitors were used in this area as well, but these sound monitors of course were only effective if they were turned on. The following vignette demonstrates the tensions within the disciplinary function.

Emma told me of the distress she experienced one afternoon after learning her son had been left crying unattended while nursing staff sat in the nurses’ station. She had had a particularly upsetting therapy session with the social worker that afternoon and needed some time to rest and clear her head. Nursing staff had agreed to look after her son and put him to sleep while she did this. Restless in her bedroom, she got up to go to the toilet and could hear the distinctive cry of her son. She tried to go in to pick him up, but the door was locked and she couldn’t get in. Even more distressed by this, she marched to the nursing station only to find the nurses happily chatting away; the sound monitors were not on. She immediately found the nursing director and demanded that her son was given to her. This caused a lot of distress for Emma and generated mistrust in the staff.

From Emma’s perspective there was an expectation that in order for her to be considered as a good mother, she should be responsive to her child. However from

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33 Infants are encouraged to sleep in the room with their mother, although in early admission babies are often kept separately to allow the mother a full night’s rest. Also, if a mother was deemed to have infanticidal tendencies, babies slept separately.
Emma’s perspective, the same rules did not appear to apply to Oliveto’s staff. Nursing staff had the authority to care for Emma’s child in ways that they thought appropriate. Emma, as a subject of Oliveto’s disciplinary practice, had very little room for agency in relation to this scenario. Although the situation was brought to the attention of authorities within the unit, no disciplinary action was taken against staff members. The apparent contradictions in this circumstance are a reflection of the unequal power dynamics inherent in this institutional context.

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**Kitchen & Dining: Surveillance through Informal Networks**

Glass windows surrounded much of the dining area, with a view into (and out of) the kitchen as well as to the outdoor area. The kitchen also had a child barrier in the form of half a door, used particularly when toddlers and crawlers were admitted in the unit, to prevent any child injuries occurring. A photo of a badly burnt infant caused by boiling water was used as a reminder for parents to keep their children out of the kitchen area. Several methods of surveillance occurred within this space. It was from the kitchen that food was served by one of the two kitchen/cleaning staff, and where mothers or other caretakers prepared meals, both solid and liquid, for the children admitted into Oliveto. It was the responsibility of kitchen staff to receive food from an external kitchen and make sure that patients got their allocated share of food for each meal. Kitchen staff conducted their own form of surveillance by keeping mental notes of patients’ food consumption. If kitchen staff considered that the food habits of mothers did not conform to what they considered *appropriate* or *healthy* eating, they would generally pass this information on to other staff members through informal
networks or 'gossip'.\textsuperscript{34} The role of informal repertoire has been recognised to have
an important function in mental health settings as it is through this transmission of
information that patients are attributed volition and agency (Barrett 1994:4). Staff
members passed moral judgements over patients’ behaviours and actions that had
the potential to inform decisions about the patients' treatment progress, despite
never being formally noted and included in case notes (Barrett 1994:4). These
opinions were not recognised as professional opinions; nevertheless, 'gossip' still
informed staff opinions about patients.

Kitchen staff had a unique position within the unit, as they were not officially part
of the mental health team, however because of the work they did, they were often
in closer contact with patients than many members of the multidisciplinary team
(apart from nurses), and had a unique vantage point for observation and
surveillance. It was not unusual for me to be chatting to one of the kitchen staff
and be told about their observations of patients. They often shared with me their
thoughts regarding the women admitted, not only about food consumption, but
also around a mother’s behaviour, actions and interactions with her child and
others. They were generally the first to tell me about who liked who, who was
causing trouble in the unit, who dressed inappropriately, or who was difficult.
Although not an official part of the psychiatric team, they were an integral part of
Oliveto’s informal network. Their attitude towards patients reflected many of the
staff attitudes towards patients. The fact that the mothers were in Oliveto with
their children meant they were a target for scrutiny around their parenting

\begin{footnote}
34 There are numerous anthropological studies that explore the use of gossip as an informal speech
repertoire used to maintain the interests of a group. For the most notable examples see Gluckman
(1963) and Haviland (1977).
\end{footnote}
practices. The kitchen staff would often discuss their concerns about patients’
behaviour with nursing staff and this would occasionally be brought to the
attention of the multidisciplinary team in staff meetings.

Kitchen staff judgments were also occasionally directed at me. Six months into my
pregnancy, I made myself a coffee using Oliveto’s kitchen facilities. Upon seeing me
boil the kettle, one of the kitchen staff asked me if I was making myself a cup of tea,
I corrected her and told her it was coffee. She was quick to scold and inform me
that I should not be drinking coffee because it was bad for my unborn baby’s heart.

After this interaction, I felt sad and guilty at the thought that someone thought I
was trying to cause damage to my unborn child. I felt as if someone was judging
my own mothering skills, even though I had not yet given birth to my child. I also
felt simultaneously defiant about being judged for my behaviour by someone who
knew very little about me. However, this situation reminded me that being a
woman in a pregnant body made me a social body; a body that is held socially and
morally responsible for the life that was growing inside of me. The same moral
responsibility extended to mothers of young children — highlighted particularly in
the Oliveto context. The coffee experience enabled me to feel, in a minor sense, the
guilt and sadness mothers in Oliveto described when being disciplined or criticised
about their mothering skills. Kitchen staff thus had a small but important unofficial
role in this ethnographic project, because they demonstrated how societal values
were embedded in the everyday world of Oliveto. What set the position of kitchen
staff apart from other staff in Oliveto was that they had not been granted the same
authority to use their opinions to make decisions that could affect the agency of
mothers, yet they nevertheless remained influential in how mothers were perceived in Oliveto.

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**Regulating and Normalising**

Within the same kitchen space, other forms of surveillance also took place. The large majority of mothers in the unit bottle-fed their babies.\(^{35}\) Mothers who fed their children milk formula were asked to measure and record their child's milk consumption for the day. This was particularly relevant for younger children who would have regular feeds. Mothers were asked to record the amount, and document all of these details on a form attached to a clipboard kept in the kitchen. This was checked regularly by nursing staff to ensure that their child or infant was receiving what was considered to be an adequate food intake. This chart would also become a focus for discussion for some nurses with mothers who were believed to be over feeding their child, or not feeding their child enough.

As the overwhelming majority of patients bottle-fed their children, this area was often congested with bottles and sterilising equipment. The importance of naming and sterilising drink apparatus was cautioned, as gastroenteritis outbreaks were common in the unit. Kitchen staff were the first to make sure that nursing staff were aware of any unsanitary behaviour by patients. Mothers with more severe mental health diagnoses (for example schizophrenia), were often labelled by kitchen and nursing staff as *dirty* and *unhygienic*.

Breastfeeding mothers were surveilled in different ways. They were regularly asked what times they fed their child, how long the feed took, and whether the

\(^{35}\) Many of the medications that mothers were given while in Oliveto were not suitable for breastfeeding mothers.
child suckled from one or both breasts. Although it was difficult to measure the milk consumption of a breastfed baby, in instances where there were concerns over the child’s weight gain, referred to as *failure to thrive*, the baby would be weighed before and after a feed to measure how much milk was consumed for that feed. If staff felt that the child had not received enough milk from its mother’s breast they sometimes suggested *topping up* the child’s feed with milk formula. Oliveto’s staff concern with weighing and measuring a child’s nutritional intake was based on scientific principles that set guidelines for optimal nutrition determined by scientific research. Growth percentile charts (for height, weight, and head circumference) were developed to measure the *healthy growth* of infants, and were used in this context to further surveil mothering practices.

Authorities in Social Control

In Oliveto, patient information was kept confidential from other patients or visitors—this was made evident to me, particularly during in the ethics process (See Chapter One). However, patient confidentiality between staff members was more flexible, as noted in Oliveto’s welcome booklet given to patients when they arrive. The booklet (Oliveto 2007:10)\(^{36}\) explained:

> *Due to confidentiality guidelines, staff will not discuss your care with family or friends without your permission. You should be aware that all information is shared between team members. A team meeting is held each Thursday morning for sharing of information and planning the most appropriate care for you. Frequently community agencies that may be*  

\(^{36}\) The pseudonym Oliveto has been used to preserve anonymity.
involved in your care are invited to participate in planning for you when you return back home.

The sharing of information about patients was an integral part of the surveillance practices in Oliveto. Through the exchange of information, staff members were able to make what they considered to be informed decisions about the patient’s treatment throughout their admission (and beyond). This point was made apparent after an incident I had with a nursing team member who wanted to know what I had been talking to one of her patients about. When I explained my own confidentiality agreement with the patient (everything is kept confidential unless the informant spoke about causing harm to herself or others), she was very upset with this agreement and exclaimed: No one is confidential in here...patients all know that! The nurse’s comment about patient confidentiality was indicative of the imbalanced power dynamics in Oliveto. Patients’ cases were openly discussed in team meetings but also in less formal settings where staff members interacted, such as the hallways, and nurses’ station. Students training in Oliveto were also privy to patient information, however, patients were not given access or authority to formally contribute to their own case notes. Patient contributions were never direct; their contributions came in the form of interpretations provided by those granted biomedical authority. As far as I was aware, patients did not have access to their own case notes, nor did they have the authority to change or remove any of the information within them. The information written about them remained the property of the State’s Public Health Service hospital\(^{37}\) for the duration of that

\(^{37}\) This information could be accessed, but only via an application. Information could not be changed or removed.
person’s life. In Oliveto, case notes were used for discussion and theorising by clinically trained professionals who had earned their authority to this right through their tertiary training.

As already noted, psychiatric staff had the most authority and autonomy in the unit. Due to their tertiary experience and technical training in the areas of Medicine and Perinatal and Infant Psychiatric knowledge, they had power over staff members whose knowledge in this area was considered less superior. It has been argued that the theory of medical dominance first proposed by Freidson (1970; see also Coburn 2006; Willis 1983, 2006) remains historically hegemonic in countries such as Australia (Benoit et al. 2010). Medical dominance was evident throughout my fieldwork: even among the staff with psychiatric training, a distinct hierarchy was apparent. Dr Margaret, an experienced Perinatal and Infant Psychiatrist and medical unit head, was at the top of the chain of command in the unit. Dr Margaret only occasionally treated patients directly. Her involvement in the daily practices in Oliveto relied heavily on her staff members to perform surveillance for her and report back to her in staff meetings. During my time of ethnographic fieldwork, she was rarely present. Despite this, as the supervisor of the unit she made the final decisions for admission and treatment in cases of uncertainty. Her word was final.

In Dr Margaret’s absence, the responsibility of psychiatric authority lay with child and adolescent psychiatrist, Dr Olivia, who worked part time (0.7) at the unit. As a senior psychiatrist, Olivia was the medical person in charge of running the day-to-day operations of the unit, although it was her job to conduct the detention
Dr Olivia also played a significant role in making decisions about what happened to patients throughout their admissions in Oliveto. She worked in collaboration with the multidisciplinary team to organise discharge plans that were considered most appropriate for patients and their children when they left. In Dr Margaret’s absence, Dr Olivia was the chair of ward rounds and her decisions in these meeting were conclusive.

Oliveto’s senior psychiatric registrar, Dr Sophie, attended and treated the majority of patients in the unit, attending to the more practical day-to-day care of patients. In Oliveto, psychiatric registrars did the bulk of the psychiatric work with patients. Their responsibility was to look after the mental health and physical needs of patients (although physical needs were generally secondary), as well as attending to the physical needs of the babies, with support from Oliveto’s paediatrician who attended the unit once a week. It was a psychiatrist’s (generally a registrar accompanied by a medical student) responsibility to conduct the initial psychiatric assessment with patients, follow-up psychiatric appointments, and be available for any crises that may occur while patients were admitted. In the initial admission assessment, psychiatrists followed a Maudsley Psychiatric History interview guide for collecting information about the patient used for psychiatric evaluation (See Chapter Four). In Oliveto, the initial psychiatric meeting was generally conducted with a psychiatrist, medical student and a nurse. Following

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38 For those detained under the Mental Health Act.
39 During my time in the field, two more registrars also worked there, however only for very short periods so their involvement in my fieldwork was minimal.
40 As part of a public medical system, medical students at the affiliate university which sent students to the unit in their fourth year of training, are required to do a psychiatry rotation- those with an interest in Perinatal and infant mental health chose Oliveto. Patients were always asked first if they agreed to let a medical student be part of their meetings. I do not have any ethnographic data as to whether patients agreed or refused.
the Maudsley Psychiatric History, an in-depth psychological and medical (for example, past illnesses and/or surgeries) history was taken and noted down in the patient’s case file to remain on record. Patients were objectified in this process (also referred to by Foucault as the medical ‘gaze’ (1973)) separating the person from the illness, making the mother, and her relationship with her child, an object of Oliveto’s Perinatal and Infant Psychiatric discourse. Psychiatric staff were therefore focused on illness and the management of symptoms through techniques of pharmacological control. Only qualified psychiatric staff were able prescribe and in some cases enforce (although nursing staff were responsible for overseeing this) the administration of medication because of their expertise in this area. Their training and academic membership in the area of psychiatry gave them authority to use their clinical (and subjective) judgments to prescribe medication to control illness behaviours considered deviant (see Chapter Four for further discussion).

An additional responsibility for the psychiatric registrar was to guide medical students on their psychiatric rotation. As students, their autonomy within the unit’s system of power was less than the fully qualified psychiatrist as they were still in training. However, because of their medical training, they were still granted more privileges than others working in the unit’s power system, particularly nursing staff. Students had access to patients’ case notes and were expected to be involved in therapeutic encounters. They were also made an integral part of the multidisciplinary team during their training and further socialised into the role of medical professionals by contributing their interpretations of patients’
presentation at ward rounds. The expectation of medical dominance was evident in the attitude of some medical students. The students I encountered were strictly focused on their psychiatric work and many remained distanced from informal interactions with patients: they did not chat to patients or play with children but kept a professional distance as modelled by the other members of the medical team. Nursing staff and at times, allied health staff, more informally interacted with patients and their children. It was rare for psychiatric staff (including medical students) to do this.

The power imbalances inherent in the medical model appeared deeply ingrained in some medical students. One medical student was offended when asked to contribute to tasks that she considered being below her position, as the following field excerpt explains:

> Amy, a medical student was very disgruntled today when she was asked by the nurse in charge to assist with one of the babies. Amy did as she was asked, but later complained to her fellow students. I'm not a nurse. I'm not here to do nursing work! Where does he get off asking me to do his work!

Within theories of medical dominance, autonomy of one's own work and authority over other health professions are discussed as features of medical power (Willis 1983:2-3). As a medical student, Amy’s role in the unit was ambiguous. She had membership to the medical domain through her tertiary training and therefore was given authority in some contexts, yet as a student she lacked autonomy. Amy’s statement demonstrated how her perceived role definition was aligned with her medical knowledge. She had already constructed the work of nursing staff as less important than hers. Amy’s assertion that she was not here to do nursing work
highlighted her belief that as an individual with medical training, she should have dominance over the nursing profession. This interaction may have had different results if she was requested to do the same by a senior psychiatrist. In my observations, all students always did as they were asked by psychiatrists.

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Regulating the Psychological and Social Lives of Mothers and Babies

Allied Health staff (psychology, social work and occupational therapy) were considered an important part of Oliveto’s team and its biopsychosocial approach, however, their professional power in making decisions about a patient’s future was limited. Although their involvement in case construction was influential, their suggestions could always be overridden by decisions made by the psychiatrists. Oliveto’s Allied Health team members worked in conjunction with psychiatric staff in constructing patients as a case, focussing predominantly on the psychosocial elements of treatments, however as indicated through their involvement on decision making, medical dominance (and the biological) prevailed.

Group Surveillance

In Oliveto, psychologist Emily’s main role was to run group therapy sessions in which Cognitive Behavioural Therapy (CBT) techniques were used to discuss mental health in general. These group sessions could be understood as an exercise in generating normalising values and reproducing sociocultural norms about managing emotions consistent with women’s social role as mothers. The group sessions simultaneously provided an opportunity for further surveillance of mothers in their acceptance of these norms. The topics that were chosen for

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41 Psychiatric staff focused on the biological areas of the patient’s case, whilst the psychological and social remained the domains of the allied health professionals and nursing staff.
discussion for each group were dependent on the mix of patients at the time, but generally the sessions were applicable to everyone (for example, general self-esteem, stress management, assertiveness). In her sessions she also included discussions that related to the challenges that motherhood posed especially in regards to infant and child development facilitated through the Circle of Security template (see Chapter Six). Mothers were asked questions about how they perceived their behaviour in relation to what was considered culturally normal and were then asked think about (or were taught) how to alter their behaviour to be more closely aligned to cultural norms. Emily also worked individually with patients, but generally only with mothers who were understood to suffer with generalised anxiety about their inability to maintain control in their life in the ways they had before their child arrived. Anxiety was a commonly constructed barrier to the unpredictable nature of caring for children which sat in contrast to perfectionist ideals of order and control.

Oliveto’s psychologist would also take some groups out on excursions and do group activities (craft, music) if she felt that the blend of patients made it difficult to conduct Cognitive Behavioural Therapy (CBT) type sessions. Conducting her work in groups posed an interesting platform for disciplinary surveillance. During her sessions, Emily was able to observe the way patients interacted with others as well as their ability to identify their perceived problem (referred to as having insight) in a more public space. Insight in this context could also be considered a form of self-surveillance where the individual recognised that they did not fit with what was considered normal and were willing and able to adapt because of this. Having insight demonstrated to staff that the patient acknowledged their deviance
and was willing to try to fit within the normal boundaries of cultural behaviour. Insight was seen as a positive attribute and was rewarded, as it required the woman to become aware of her thoughts or behaviours, and alter them in accordance with the norms taught in Oliveto; a practice in self-surveillance.

Screening Tools, Scales and Assessments

Oliveto used a number of screening tools, scales and assessments to rate and measure various elements of health related to the mother-child admission. The most common was the Denver Developmental Screening Test (Frankenburg et al. 1992) and the Louis Macro screening tool (Louis et al. 1997). Oliveto’s psychologist was responsible for conducting Denver Test (as it was colloquially referred to), a screening tool used for evaluating childhood development. Using the scale was another normalising technique employed in Oliveto to try to regulate child development in line with cultural expectations and guidelines. As Javier’s case in Chapter Two demonstrated, a child who did not match the developmental expectations of this screening test was pathologised as having developmental problems. The results of the assessments were shared in ward rounds along with descriptions of the specific areas in which the child was believed to be delayed (motor skills, speech, social skills, and cultural behaviours such as bottle feeding a doll) and the perceived cause of these delays. Commonly, childhood development issues were blamed on the relationship between mother and infant and the mother's inability to interact with her child in culturally acceptable ways understood to encourage developmental milestones. This structured and

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42 The original Denver Screening was first produced in 1967. The version cited here is a major revision that was still in use in Oliveto.
43 See Chapter Seven for further discussion about relevance of development.
prescriptive surveillance technique produced normalised assumptions about childhood development, while also fuelling discursive assumptions about a deviant mother’s abnormal involvement in their child’s life.

The other commonly used screening tool was the Louis MACRO — MACRO being an acronym for Maternal and Child Risk Observation. It was created as a clinical rating tool to help mental health staff measure and assess parent-infant/child risk in the presence of maternal mental illness. Development of the scale was facilitated through research conducted in Oliveto and therefore served as a tool specific to the needs of the unit. The areas of measurement provide insight into norms of cultural behaviour in relation to child care and safety. The Louis MACRO scale measured the mother's ability to: maintain the child/infant's safety (holds correctly, keeps out of danger, does not yell, uses safety restraints in strollers and chairs and so forth), maintain culturally appropriate physical care (dress for hot/cold weather, does not let infant sleep through feeds, bathes infant at least every second day, gives formula that has been prepared correctly and at the right temperature, with credit given to mothers who breastfeed, is organised and has a routine for the baby), and emotional care of the baby (looks infant in the face/within eye distance when feeding, addresses infant by its name, talks/sings to infant, responds to infants vocalisations) (Louis et al. 1997). The scale was also used to measure the infant’s characteristics, or as it was described to me by one staff member, the likeability of a child. I first learnt of the Louis MACRO scale in a ward round when one of the psychiatric staff asked the team if a Louis MACRO had been done on a mother and child: the child in question had unusual facial features and made an unusual noise when trying to get her mother’s attention. The
assumption raised through requesting the scale to be implemented was that the child had low likeability. Another term that was often used for a child who did not fit the mould of what would be described as a ‘normal’ looking child was a FLK, an acronym for funny looking kid.

These assessments were created within the paradigm of Perinatal and Infant Psychiatric knowledge and measured observable actions and interactions in relation to biomedically set norms. Through these assessments, Oliveto’s staff were able to rate and measure culturally specific behaviours of the patients and children admitted in Oliveto, and use them to justify normalising practices and treatments.

Therapeutic Video Surveillance

Oliveto’s occupational therapist, Kelly, specialised in mother-infant therapy (see Chapter Six). Her expertise was in the area of mother-child relationships with a specific focus on the attachment relationship between the dyad. Kelly had her office in an area geographically removed from the main unit and would come in for staff meetings. She was very rarely in the unit so spent very little time interacting with patients within the unit’s space. Her role was unique because she had the only professional role that worked with the mother and their child(ren) together in a therapeutic scenario. Because of this, her professional autonomy was distinct from the rest of the team. Unlike many of the other professions within Oliveto, she described how she allowed herself to express emotion with her clients and she considered this an important part of her therapeutic work. It was through her mother-infant therapeutic sessions that video surveillance took place. Mother-infant work played a significant role in the treatment of mothers who were
believed to have significant problems in their relationship with their child. Mother-infant therapy relied on attachment principles to identify transgenerational patterns of relationship dysfunction.

Technologies of surveillance were explicit in mother-infant therapy. Mothers were aware that their actions were being video recorded. The recording of the mother’s interaction with her child was then used as a therapeutic tool for ‘reflective functioning’ (Fonagy & Target 1997) or *insight* into why the relationship may not be conforming to expected norms. Through video surveillance, mothering behaviours were regulated and disciplined.

The use of video recordings as a reflective source of surveillance meant that the recordings became a tool for encouraging mothers to begin to govern themselves. They were asked to watch their interactions with their child, and then think about how their interactions with their child may relate back to their own childhood experience with their mother (see Helen and Javier’s case in Chapter Six). Through a coercive process of self-change, mothers participated in their own transformation and reform. According to Rose (1996) ‘psy’ disciplines rely on self-regulation for this process to be successful. The individual must be able to have insight into their deviant behaviour by confessing their deviance ‘in a particular vocabulary... and according to a particular explanatory code derived from some source of authority’ (Rose 1996:32). In the case of mother-infant therapy, the explanatory code derived from the psychological discourse of attachment.

Many mothers that I spoke with found the video work quite confronting and upsetting. This surveillance tool was a normalising technique aimed at adjusting maternal behaviour with regard to expected cultural norms of mothering. Video
surveillance technology was considered a therapeutic tool in the mental health community, and has been used extensively in other unrelated settings to reform deviant behaviour, for example closed-circuit television (CCTV) cameras capturing behaviour in public spaces used for evidence used in court rooms (Walby 2005:195). Oliveto’s video surveillance was also used as a tool to train other mental health professionals on how to conduct surveillance in therapeutic settings.

Institutional Surveillance beyond the Institution’s Walls

Oliveto also employed a social worker, April, whose office was located within the unit. She organised appointments with patients at mutually convenient time for counselling about their living and financial situations, however she also often chose to speak with patients and play with children informally in the open spaces of the unit. April had a history of working with domestic violence cases so this was an area of special interest for her. Her work often involved working closely with young and single parents, and those in difficult socioeconomic situations. She was responsible for finding appropriate housing for such patients, and making sure that they were discharged to safe and suitable environments. Her role in normalisation techniques thus stretched beyond the confines of the unit into the external community.

She was also particularly interested in involving the male relations (usually partners) of mothers in Oliveto and including them in the relationship with their child. April would try to engage with them in whatever way she could. This often meant that her areas of work extended beyond her office, through to the garden area, and even into patients’ homes. She spoke of her belief that the men played an important role in the infant’s and family’s life and would try to have chats (as she
referred to them) with the men on any occasion that she could. Her conversations with patients, and particularly with their partners, were shared with staff in ward round meetings. Her discussions with patients and those associated with them (partners, family and friends) were considered through a Perinatal and Infant Psychiatric lens. *Chatting* in this context was therefore viewed as further opportunities for surveillance and assessment of the social world of the patient and its influence on Perinatal and Infant Psychiatric factors.

*Oliveto’s social worker would occasionally conduct home visits with patients, and observe their living situation. Throughout my fieldwork, these visits did not appear to be formally arranged, instead April would offer to drive patients and their child(ren) home for weekend leave and report back to the team about the living situation to which the child and mother were returning. Her reports of these situations in staff meetings often caused judgements to be made based on assumptions produced through power/knowledge imbalances.*

*The same afternoon that I sat with Emma and Kate, musing over strapping their immobile children into high chairs, the same duty nurse approached us awkwardly, raising the issue of how Kate and her daughter Sally would be getting home for weekend leave later that afternoon. It had been planned that Kate’s partner’s mother would be picking them up because her partner had recently lost his licence. At the last minute, his mother had changed her mind, leaving Kate and her daughter unable to get home. Emma and her husband had offered to give them a lift because they lived in the same direction. The nurse announced that this was not allowed because*
it was against Oliveto’s policy: patients were not allowed to drive with each other. Both patients were surprised by this and asked why this was the case. The nurse advised that it was just a policy that they had. Emma explained that it would be her partner who was driving, not her and questioned why that would be a problem. The nurse was unable to explain except to say that usually it was to do with concerns over patients driving while on medication, but since her partner was the one driving, she was not sure what the policy was. The nurse went to the nurses’ station to check with another staff member.

When the nurse returned, she said there was concern about how the children would be in the car safely: how would they be bolted in? Can two fit in one car? Emma appeared almost offended by this comment. Later Emma exclaimed: of course the kids would be bolted in; do they think I’m completely nuts? I would never drive around with a child not securely strapped in. Next the nurse questioned where the chair was going to come from as she was advised patients were not allowed to borrow Oliveto’s spare car seat in case it was needed.

When Kate returned, she was told she could not go with Emma because of the car seat issue. Kate was upset. She sent a text message to somebody and then called her boyfriend. The conversation between the pair escalated and her partner began to get angry. She told him not to get angry about her not having a lift and she would try to work out something. He had told her that he wanted to jump in the car himself. However, he knew this was not an option because he had no licence and staff was aware of this. He had been
stopped by police the week prior for driving unlicensed and could possibly be going to gaol as a result of this (and previous charges). Kate tried calming him down but appeared quite distressed when she got off the phone.

After lengthy discussion in the nurses’ station, the nurse returned and told her that April (the social worker) was willing to give Kate and her daughter a lift home. She lived nearby and was going past her area so could easily drop her home. Kate said she felt bad asking April to do this but eventually agreed to go with her. I overheard Jane, (an OT student) saying that she was going to go for a drive with April to drop Kate home. It made me question whether perhaps the drive was more than just a lift home: were they planning to conduct an assessment of the house, or perhaps to keep April safe from Kate’s boyfriend who had a history of violence? I asked Jane about this but she did not know, all she could tell me was that she had some free time and April asked her to accompany her on the drive.

Later, April came to me and stated: ‘you were right... about Kate. It is not the main reason why I’m going but if we can do that too, great’. I asked if she would be going inside the house, and she didn’t really know. Her response was we’ll just see what happens.

The following week in the ward round meeting, April reported to the team on her visit to Kate’s home. She explained that Kate did her best to make sure that April did not enter the house when she brought her bags to the door, but she did notice a distinct smell of marijuana and a pile of pillows
covering what she believed (because of the smell coming from the house) to be a bong.44

This ethnographic excerpt raises a number of questions around the issue of power and agency in relation to Oliveto’s governmentality practices. Safety was the primary reason cited for patients not being able to share transportation; concerns about the influence of medication on patient’s driving ability were raised, but also child safety in relation to car restraints. The agency of mothers in decision making around issues that involved themselves and their children was limited, and the institutional space was traversed by staff members in an attempt to reinforce governmentality. As patients of the unit, their actions became the responsibility of Oliveto’s staff to manage, particularly in cases where child safety was a concern. Surveillance of Kate stretched beyond the boundaries of the unit, to penetrate her home environment to some extent. April used her authoritative role to observe Kate’s living environment to make judgements about the safety of the living situation to which Kate and her daughter would be returning. Within Oliveto’s Perinatal and Infant Psychiatric discourse, what could otherwise be considered an intrusive interaction was justified on the basis of safety for both the mother and her child due to concerns of potential domestic violence and substance abuse. Governmentality thus extended beyond the institutional walls.

Communicating Surveillance Information

Communication between staff members about their observations, surveillance, clinical and moral judgements about patients informed treatment practices in

44 A device used for smoking marijuana.
Oliveto. Information exchange occurred in both formal interactions such as weekly ward rounds and daily handover meetings. Formal vocabularies were considered ‘objective, professional precise and non-judgemental’ (Barrett 1994:1). The repertoire of informal speech transactions differs considerably to formal case presentations or written clinical documents, yet it too permeates and contributes to clinical practice (Mattingly 1998:274). The switch between these two types of speech acts could occur within one speech event (Barrett 1994). While formal speech served to convey clinical information that reduced information into shared discursive knowledge attributing behaviours to illness, informal speech gave insight into the moral evaluations made by staff members attributing patients with agency and volition. This was particularly evident for women diagnosed with (or spoken about having) borderline personality disorder (see Chapter Eight).

No matter how the information was collected, whether through observation in therapy sessions, notes written by psychiatrists, or informal communication networks, this information was used to make decisions about mothers and babies, and their treatment and progress in Oliveto.

**Handover: Daily Information Exchange between Oliveto's staff**

Almost every day of the year, nursing staff in Oliveto worked in twelve-hour shifts with mothers and their children. At the end of each shift, staff from the previous shift met with those from the next shift and ‘handed over’ any information they felt was necessary to know when working with the admitted patients. Considerable judgment and personal feelings about patients were also exchanged at these meetings. The handover from night to day staff (in the morning) tended to be more formal, being conducted in a meeting room and involving not only nursing staff but
also allied health and psychiatric staff. The evening handover was less formal and tended to be nursing staff handing over to the night staff in a quiet area of the ward. In these meetings, staff would report observations of the behaviour of mothers, particularly in relation to their children. They would also discuss the mental health state of mothers, patient compliance with medication and other rules of the unit, as well as any significant interactions with staff members. Patients’ appearances, willingness to shower, get out of bed, feed their child and eat meals, as well as sexual activity were all topics of discussion. Notable in handover meetings was the amount of personal judgment that was given as ‘information’ for staff on the next shift. A lot of what was said between staff members, whether it was information transferred in handover meetings or daily ‘chat’ or ‘gossip’ between staff members, was not written down but was still used to inform staff constructions of a patient and their illness, and so therefore affected their clinical treatment. Laing suggests that ‘gossip’ is an ‘expressive and communicative repertoire of any community’ (1993:37). The underlying assumptions made in these informal speech repertoires could often demonstrate moral judgements made by health practitioners (Barrett 1994; Payne, Hardey & Coleman 2000). Through gossip and chat, staff attributed patients with volition and agency over their behaviour, however as informal speech acts, this information was not included as written data inpatients’ case notes so did not have the same permanence (Barrett 1994:4).

Ward Rounds: Weekly Information Exchange between Oliveto’s Staff

Every Thursday, members of the multidisciplinary team and one nurse nominated to speak for the nursing staff (sometimes different nurses were called in to speak
for different patients) would meet at 8.30am to discuss patients’ cases in detail. These meetings would often go on for several hours. The room would slowly fill up around a group of small tables laden with food provided by a different rostered staff member each week. The Head of Nursing nominated herself as 'coffee maker’ for all those in attendance at the meeting. The lack of authority of nursing staff in this context was made evident. Despite having the most extended physical contact with patients, their contribution to the team discussion was minimal. When questioned about this issue, nursing staff recognised their lack of authority in this context, but the majority appeared to accept this with little complaint.

The most senior psychiatrist available usually chaired these meetings on the day. When Dr Margaret was available she would chair, but more often than not, the role was fulfilled by Dr Olivia. During these meetings, all of the information gathered through Oliveto’s surveillance, observation, regulation and normalising techniques, would culminate. With this information, decisions were made about patients’ treatment and progress through the mental health system. There was a pattern to how ward rounds occurred. A trainee psychiatrist on the team presented each patient and a general history (which was often read directly from the case notes) was shared among the team. Each of the staff members involved with the patient shared their observations with the team; nursing staff were almost always left until last. Discussions among the team were often emotive, particularly with disciplinary conflicts. Concerns over child safety and psychological well-being in the context of the child’s attachment relationship often elicited highly emotive responses from members of the team. The management of the mother’s psychiatric illness was always considered in relation to the impact on
the child. A large part of discussion around mother-infant admission was the assessment of risk for the child, mother or anyone else that may have close contact with the mother. As mothers, assumptions of normative attachment ideals gave way to moral evaluations about the woman as a mother, rather than the woman as a patient. In such a way, moral evaluations became an integrated part of Oliveto’s multidisciplinary discussions.

Although patients were admitted with a referring diagnosis, and this was confirmed, or altered, at the time of admission, patient diagnoses could be shifted during their admission in Oliveto. In team discussions, based on observation and surveillance, diagnoses were occasionally altered so that the patient was able to access more appropriate services for her, her child and her family’s situation (see the next Chapter). For a patient to progress though the Oliveto system and be discharged, they needed to show signs of improvement. Improvement in the Oliveto context meant conforming to cultural norms through self-regulation and demonstrating insight into her condition (see Chapter Six).

Based on the information shared in interdisciplinary interactions, (multidisciplinary meetings, case notes and communications with external services) Oliveto’s staff discussed possible treatment options and determined the length of stay in the unit. A patient’s behaviour towards staff and others also contributed to their progress through the Oliveto system. If a patient did not conform to norms in the way that staff believed they should, this then had implications for their progress through the system, and the timing of their discharge.
As a mother and baby unit, Oliveto’s power relations operated through twin ‘psy’ discourses: Psychiatry for classifying and treating illness behaviour which will be discussed in the next chapter, and the psychological construct of Attachment for defining the mother’s illness in relation to her relationship with her child (this will be discussed in Chapter Five). Through governmentality and disciplinary techniques, maternal subjectivities were shaped to fit within expected cultural norms. Disciplinary technologies operated through Oliveto’s multidisciplinary team, with varying levels of authority, autonomy and power dispersed among its members. The technology of surveillance and observations facilitated through panoptic principles and predominantly nursing staff had a coercive effect in the self-regulation of maternal subjectivities. Medical dominance was observed to be in favour of those with more authoritative knowledge in Perinatal and Infant Psychiatric discourse; however power relations were observed as diffuse and not always operating in a hierarchical order. Power could thus operate through adhering to knowledge produced within the disciplines, or exercised through resistance by not providing information or a lack of action.

In the following chapter is in-depth exploration of Oliveto’s psychiatric practice that questions the taken for granted assumptions embedded in psychiatric knowledge. Through my analysis, I give focus to the role of psychiatric diagnosis in informing a biological view of mental illness and illuminate the subjective nature of diagnosing psychiatric illness. Chapter Four aims to continue the discussion of power that is embedded in psychiatric knowledge.
CONSULTING PSYCHIATRIST: We have significant concerns about Julia. She has had a long-standing diagnosis of schizophrenia which she has not always been entirely happy with. She has been in Oliveto for five weeks. The main feature with her mental illness is to monitor her.

MEDICAL UNIT HEAD: What medication is she on?

CONSULTING PSYCHIATRIST: Quetiapine — extended release, daily dose. Domenic has reviewed her psychiatric phenomenology...

REGISTRAR: Yes, Julia has increasing hypomania. We’ve spoken about prescribing Lithium to her... There is evidence of grandiose functioning. She is distractible and has indiscreet behaviours. There are also some romanticised ideas about the male doctors.

NURSE: Yeah, she wanted to buy the men a nice shirt each; a pink one for Alex (med student)... and had to be talked out of it (giggles from some staff members).

REGISTRAR: On Monday she had an appointment with the medical unit head where they let her ‘have free run’ for five minutes. She had a flight of ideas, moving from one topic to another. She has manic features. Without Quetiapine she probably wouldn’t be able to sleep because of her mania.
NURSE: She needs to have boundaries! She’s manic at the moment with obsessive letter writing. She has thousands of pages of paperwork.

REGISTRAR: She was given written information about Lithium and went away thinking about the change in drugs.

NURSE: She is only even considering it because she was given it by the [male] registrar, she would have argued it if given to her by anyone else.

CONSULTING PSYCHIATRIST: She’s thinking about it, not resisting...

NURSE: Over the weekend she wrote hundreds of pages, and has a folder full of paperwork: evidence of her hypomanic state.

MEDICAL UNIT HEAD: How often has she been going out lately... leaving the facility?

CONSULTING PSYCHIATRIST: She leaves for long periods of time, not a good idea for her.

MEDICAL UNIT HEAD: She can’t leave the facility with Lilli [her daughter] without a staff member accompanying her. At the moment she’s not focussing on Lilli, her concentration’s taken over by guardianship issues.

CASE WORKER: She is still as unwell as before. She’s always been over-inclusive. The way she is acting now is the kind of behaviour that brought her into Oliveto.

MEDICAL UNIT HEAD: What is her current diagnosis?
CONSULTING PSYCHIATRIST: Long standing schizophrenia

MEDICAL UNIT HEAD: That can be re-assessed now.

NURSE: (muttering) Persecution disorder?!

REGISTRAR: An affective diagnosis would be kinder possibly, schizo-affective disorder?

MEDICAL UNIT HEAD: I think she could even be bipolar, it's more hopeful. ‘Affective’ has a much stronger connotation.

REGISTRAR: She’s hypomanic, her concentration is poor. We can’t judge her parenting skills until this is sorted.

This discussion about Julia’s case reflects the ways in which Oliveto’s multidisciplinary team sought a name for their patient’s illness, with a corresponding medication to treat it. The discussion also shows how the symptoms Julia presented might be attributed to several different diagnoses. Through the process of diagnosis, behaviours are evaluated as either normal or abnormal, and then matched to symptoms of mental illness. Applying a psychiatric lens, practitioners referred to the criteria of diagnostic categories, which in turn informed decisions about the most appropriate (in this case pharmacological) treatment for symptom management. After an initial diagnosis required for referral, a review of this diagnosis would be made on admission, treatment options discussed, and roles and responsibilities designated among Oliveto’s team.
Using Julia's case and other ethnographic examples, this chapter explores how diagnoses functioned as both a process and label (Jutel 2009:279), both having implications for the women who found themselves recipients of these fundamental medical practices. Through ethnography, I describe how psychiatric diagnoses played a powerful role in the interpretation and structuring of women’s experiences and difficulties, revealing the ways in which diagnoses were confirmed, adjusted, manipulated and justified, and the consequences these processes had for those involved. In this chapter I give emphasis to the role that psychiatric diagnoses played in informing the knowledge used by mental health practitioners in their practice; diagnosis emerged as a fundamental contributor to the shared social discourse for all informants in Oliveto. Whilst the level of engagement and understanding each group of informants (psychiatrists, patients, allied health and so forth) had with diagnoses varied significantly, it was through a diagnosis of a mental illness in the postnatal period that all patient informants came to share the same institutional site.

In contemporary mental health care, diagnostic and therapeutic practices are informed by a body of mental health knowledge that includes a number of ‘disciplines’ (Roberts 2005:36), represented in Oliveto by its multidisciplinary team including: psychiatry, psychology, social work, occupational therapy and mental health nursing. Whilst all members of the team contributed to discussions around diagnoses and case management, the therapeutic focus of each disciplinary group was diverse, and sometimes conflicting, so did not represent a unified body of mental health knowledge (Roberts 2005:37). Despite this, the concept of mental
illness and psychiatric diagnoses formed a common knowledge about mental health that all team members shared.

This chapter considers how diagnosis was central to Oliveto's psychiatric practice: as mentioned, a diagnosis of mental illness in the postnatal period was fundamental for facilitating admission. Defining a patient's experiences through diagnosis provided a common language whereby all those involved in care had a 'socially-shared discursive resource' (White 2002:411) with which to communicate. Through the common language of diagnosis, information was exchanged from the referring medical practitioner to the staff at Oliveto, and then became fundamental in constructing and organising case work. It was therefore pivotal for Oliveto's daily working environment. Throughout this thesis, I consider psychiatric diagnosis critically, recognising that categorisations of mental distress (or social deviance) are social constructions that reflect biomedical beliefs about mental health and illness in a particular place and point in time (Ussher 2011:4). Although accepted as taken for granted knowledge by those within the 'psy-professions' (Rose 1996:2), I take the view that diagnosis reflects the interests of experts in the field of mental health. Through one of the many psychiatric diagnoses identified in the 'Diagnostic and Statistical Manual of Mental Disorders' (DSM), mental health practitioners reify their right to regulate and control the behaviour of individuals deemed mentally unwell (Ussher 2011:4). The DSM, as the principal biomedical reference text for the identification and classification of what are considered abnormal or ‘deviant’ behaviours formed and informed Oliveto's psychiatric practice.
Through ethnography, the instability of psychiatric diagnoses was made apparent. Despite the checklist approach provided in the DSM, the clearly defined criteria were in fact blurred categories reliant solely on the clinical judgement and evaluations of Oliveto’s staff. As discussions about Julia’s case show, symptoms could be interpreted differently by varying members of the multidisciplinary team. Julia’s referring diagnosis was schizophrenia, however, as the discussion by Oliveto’s team demonstrated, the diagnosis was reviewed with questions about the applicability of this diagnosis to her symptoms. Over my time in the field, I was struck by the mismatch of diagnoses between what was written in formal documentations, what was discussed about patients in both formal and informal networks, and what patients could tell me about their own diagnoses. The shifting of diagnoses discussed in cases like Julia’s from admission to discharge also raised a number of analytical questions: what was the true function of a psychiatric diagnosis? What purpose did it serve in the Oliveto context? And how did it inform Oliveto’s psychiatric practice?

**Diagnosis: Translating Illness into Disease**

Within the anthropological and sociological literature, a distinction is made between disease and illness (Kleinman, Eisenbruch & Good 1978; Singer & Baer 2007). Illness refers to the individual’s perception of ill health; the way that it is experienced, expressed and the individual’s pattern of coping (Kleinman 1988:7). Disease on the other hand, is ‘a natural entity that can be identified through various bodily signs, such as a high temperature, elevated blood pressure or rapid heart rate’ (Singer & Baer 2007:65). It also ‘refers to the way that practitioners recast illness in terms of their theoretical models of pathology’ (Kleinman 1988:7). 
Through a psychiatric lens, illness experiences are recast and interpreted as disease through psychiatric diagnoses formulated in accordance with the DSM. At the time of this research, diagnoses were formulated in reference to the then current DSM-IV-TR, in which symptoms were presented as a checklist for the easy identification of illness categories. As a specialty within medicine, psychiatric practice follows a medical model, which, common to all medical practice, uses diagnosis as a classification tool (Jutel 2009:278). Practitioners of psychiatry are trained to use diagnosis to identify individuals as ‘sick’, speculate about the future course of the individual’s illness, identify what caused the problem, and attempt to improve the condition through an appropriate treatment (Pilgrim & Rogers 2005:2). Within a medical model framework, mental health problems could therefore be considered synonymous with disease located in specific organs of the body (in this case the brain), altering its anatomy and physiology thereby causing symptoms (McDonnell 2004). The medical model however, normally relies on identification through visibility of pathologies (either to the naked eye or though medical technology — C.A.T scans, blood tests, and so forth) for diagnosis and application of appropriate treatment, yet this is generally not possible for mental illness. In Oliveto for the most part, mental illnesses were not diagnosed through visible identification, but instead were formulated through the judgements made by practitioners who had received training in the translation of behaviour into symptoms of psychiatric illness identified in the DSM-IV-TR.

In contemporary psychiatry, the practice of treating the ‘symptoms’ of mental disorders, as opposed to their cause, has been attributed to the introduction of the DSM (Horwitz 2007; Manning 2011; Mayes & Horwitz 2005; Szasz 1961). In 1952
the first DSM, published by the American Psychiatric Association, sought to standardise psychiatric diagnoses, which prior to this, had been open to several different classifying systems. The acceptance of the DSM as the dominant reference manual for the diagnosis and treatment of mental disorders continued over time with several editions and revisions published.45

The third edition of the DSM (DSM-III), published in 1980, has been recognised as an influential introduction to psychiatry (Mayes & Horwitz 2005; Wilson 1993) and a fundamental socio-historical contributor in informing biological assumptions of mental illnesses. It imported a diagnostic model from physical medicine where diagnosis is the keystone of practice, thereby aligning psychiatric practice closer to other medical disciplines (Mayes & Horwitz 2005:250). These changes resulted in strong reactions from different quarters. Theoretical arguments put forward in the 1960s and 1970s by Thomas Szasz (1961), R.D. Laing (1960), David Cooper (1967), and Franco Basaglia (1961) in what came to be known as the anti-psychiatry movement, challenged the fundamental assumptions and practices of psychiatry. The argument by anti-psychiatry theorists was that mental illness could not be defined objectively in the ways that the DSM tried to promote (Mayes & Horwitz 2005:251). Unlike physical illness and abnormalities of the body, it was argued, the presence or absence of mental illness required clinical judgement, and could not be compared to observable disease or damage. Anti-psychiatry theorists believed that psychiatric diagnoses did not meet the scientific standards of truth through objectivity and reason. They relied too heavily on interpretation by a select few (psychiatrists) and were therefore

45 At the time of my field work (2008-2009) the DSM-IV-TR was the most recent publication. The DSM-V (2013) was released at the time of writing this thesis.
considered inconsistent, questionable and dangerous to individuals and to society, as normal behaviours could be pathologised and the parameters for deviance become arbitrary.

Despite anti-psychiatry critiques, through its classification of psychiatric symptomology, the DSM-III was granted a new scientific status and the checklists for psychiatric diagnosis became accepted practice. The DSM-III was a catalyst for change in psychiatry, contributing to the biological vision of mental health evident in Oliveto. It emphasised symptom-based pharmaceuticals as treatments over cause-related talk therapies and behavioural changes (Mayes & Horwitz 2005). The DSM has continued its widespread popularity among many mental health clinicians, publishing a number of revisions that included the deletion of some diagnoses, as well as the inclusion of other new diagnostic in the DSM III and DSM-IV. In the DSM-IV-TR (text revision) additional text was added to include extra information about each diagnosis, along with new axes that incorporated psychosocial, environmental, childhood and medical factors. Fabrega’s critique of the DSM-IV argued, that the language used ‘reflects culturally particularistic assumptions about the nature of mind, behaviour and personhood drawn from Western European culture’ (1996:8). These assumptions are produced through an interplay of biosocial factors that produce illness conditions, sociocultural standards about behaviour and academic conventions about rationalism, voluntarism and autonomy that are produced through Western thought (ibid).

Diagnosis and Diagnosing in Oliveto

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46 Anti-psychiatry has also been the subject of critiques arising within the areas of critical health psychology, anthropology, sociology and systemic therapies.
The term diagnosis refers to the label given to an illness or disease, as well as the process whereby the label is identified. The first process of diagnosis occurred for Oliveto patients outside of the facility providing a label that could convey to staff in Oliveto information about the patient’s condition. After admission Oliveto’s medically trained staff, or medical students on their psychiatric rotation, would review this diagnosis using an interview tool called the *Maudsley Psychiatric History* (see Goldberg & Murray 2006), referred to colloquially as the *Maudsley*. Briefly summarised, the *Maudsley* involved taking a detailed description of the patient’s representation of their presenting complaint assessed in the context of the doctor’s referral and a history of the presenting complaint. Ethics prevented me from observing a patient’s psychiatric history being taken, so my ethnographic data only began at the point where information collected in the interview was shared with the multidisciplinary team during the Thursday weekly ward round meetings. It is important, however, to understand how the process used for gathering this information occurred as it was as a result of this medical interaction that information about the patient was shared and discussed with Oliveto’s multidisciplinary team.

I have chosen to focus on one element of the psychiatric history —the mental state examination (MSE) which was routinely conducted by one of Oliveto’s psychiatric staff members (if not the psychiatrist, then a psychiatric registrar or a medical student on a psychiatric rotation). The MSE assessed the patient in terms of several categories: the patient’s appearance, behaviour, speech/conversation, perception, cognition, insight, judgment, rapport (with the clinician) and communication. The individual’s behaviour in relation to the interviewer was
judged at the time of the interview, and then constructed to fit into discreet categories consistent with psychiatric practice, into symptoms of their mental illness (Lupton 1994). Past medical and psychiatric histories were also taken into consideration along with medications and potential substance abuse. The phenomenological experience of the woman was overridden with psychiatric reconstructions in favour of medicalised explanations that matched symptoms with diagnostic categories identified in the DSM. It was through the collation of these assessments that the referring diagnosis was either confirmed or adjusted and treatment plans prepared. The results of an examiner's assessment were presented to the multidisciplinary team in ward rounds whenever a new patient was admitted. A medical student, under the guidance of a psychiatrist or psychiatric registrar, was typically responsible for presenting their assessment to the team. Patients were never directly involved in this process.

The subjective nature of these assessments cannot be ignored. Many of the analytical categories required for the MSE cannot be formally defined, even in the context of science and psychiatry. The assessment of these categories relied on the interviewer's everyday knowledge of general cultural meaning and social norms and therefore inherently includes the subjectivity of the examiner (Addlakha 2008:51). If the information gathered in this medical encounter was used to confirm or adjust referring diagnoses, then a critical examination of this interaction must also question the scientific rigour of the process. The significant power imbalance in these interactions was apparent: the patient's future outcomes were based entirely on the decisions of the examiner. The examiner's interpretation of this encounter ultimately determined the diagnosis and
treatment that patients received. However, as was demonstrated in Julia’s case, the understanding of symptoms in psychiatric practice could be translated differently by different individuals, particularly when individuals had different disciplinary training. The difference in opinions often caused friction between staff members, particularly in cases when personalities and ideological beliefs clashed around the emotive issues of mothering and child safety.

In Oliveto, psychiatric diagnoses were indivisible from power structures (see Estroff 1988; Rhodes 1992), with biological treatment having dominance over the psychological and particularly the social models. The biopsychosocial model of treatment offered in Oliveto by its multidisciplinary team meant that treatment plans were negotiated and devised using the discipline specific skills of different staff members as required. Within this model, the biological took precedence over other treatment modalities and had the authority to overrule all decisions. The dissection of casework meant that approaches were sometimes fragmented, with parts of the person ‘disarticulated’ (Barrett n.d.) and distributed among the professionals in Oliveto’s multidisciplinary team, a common finding also discussed in other medical anthropological ethnographies (Barrett 1996; Lucas 1999; Pilgrim & Rogers 2005).

Throughout the process of psychiatric diagnosis, it was medically trained individuals (psychiatrists, medical students) who were granted the authority to be involved in diagnostic processes. Nursing and allied health staff, although often having had more applied experience with mothers with mental health problems, had limited involvement in these processes. Although included in staff discussions around diagnosis, the dominance of the medical professions in Oliveto was still
apparent (see Chapter Three). Freidson’s (1970) sociological research was the first to bring attention to this phenomenon. In what he termed ‘medical dominance’, Freidson highlighted how those in the medical professions held authority over medical knowledge in health care settings by virtue of the many years of training received, and formalised within the institutions that they operated. Following on from this, Willis’ (1983) historical study on the dominance of medical professions in the Australian context identified three specific modes used by those in the medical profession to dominate health care setting; subordination (making sure that other professions worked under their control), limitation (restricting some profession from access to certain areas) and exclusion (denying official legitimacy through formal licensing) (Long et al. 2006:506).

Although other authors have argued to the contrary (see for example Daniel 1994; Freidson 1994; McKinlay & Stoeckle 1988; Nancarrow & Borthwick 2005; White 2000), it was my observation that medical dominance was still operating in the Oliveto context. Even when a diagnosis had been agreed upon after admission, medical staff continued to hold the authority to decide the best treatment options, and held the administrative responsibility to decide the allocation of professional specialties for each case.

Diagnoses Treated in Oliveto

For the most part, women in Oliveto had a formal diagnosis of a mood disorder with a postpartum onset, commonly referred to as postnatal depression (PND). A register kept with the diagnoses and other details of patients admitted into the unit (name, admission, discharge dates, child and partner’s name, religious background) categorised the majority of my informants with PND. Although not
identified in the register, a significant number of these women were also discussed as having borderline personality disorder (BPD) generally in conjunction with their mood disorder (BPD is discussed in detail in Chapter Eight). There were also a small number of women like Julia diagnosed with psychotic disorders — diagnoses most of them had received many years before their admission into Oliveto, but since the birth of their child their illness behaviours had raised concerns about their ability to parent their child(ren) in accordance with acceptable cultural norms. Prior psychotic illness was deemed significant because of the assumed heightened risk this mental illness might pose for the child.

As an acute psychiatric unit, Oliveto admitted and treated only severe and acute cases of postnatal mental illness that were often complex involving a number of different external services, including legal services. Simple PND, although a label typically used by patients to describe their illness, tended to be treated outside of the Oliveto facility as described in the following comment from a nurse.

We used to get the typical postnatal depression with the picket fence and the loving husband and the supportive family...nice and neat, teary, weepy, not coping, you know, did really well, got better, went home. We don’t see them now because the community looks after them. We’ve tried to teach GP’s to treat early and get community facilities in charge.

In her comment, the nurse is referring to pharmacological treatments prescribed by General Practitioners for the symptoms of depression and anxiety, again implying a biological basis to symptoms. However, as also suggested by her comment, admissions into Oliveto were more complex, requiring a broader approach to treatment plans, which will be described further below. Her comment
also indicated that people admitted to Oliveto presented more complex cases that required a multidisciplinary approach.

The complexity of cases seen in Oliveto is reflected in the difficulty some students experienced when first asked to provide a psychiatric diagnosis for women in Oliveto, as expressed in the following student’s comment:

*I have difficulty diagnosing them...not because I don’t understand the diagnostic process, but because I don’t always think the labels are appropriate. Some women weren’t coping at home but they seem normal here. Some of these diagnoses are more to do with life situation rather than medical problems.*

The student’s comment captures the contradictions in Oliveto’s psychiatric practice. Through a psychiatric lens, diagnoses used for referral were treated predominantly as medical problems, despite the often spoken about biopsychosocial focus.

Critiques of contemporary psychiatric practice link indicators of psychiatric disorders to the ‘individual’s symbolic behaviour and hence the self’ (Fabrega 1996:6). Unlike general medicine where accounting for disease ‘is a commentary about the physical body and indirectly about the self’, disease accounting in psychiatry is a direct commentary on the self and of the self’ (Fabrega 1993:167 author’s emphasis). If the ‘self’ is composed of social behaviour, and psychological experiences put together, then to diagnose psychiatric disease means to ‘qualify the self medically’ (Fabrega 1989a; Fabrega 1993:167; see also Fabrega 1989b). Although social behaviour, measured predominantly though the mother’s
parenting of her young child (see Chapter Seven) and psychological experiences, particularly those of early childhood (see Chapter Six), accounted for a significant part of the treatment practices in Oliveto, an emphasis on the biological basis for illness and for treatments still remained.

Shifting Diagnoses

The discussion of Julia’s case provides an example of how a diagnosis was fluid and difficult to determine, with Oliveto’s staff having the power and authority to make decisions about mothers in their casework. I spoke with several staff members about the shifting of diagnoses, and I was given a number of explanations. For the most part, their decisions were justified as being the best strategies for allowing the patient access to pharmacological treatment, access to services and so forth. For example, the services offered at the time of discharge were often linked with specific diagnoses, so effort was made to ensure that women had the appropriate diagnosis to link her with the most suitable services. When asked about Julia’s case and the shift in her diagnostic label from schizophrenia to schizoaffective disorder or bipolar disorder, it was explained to me by Oliveto’s Medical Unit Head in the following way.

[Changing the diagnosis] de-stigmatises it in our own minds and kind of puts in some therapeutic optimism instead of therapeutic nihilism. Just the sense of – oh well there’s a sense of mood component to it, which is the affective... it’s much more treatable. Whereas schizophrenia is a much more chronic diagnosis...if we start to say that there’s a mood component, could respond to a mood stabiliser, it gives us new pathways to try treatments.
It’s to do with accessing treatment forms, not specifically resources in the community.

This explanation reflects two important concepts. First diagnostic labels were seen to have certain stigmas and assumptions attached to them, even for the mental health workers providing the diagnostic label. This in turn affected the way staff interpreted the behaviour of the patient. Second, psychiatric labels were not only applied in order to satisfy DSM criteria, but were also being used to negotiate the system to gain access to resources for patients that would otherwise be withheld from them. Changing a diagnosis could also indicate a change in pharmacological treatment better suited to the patient’s symptoms.

Accepting and Rejecting Diagnoses

In my discussion with patients in Oliveto, few expressed negative reactions to the diagnosis they had received for admission. Although experiencing the symptoms of mental illness was difficult to cope with, receiving a diagnosis signified a social awareness of their experiences as legitimate. The birth of a new baby is often an exhausting time for mothers, with very little sleep or time for rest. In many cases, sleep deprivation amplified symptoms of anxiety and depression, and so were easily confused as expressed in the following comment by a patient.

\textit{The tiredness was getting on top of me, I wasn’t getting any relief...I had visions about awful things that could happen to Jamie... I couldn’t keep my eyes open, and when I was [awake], I was jumping around, anxious.... I wasn’t aware that I was sick. I knew I was tired... It was all a bit of a blur.}
In her discussion with me, the patient went on to explain how realising she was ‘sick’ and not just tired, gave her a sense of relief. Although she was not comfortable with the idea of being sick, recognising that the way she was feeling was in fact a sickness meant that it was treatable. Assuming the ‘sick role’ (Parsons 1975) also legitimized her exemption from normal life duties while being treated for her illness, without the expectation from others to remain socially engaged.

However, this was not the case for all patients, particularly for those like Julia who were diagnosed with psychotic illnesses that held a greater stigma. In our private conversations Julia told me that she always felt that her diagnosis of schizophrenia when she was twenty-two was unfair and incorrect. Julia was one of the few participants in Oliveto who was able to articulate her knowledge about her mental illness, her official psychiatric diagnosis and the expected features of this categorisation of mental illness.

*Julia explained the events that led to receiving her diagnosis of schizophrenia from her perspective. She told me she was diagnosed after going to her local public hospital claiming to have been poisoned by her father; she believed he had unintentionally tried to poison her with rat droppings. She went on to explain that her father had a disability and was not able to clean up the difficult areas of the house; she described him as unhygienic. She had found rat droppings in the food he gave her and at the time she thought that he was trying to poison her. The doctors in the hospital did not believe her, so they locked her away in a glass room. They gave her all sorts of injections and she was kept in hospital for several days while they tried to work out a diagnosis. After three days they told her she*
had schizophrenia. Julia expressed to me her regrets about the day she went to the hospital. She felt that if she had been dressed differently (not in track pants) and was calmer she might not have been diagnosed. She suggested that if she had waited to calm down a bit, none of this would have happened and she would never have entered the mental health system.

Another patient, Georgia, who was diagnosed with schizoaffective disorder, expressed the same frustration over her belief that she was labelled with the wrong diagnosis. She was a very willing informant and wanted to share her story in the hope she could help others in her situation.

Georgia told me she was diagnosed with schizoaffective disorder when she was twenty-six years old and living at home with her parents. The first episode occurred when her parents rang an acute care emergency intervention service because they were concerned that she was staying up too late. She felt that the reason her father didn't like her staying up late (11.30pm) was because he did not like her leaving the lights on and wasting electricity. When the acute care team arrived, she was so angry with her parents that she went silent. She thought it best not to talk. All she wanted to do was yell at them and tell them to piss off and leave her alone. Her silence was interpreted as a symptom of her mental illness and from then on was labelled as schizoaffective. She felt that this diagnosis was unfair because she has since learnt that schizoaffective disorder often displayed symptoms of acting out (referring to impulsive, uninhibited or uncontrollable behaviour), being aggressive and experiencing hallucinations and visualisations. Georgia told me she had not experienced
any of these things, yet she was detained in an adult psychiatric unit for quite for some time. She said that the events of that night were what placed her in the system and she had not been able to escape since. She felt strongly that her diagnosis was incorrect and that it was because of this that she had lost many of her rights as a human being. Georgia believed that she had no say and that no one really gave her a voice. For this reason, Georgia expressed her interest in being involved in my research; she wanted things to change for the mentally ill and sharing her experiences with me gave her control over circumstances where she had previously felt denied of any agency. She thought the detention laws were completely unfair. Georgia knew the laws were going to be getting tougher, and this concerned her.

Both Julia and Georgia shared their regrets about the night that they were first diagnosed with a mental illness. They both reflected that if they had reacted differently in the psychiatric encounters and behaved in ways that were considered ‘normal’ (for example had not become angry, dressed more appropriately, spoken when spoken to) the treatment and resulting diagnosis they received may have been less detrimental. As women diagnosed with psychotic illnesses, they both felt their rights had been restricted.

Georgia expressed how her psychiatric diagnosis had changed the way that doctors related to her. Once medical practitioners read her diagnosis from other doctors, she felt, they began to speak to her with the symptoms of her standing diagnosis acting as a filter for viewing her behaviour. In much the same way that Rosenhan’s (1973) pseudo patients found that their behaviour, which was otherwise considered unproblematic, was attributed to their diagnosis when
admitted in a psychiatric context, Georgia believed that everything she did could be moulded to be consistent with the diagnosis she already had. In Georgia's words which highlight issues of power:

When I'm in a room with a psychiatrist they listen but don't really pay attention to what I'm saying. They interpret my words in the way that they want to hear them...because they are psychiatrists, their word is final.

A recurrent theme in informal discussions with staff about patients diagnosed with chronic psychotic disorders (schizophrenia or schizoaffective disorder) was the idea that the illness was somehow overlaid onto the person (see Barrett 1996). This was made evident in comments such as the following from a nurse, who claimed: I had a clear lucid conversation with the woman behind the illness...I could have a joke with her. The implication of comments such as these was that the responsibility of managing the mental illness was beyond their control. These women were described as divided in two parts: the individual and the illness. For the majority of the time the two were constructed as existing simultaneously, but on occasions, as demonstrated by the nurse's comment, the individual behind the illness appeared. Barrett’s (1996) ethnographic findings on staff constructions of patients with schizophrenia in an inpatient unit showed similar results. He suggested that when referring to patients with psychotic illness, two frameworks were engaged: ‘One implies that the patient is a passive object who is a victim of psychiatric illness. The other framework implies that the patient can engage in consciously motivated action and is morally responsible for these actions’ (Barrett, 1996:2). Women with psychotic illnesses in this context, on the one hand, were seen to lack control over their behaviour. However the biological construction of
their illness meant that medication could help the individual control their symptoms, so on the other hand, they were seen as morally responsible to be compliant with medication.

TREATMENT: A BIOPSYCHOSOCIAL MODEL

Oliveto staff spoke of providing inpatient treatment that attended to the biopsychosocial requirements of each case— that is the biological, psychological and social factors that contributed to the patient’s distress. As patient cases were complex, often including psychological issues stemming from past traumas, particularly in childhood (see Chapter Six for discussion), and social problems related to domestic abuse, financial problems, drug addiction and so forth, treatment plans varied from patient to patient. Whilst the psychological and social were indeed factors of treatment plans in Oliveto, treating patients with medication took precedence over other treatment modalities — particularly for those who had psychotic disorders. In these circumstances it was believed that until the patient’s symptoms were under control (through the use of pharmaceutical treatments), addressing psychological and social problems was difficult as symptoms could interfere with the patient’s ability to have insight and clarity in the treatment process. The inclusion of the social and psychological causes of mental illness seen in modern psychiatry may be thought to give equal consideration, however they still ‘legitimise the disease model and the authoritative power of medicine in the diagnosis and treatment of people with personal and social problems’ (Pilgrim & Rogers 2005:142).
Within Oliveto’s biopsychosocial model biological treatments took precedence, pointing to the underlying assumption of a biological cause behind patients’ abnormal behaviour. Informed by the patient’s psychiatric diagnosis, pharmacological treatments were observed to be the primary treatment modality used for the overwhelming majority of patients; medication was generally accepted as the most effective method for managing symptoms and stabilising mental health in this acute mental health setting. The underlying assumption behind the use of medication therefore, implicated biological dysfunction as the cause of these symptoms. These features of psychiatric practice were evident in Oliveto’s staff discussion about Julia’s case, and were also evident in the overwhelming majority of women’s treatments in Oliveto; their behaviours were matched to diagnostic illness categories in the DSM-IV-TR and to medications and treatments to suit their presenting symptoms.

The overall use of medication for treatment in Oliveto was rarely questioned by those in the unit. However, the effectiveness and suitability of the particular medications prescribed were discussed in staff meetings. In my conversations with patients, many did not question the medication they were prescribed. In fact for many, medication signified a possible change to the way they were feeling and so they accepted the treatment they were offered. The following statement from a patient describes this well.

As soon as you get there they give you drugs, and you think ‘oh well, I’ll just take them if it makes me feel better...’cause my anxiety was a panic attack and feeling like this...and as soon as someone spoke to me I felt like bursting into tears. And you are so desperate to stop those thoughts going ‘zzzzzz’,
'cause they're incessant. For me I found it so draining being depressed. Because the... they're not like voices, but the thoughts in your head just won’t stop and leave you alone.

For this patient, the possible benefits of taking medication outweighed any side effects she was experiencing, so she was willing to accept the treatment offered. Apart from the side effects of anti-psychotic medication, patients rarely spoke with me about resistance to taking the medication prescribed. In fact, certain medications were spoken about favourably. Lorazepam, a drug used to treat anxiety disorders was offered to patients with severe anxiety. Of the patients who spoke to me about this treatment, it was medication that they enjoyed taking, so much so that they even created a nick-name for it—a loraz.

For many patients, medication that assisted with sleep was administered on admission, with the rationalisation that the mother needed to catch up on lost sleep while nursing staff took over the night care of their child. Whilst many mothers were appreciative of this, a discussion I had with a patient after her discharge highlighted a concern regarding this practice.

You don’t find out a lot [from Oliveto staff]... well I suppose I didn’t ask questions. But you don’t find out how addictive it is. And you’re not meant to have it every day, they’re sleeping tablets, you’re only meant to have them when you need them...they just give them to you at night, and say ‘here’s your medication’ so you have them and you don’t think while they’re giving them to me that they are so addictive.

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47 Belonging to a class of medications called benzodiazepines which have a minor tranquiliser effect.
I use this discussion to demonstrate that many patients did not question the medical authority or Oliveto’s staff in relation to medication compliance, although if they were offered more information about the risks and side effects, they may question acceptance. Compliance with medication did not appear to be a large problem with patients in Oliveto. However, patients being treated for psychotic disorders were often spoken about as having medication that did not agree with them. In response to new medications, patients complained about significant weight gain, inability to concentrate, and the ineffectiveness of particular medications. In some instances these complaints were taken into account and medications were adjusted accordingly, but ultimately if psychiatric staff believed that a patient needed to take a specific medication, then they had the power to enforce this. Psychiatric staff had the authority to request a Community Treatment Order (C.T.O), where the patient was required to take medication regularly administered by a third party, even if the patient felt that the medication disagreed with them.

Julia told me that part of her manic letter writing (as described by staff), was in response to a CTO that had been recommended for her. Oliveto asked that Julia receive her medication by ‘depot’, an injection that releases medication slowly over long periods. She was angry because, from her perspective, she had given staff no reason to believe she should need the depot; she explained that she had always been compliant with her medication. Also, she did not like the side effects

48 A Community Treatment Order (CTO) is an order requested by a psychiatrist or authorised medical practitioner that enforces a person with mental illness to cooperate with medication for the treatment of their illness, even if they feel that the medication does not agree with them. In the Australian state where this research was conducted, a CTO could only be issued by a psychiatrist or authorised medical practitioner.
of the medication, which caused her excessive weight gain, and generally felt that the medicine did not agree with her. She explained that her last blood tests that screened for medication compliance had been slightly elevated, consistent with missing one tablet. She was writing in preparation to appeal her case. In this circumstance, her illness was conceptualised as severe and organic, and so beyond the patient’s ability to control her symptoms. Her mental illness symptoms were therefore considered a threat to her own safety and the safety of others, in particular her child. As a result of her diagnosis, her autonomy in decision making around the acceptance of medication was denied.

Through a referral from a medical practitioner, using one of the many diagnoses identified in the DSM-IV-TR, women were admitted into Oliveto. Information about the patient’s condition was conveyed to the medical practitioners in Oliveto who also shared the same knowledge about mental health that the DSM diagnosis provided. On the basis of this diagnosis, patients’ treatment plans were devised and distributed among the professionals in Oliveto’s multidisciplinary team. As mentioned earlier the precedence given to biological treatments within Oliveto’s biopsychosocial model was made evident through the predominant use of medication. Critiques of the DSM (from the DSM-III onwards) attribute this to the checklist approach of matching symptoms of mental illness behaviours with corresponding pharmacological treatments. In addition to this, the subjective nature of decision making around the interpretation of symptoms of mental illness revealed a significant power imbalance, whereby those with tertiary medical training were granted authority over other professions and over the patient. This was further demonstrated through the authority that medical professionals held to
shift or change diagnoses, or order pharmacological treatment compliance through legal avenues. The acceptance of diagnostic labels and of biological treatments however, went largely undisputed by the majority of informants in the field, signifying both authority of the medical profession and the acceptance of biological treatments for mental illness.

Within the multidisciplinary team approach offered in Oliveto, biological assumptions were observed to be dominant: however, biological interventions were only one aspect of treatment plans in this context where a dyad of mother and child was admitted. As the next chapter will demonstrate, the psychological construction of the mother-infant relationship, or attachment relationship, was also a fundamental focus of practice in Oliveto.
ATTACHMENT

The perceived importance of addressing mental health issues as early as possible became evident to me in my first weeks of fieldwork. The term *early intervention* was often used to stress the importance of this. To my surprise, this meant not only the mother’s mental health condition, but also the threat of mental health problems, and by extension potential developmental and behavioural problems in the child if they were not addressed in the child’s first years. The ‘quality’ of a mother’s relationship with her child in the early years was considered a key factor in this.

While Oliveto admissions were primarily facilitated through a mother’s diagnosis of mental illness, it was the relationship between the mother and child that determined the progress for the dyad’s discharge. Staff approached patient admissions as an opportunity to treat and stabilise the mother’s mental health condition, but also to prevent any possible future damage to the child’s social and emotional wellbeing. This thinking was based primarily on the assumptions produced through John Bowlby’s Attachment Theory (1952 [1951], 1958), a long standing psychological construct, promoting the idea that the relationship between a child and its primary caregiver (always the mother in Oliveto) set the template for the child’s relationships for their entire life. In Oliveto, mothers and their infants were observed and surveilled in numerous ways (see Chapter Six for further details) to look for pathology in their relationship. This pathology was believed to be transgenerational, a legacy given to the mother from her own
mother, which is, it was argued, transmitted to her from her own early relationships.

‘Attachment’: A Psychological Theory

Attachment (Bowlby 1958) is a psychological construct first theorised by John Bowlby to define ‘lasting psychological connectedness between human beings’ (Bowlby 1971 [1969]:194). His theory of attachment revolutionised the thinking around the relationship between a mother and child by applying scientific principles for demonstrating an infant’s dependency on a primary caregiver to fulfil its basic needs. More often than not, the primary caregiver was referred to as ‘mother’ in his theorising. Bowlby’s theory of Attachment was later expanded by a number of theorists, most notably Mary Ainsworth, who empirically researched Bowlby’s theories and provided a set of markers to identify the type of attachment styles, and their pathologies. Attachment Theory is of significant importance to understanding practices in Oliveto, as it was the main psychological structure that underpinned all therapeutic practices in the unit, and to a large extent, set the rules for culturally appropriate behaviour of mothers in the wider social context in which the unit existed. Further to this, I argue that Attachment Theory and its various articulations presented themselves in the ideologies that infused everyday practices within Oliveto (see Chapter Five for a full discussion). For this reason, the influence of Attachment Theory and its discursive application within the unit were fundamental for therapeutic work with mothers and babies in Oliveto.

This chapter explores the origins of Attachment Theory and its development over time to provide the context whereby Attachment Theory was applied in Oliveto. It
also gives insight into the biological assumptions made around mother-infant attachment and by extension the consequences for maternal and infant wellbeing. In addition to this, I demonstrate how Bowlby’s long standing theory still holds relevance in Oliveto and other contemporary psychiatric contexts, despite significant evidence to suggest the universalist claims of the theory are unfounded.

‘Maternal Deprivation: A Source of Social Infection’

Bowlby’s original work that led to his development of Attachment Theory began with his observation of orphaned and homeless children after the Second World War. Bowlby conducted an empirical study through the Tavistock Clinic, which examined forty-four cases of young maladjusted boys (see Bowlby 1944) who were considered to have ‘affectionless psychopathy’, or the inability to form enduring relationships. He found that these cases commonly revealed a disruption in the individual’s maternal relationship during infancy. It was from this that Bowlby first began exploring the links between the experience of early family interactions and personality formation, hypothesising that the absence of maternal love in early childhood could lead to pathological behaviour (Bretherton 1992:760).

Shortly after this study of forty-four boys, Bowlby was commissioned by the World Health Organisation (WHO), to report on the psychiatric needs of children in Europe and the United States (between 1948 and 1950) who had been orphaned or separated from their families. His report ‘Maternal Care and Mental Health’ (Bowlby 1952 [1951]) described how children displaying emotional and

49 Bowlby referred to these young boys as ‘juvenile thieves’. 
developmental difficulties was a result of what he termed ‘maternal deprivation’\textsuperscript{50}. Bowlby’s concept of maternal deprivation was supported by a body of literature published in the 1930s and 1940s (see Goldfarb 1943, 1945, 1949; Levy 1947; Rheingold 1943) suggesting that infants in institutional care almost always had inferior development (Eyer 1992:48). Bowlby was the first theorist to pull all of these studies together to form a coherent argument about the negative effects that lack of maternal care could have on infant mental health. He added that maternal deprivation could occur in seemingly ‘normal’ home environments. He believed ‘...[d]eprived children, whether in their own homes or out of them, are a source of social infection as real or serious are the carriers of diphtheria or typhoid’ (Bowlby 1952 [1951]:157). With his concept of maternal deprivation, Bowlby began positing the idea that the relationship between a mother and infant could be pathological, suggesting that a child without maternal love could develop an illness synonymous with a disease, treatable by medical (psychological) intervention. Consistent with the ideals of the social hygiene movement, mothers were placed in a position of responsibility for their child’s, and by extension, societal wellbeing.

Bowlby’s report (1952 [1951]) had worldwide impact, promoting practical changes in the institutional (hospitals, orphanages) admission of children, as well as an abundance of research and theorising about the importance of the primary relationship between an infant its mother. Although Bowlby was clear in his writing that mothers were not the only important influence in a child’s life, the term ‘maternal deprivation’ suggests the role of the mother as paramount for ensuring a healthy psychological future. The role of fathers was given very little

\textsuperscript{50} A second edition of this was published entitled \textit{Child care and the growth of love} (Bowlby 1965) which included a chapter review by Mary Ainsworth.
recognition in his theorising, however, nannies and permanent surrogate carers were mentioned.

Transgenerational Transmission

It was after his initial research among homeless and delinquent children that Bowlby’s theorising began. In 1948 he spent two years observing and documenting the behaviour of young children who had been separated from their parents (Bowlby & Robertson 1952). His findings inspired theoretical work highlighting the importance of attachment from the beginning of life for secure human development (see Bretherton 1992). He was interested in family dynamics in both healthy and pathological patterns between infants and their caregivers (particularly mothers) and how these could be transmitted from one generation to the next.

Like Freud (1940), Bowlby continued the belief that an individual’s first significant life relationship formed a template whereby all other love relationships could be understood. Inherent in this thinking was the concept of transgenerational transmission of these relationship formations which Bowlby first explored in his early theoretical and clinical work. He believed that through helping a parent he could also help the child. The following excerpt from an early paper describing his work with mothers having parenting difficulties demonstrates this:

...a weekly interview in which their problems are approached analytically and traced back to childhood has sometimes been remarkably effective. Having once been helped to recognize and recapture the feelings which she herself had as a child and to find
that they are accepted tolerantly and understandingly, a mother will become increasingly sympathetic and tolerant toward the same things in her child. (Bowlby 1940:23)

Bowlby’s early ideas for therapeutic intervention performed across generations were the cornerstone of therapeutic work in Oliveto. As this thesis will demonstrate, his theorising which began with a child focus was expanded to study the mother’s (or primary caregiver’s) role in the attachment relationship. Bowlby continued to develop his theory of Attachment\textsuperscript{51} which spanned several decades. With his theorising, he began to generate the belief that ‘the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment’ (Bowlby, 1951:13).

In a paper given about the life’s work of his father, John Bowlby’s son, Sir Richard Bowlby spoke about his father’s interest in the mother-infant relationship (Bowlby, R. 2004). He felt that his father’s motivation behind writing the theory was probably fuelled by his own up-bringing. His father was one of six children to wealthy English parents. The social practice at the time for people in his parents’ social position was to have their children cared for by paid nannies. As a young boy, Bowlby had formed a strong relationship with one of his carers, who left his family home to find better paid employment elsewhere when John was four years of age. This was said to have devastated him. It is perhaps for this reason that Bowlby always expressed that it was not only mothers, but also mother substitutes

\textsuperscript{51} His theories culminated in a trilogy of books about human attachment, separation and loss (Bowlby 1971 [1969], 1973, 1980).
that could provide the role of attachment figures to young children. However, he did stress the importance of ‘one’ attachment figure over several, theorising that was strengthened by appropriating ideas from animal behaviour studies.

**The Biology of Attachment**

Attachment behaviour is regarded as a class of social behaviour of an importance equivalent to that of mating behaviour. It is held to have a biological function specific to itself.

John Bowlby (1971 [1969]:179)

At the time of Bowlby’s theorising, the mainstream view held in psychology was that the infant’s attachment relationship with its mother was defined through the mother’s ability to provide food through nursing (Keller 2013:176). No longer satisfied with the conclusions drawn from psychology, Bowlby turned to an evolutionary approach to support his theorising. Borrowing ideas from ethology, the scientific study of animal behaviour in the natural environment, he was able to support his theorising in scientific terms. Bowlby drew parallels with his observational work and Konrad Lorenz’s (1935, 1937) study of imprinting in geese. Lorenz had shown that goslings formed social bonds with almost any moving object that they were introduced to in the critical period after birth. This was particularly intriguing for Bowlby as it suggested that the social bond that was formed was not only for food. Bowlby began to introduce ethological ideas such as ‘signal stimuli’ or ‘social releasers’ that he described as specific responses which promoted attachment between mother and infant. Bowlby wrote: ‘The infant is
endowed with at least two innate responses which have social significance, namely crying and smiling’ (Bowlby 1956:588). With this he began espousing an instinctual rational for his theoretical ideas, demonstrating how attachment behaviour was an evolutionary survival technique, protecting the infant from danger through the promotion of proximity to its mother. In doing so, he also reinforced the now widely accepted cultural assumption that the act of mothering is natural for women, indeed even instinctual (Badinter 1981; Hrdy 1999; Kitzinger 1978; Ruddick 1989).

Bowlby adapted this instinctual rationale to form an empirical basis for identifying a range of ‘attachment behaviours’ a child displays within its first year. These included the infant protesting departure, greeting return, clinging when frightened and following (with their eyes or crawling when mobile). Bowlby postulated that this innate instinct to attach and remain in close proximity to one main attachment figure (what Bowlby termed ‘monotropy’52) was essential for the infant’s survival. He often referred to this main attachment figure as ‘mother’ however he was clear to distinguish that his theorising was ‘concerned with the person who mothers the child and to whom it becomes attached, rather than to the natural mother’ (Bowlby 1958:351). Bowlby also identified a range of behaviours that promoted ‘proximity’ (crying, gazing and cooing) which the child displays to attract closeness to its caregiver. He described how an attachment develops between an infant and its caregiver as the infant’s instinctual cues are responded to. Bowlby (1958:351) suggested:

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52 Bowlby later revised his concept of ‘monotropy’ after observing attachment patterns in an Israeli Kibbutz. In his revisions, he identified that while infants may originally attach to one main figure, they went on to form several attachments to a number of significant figures.
...the attachment behaviour which we observe so readily in a baby of twelve months old is made up of a number of component instinctual responses. They serve the function of binding the child to mother and contribute to the reciprocal dynamic of binding mother to child.

These instinctual cues were thought to be imperative for the infant’s survival in the early years, but were also important for later emotional development. Bowlby saw the critical period for attachment between a mother and child as the first two years of a child’s life. If the attachment process was disrupted within that time, he argued, the child could suffer long-term consequences due to maternal deprivation. A child’s relationship to its mother (or the person who mothers him or her) in Bowlby’s view was fundamental to the development of a healthy ‘internal working model’ (Bowlby 1971 [1969], 1973, 1980). This model was the basis by which the child learns to understand the world and guides them in their emotional and social behaviour in the future. Bowlby believed that an individual’s effectiveness when interacting with others, their ability to see others as trustworthy, and their ability to see themselves as valuable, all rest upon the dynamics that occurred in their first significant relationship. The internal working model was believed to have a significant impact on the transmission of attachment patterns across generations.

Bowlby’s work challenged the position commonly held by psychologists and sociologists of the time, that the primary drives motivating the relationship between an infant and its mother were physical needs (for hunger, thirst, elimination, and pain relief) while emotional needs such as love and affection were
secondary (Harlow 1958:673). He suggested that the need for physical closeness and maternal availability were of equal importance and demonstrated this by drawing comparisons of innate human behaviour with Lorenz’s naturalistic study of birds. These ideas came at a time when psychology as a discipline was trying to prove itself as a rigorous science by identifying observable and measurable outcomes to provide objective truths.

Psychologist, Harry Harlow, was inspired by Bowlby's ideas of maternal deprivation, and began conducting experiments on rhesus monkeys that had been reared in captivity away from their mothers (1958). He set up an experiment to determine the primary motives for the attachment between a mother and its infant, providing two surrogate mothers for the infant to satisfy its needs. These surrogate mothers were made from wire mesh, one with a feeding tube. He also set up a wire mesh surrogate that was covered with cloth to provide comfort for the infants. He discovered that the infant monkey would go to the wire mesh monkey for its food, but then return to the surrogate that was covered in cloth for comfort and protection when threatened with danger. Harlow concluded that the infant monkey, regardless of where their food source derived, always sought comfort (attachment) with their cloth surrogate mother and therefore the need for mother-infant attachment was just as important as food for survival. Interestingly, Harlow also concluded from his study: 'It is cheering in view of this trend to realize that the American male is physically endowed with all the really essential equipment to
compete with the American female on equal terms in one essential activity: the rearing of infants’ (Harlow 1958:685).\(^5^3\)

**Categorising Pathologies of the Mother-Infant Relationship**

Although psychological and scientific communities negatively critiqued Bowlby’s Attachment Theory at the time, his work has had a fundamental impact on understandings of mothering and infancy in today’s industrial world. This was particularly made manifest in my ethnographic study of Oliveto: the assumptions that Attachment Theory proposed were infused into the everyday practices of the unit. This is due in part to the work of Mary Ainsworth who enriched Bowlby’s theories by creating what she believed were the different variables of attachment patterns, observed in the interactions between mothers and infants. (Ainsworth 1967; Ainsworth & Bell 1970; Ainsworth, Blehar & Waters 1978).

Ainsworth’s refinements of Bowlby’s theory gave the biomedical community various categories of attachment used to identify pathology within relationships. Ainsworth worked alongside Bowlby for several years, paying close observational attention to the interactions between young children and their parents when they were reunited after long periods of separation. Ainsworth identified and created categories of basic relationship patterns. In the scientific community, the ability to categorise behaviours made them attractive, as they could be quantified and therefore seen to be objective. The categories of attachment identified were:

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\(^5^3\) Despite both Bowlby and Harlow suggesting that the attachment figure could be a man or a woman and need not be a biological relative, biomedicine and industrialised cultures more generally still view mothers as the primary caregiver of children and ultimately responsible for their child’s future emotional well-being. The proposed reasoning behind this was discussed in Chapter Two.
positive, ambivalent and indifferent or hostile (Bowlby et al. 1956).\footnote{The categorisation of attachment behaviours within this collaborative paper were Ainsworth’s contribution to the study (Bretherton 1992:762).} Harlow’s work with rhesus monkeys also contributed to Ainsworth’s theories and supported her findings.

Several years later, Ainsworth began exploring these basic relationship patterns among mother-infant interactions among the Ganda people in Uganda, Africa. Ainsworth’s study (1953) was the first empirical validation of Bowlby’s ethological theories and focused on the onset of proximity-promoting signals and behaviours in infants, and when these became preferentially directed towards the mother (Bretherton 1992:764). While it was Bowlby who first brought attention to the innate cues that infants use to attract proximity to their caregiver, Ainsworth’s work was responsible for classifying the ‘quality’ of the mother-infant attachment. Ainsworth believed that it was a mother’s responsiveness that determined the type of attachment pattern of the relationship. ‘Securely attached’ infants rarely cried and were happy exploring when their mothers were present; babies who cried frequently, even when being held by their mother and did little exploration were categories as ‘insecurely attached’; and infants who displayed no differential behaviour to their mothers had ‘no’ or ‘poor attachment’ with their mother (Ainsworth, Blehar & Waters 1978). Thus it was the influence of Ainsworth’s work that shifted the focus on attachment research from being child focused, to an emphasis on the mother and her involvement in the attachment relationship. In her research she described mothers as a ‘secure base’ (Salter 1940)\footnote{Mary Salter was Mary Ainsworth’s name before marriage.} from where children explore their world, and a ‘safe haven’ (Ainsworth 1967) to return to.
In an attempt to demonstrate the universal applicability of attachment, Ainsworth developed a similar study to the one conducted in Uganda, to assess the quality of American babies’ attachment relationships with their mothers (1963). This study was believed to demonstrate striking differences in how ‘sensitively, appropriately, and promptly mothers responded to their infants’ signals’ (Bretherton 1992:765). Ainsworth began to categorise a mother’s relationship with their child in terms of how responsive or sensitive she was to the infant’s needs/cues: she referred to the mother’s response to her child’s proximity cues as ‘maternal sensitivity’. Ainsworth concluded: ‘an infant whose mother’s responsiveness helps him to achieve his ends develops confidence in his own ability to control what happens to him’ (Bell & Ainsworth 1972:1188). Ainsworth believed that the attachment style an infant had with its mother was defined by his or her prior experiences of rejection or satisfaction from the caregiver (Ainsworth et al., 1978).

Based on these ideas, Ainsworth and her colleagues went on to create the ‘Strange Situation Procedure’ (SSP) (1970).56 The same assessment was used in Oliveto almost forty years later. The SSP was created to examine how young children negotiate a balance between proximity and exploration with their mothers in situations which were considered low stress (defined as being only with their mother), then with its mother and a stranger, and then in a high stress situation (defined as being alone with the stranger) (Bretherton 1992:765). In reference to attachment styles, Ainsworth found that mothers with healthy attachment patterns with their children, were viewed as (what she termed) a secure base from

56 Also sometimes referred to as the Strange Situation Assessment (SSA), or simply Strange Situation (SS)
where to explore the world, and a safe haven to return to in times of distress or
danger. In her research Ainsworth identified anxiety as behaviour related to
attachment that some children expressed both to strangers and on separation
from their caregiver (for example stranger anxiety and separation anxiety). The
quality of the attachment relationship (between a mother and infant) was
measured by the child's behaviour in these distressing situations and by observing
how the child relied on their mother as a secure base for exploration. Ainsworth
and her colleagues were interested in how comfortably the child found safety in
their mother's presence in these situations. In doing so, they determined three
main attachment styles for understanding this complex relationship: 'avoidant',
'secure', and 'ambivalent' attachment (Ainsworth, Blehar & Waters 1978).
According to the research conducted by Ainsworth, a securely attached child will
act in distress when their mother leaves, but will be comforted by her presence
upon her return. In a secure relationship, a mother’s reliability to respond to her
child fulfilled attachment needs: the child knew that they could rely on their
mother to provide this. A child with an ambivalent attachment became very
distressed when their mother left them and was difficult to reassure, and children
with avoidant attachment patterns avoided their mother when in a distressed
state. Ainsworth theorised that this was because the child had learnt that they
could not rely on their parent for comfort, and so consequently did not try.

Ainsworth’s contribution to Attachment Theory (Ainsworth & Bell 1970) was
significant to Oliveto's practices as these categories of attachment were used to
define the *quality* of a child’s attachment with her mother. The SSP was still in use
at the time of my research, and was incorporated in Oliveto's therapeutic
assessment of older babies (6-12 months old), however, more so with toddlers. The terms ‘safe haven’ and ‘secure base’ also formed part of the ideological language used in Oliveto (discussed in more detail in the following Chapter), and continues to be used in the psychological understanding of healthy mother-infant relationships.

In Oliveto, Ainsworth’s work also helped facilitate the surveillance of the mother-infant relationship, linking the child’s pathological behaviour to the mother (Kanieski 2010:340) (See following Chapter on the Circle of Security). Ainsworth’s work caused a shift in attachment theorising, moving focus from the identification of attachment disorders to considering attachment as a risk factor in the protection or the promotion of the child’s psychological health (Kanieski 2010:336-340). As such, the use of surveillance techniques and family monitoring increased as a preventive measure for the possibility of attachment disorders (Kanieski 2009:326).

‘Bonding’ & Mother’s Love

The acceptance of Attachment Theory or ideas that have arisen from that concept did not occur in the mainstream until the 1970s, when ‘bonding’ became a term used in hospital environments. This was principally due to paediatricians John Kennell and Marshall Klaus who published research findings that suggested that mothers who had extended contact (approximately sixteen hours) with their infants directly after birth exhibited better mothering skills (Klaus et al. 1972). The children of these mothers were also said to have scored higher in biomedically constructed developmental tests (Eyer 1992:2). Kennel and Klaus named this as
‘the sensitive period’, a term derived from the ethological observation of goats, cows and sheep that rejected their offspring if separated after birth (see Klaus et al. 1972). They went on to disseminate their ideas by presenting their findings in hospitals and other medical institutions (Eyer 1992:2). The notion of ‘bonding’ quickly became institutionalised, with a range of diverse groups (from religious organizations to feminist groups) embracing the concept (ibid). The media and natural health promotion organisations also accepted the concept and it quickly became a catch phrase for promoting mother-infant closeness. Hospitals then began to claim responsibility for ensuring that bonding could occur by providing specialised rooms for mothers and newly born infants (ibid). Over the next decade, most of the research on bonding was dismissed by the scientific community for lacking academic rigour, however postpartum bonding continued (and still continues) to be seen as a preventative measure for the maltreatment of children among biomedical health communities (Eyer 1992:4).

Indeed, the term bonding was used by many of the mothers who were admitted into Oliveto when they spoke with me about their relationship with their child. For many of the mothers, the ‘bond’ they wanted to have with their child had also been the reason they agreed to an admission into Oliveto. The social and cultural expectation that a woman will form an intimate, intense relationship or ‘bond’ with her infant was experienced by many mothers in my fieldwork. In fact, for several mothers, the absence of these feelings was what prompted them to seek help from their general practitioner in the first place. For many though, the exclusive dependency of the mother-infant relationship was overwhelming and difficult to manage, and was in conflict with the individualistic ideals they had
experienced prior to having children. In line with attachment theorising, mothers felt that their emotional bond should have been instinctive, and were confused when their experience did not match their expectations.

The Biology of Attachment: Equating Animals with Humans

In an introductory speech to Oliveto’s annual conference, the Medical Unit Head, Dr Margaret, showed the audience an image of an infant’s brain. As part of the presentation, she demonstrated how infants developed an abundance of neural pathways in the first two years of life through the experiences they have in that time — generally with their primary caregiver. This was represented by layering coloured lines to represent the ‘neurotransmitters’ which become fixed through the infants’ early interactions with caregivers. We spoke about this image again in an interview, and she described how women with borderline personality disorder, a mental health diagnosis rooted in attachment principles (see Chapter Eight for a detailed discussion), had neural pathways that had failed in the first two to five years of life and gone down a not so good pathway. The pictorial image used to describe this ‘malfunctioning’ looked like a scribble of colours across the brain.

This conversation highlighted the biological view of attachment I observed ethnographically in my fieldwork. Understanding knowledge gained from contemporary neuropsychiatry, an area of research that relies heavily on animal models for understanding human behaviour (particularly rodents), was significant for understanding Oliveto’s biological treatment of attachment pathology.

57 At the time of this research, an emerging field referred to by Coan as ‘attachment neuroscience’ (2008:242).
The information presented within this chapter about the historical underpinnings of Attachment Theory further demonstrates how the use of animal models has supported a biological rationale of attachment behaviour. Early attachment research using animals as human homologues reinforced claims about the instinctual and innate responsiveness mothers displayed to their infant’s cues, thereby equating these responses to be demonstrative of a mother’s ‘natural’ love for her child.

The idea that human behaviour could be closely linked to animal behaviour was first raised by Darwin in the late 1800s, who suggested that humans were lower-order animals that had evolved ‘instinctual’ behaviours that allowed them to adapt to their environment and survive (see Darwin 1872). In the early twentieth century, ‘instinct’ had become the interest of scientists, influencing many studies on animals and humans used to define its properties (Eyer 1992:23). However, it was not until almost fifty years later that the systematic study of primates began, providing what was believed to be an informative and economically viable view of human psychology that was unaffected by cultural influence (Yerkes 1971:3). This intellectual leap connecting animal behaviour to complex human emotions and behaviour is a tradition that is still evident in biomedical models of health knowledge and is thought to provide researchers observable and measureable outcomes which equate to truth in scientific terms.

In a critique of mother-infant bonding, Eyer (1994) put forward a philosophical argument, claiming that Bowlby’s theories of maternal deprivation and attachment were part of a paradigm shift\(^\text{58}\) that demonstrated through animal models the

\(^{58}\) See also Kuhn, TS 1962, The structure of scientific revolutions, University of Chicago Press, Chicago.
biological need for a mother and child to remain close. The bonding research that followed was widely accepted by the scientific community and public because it converged with the maternal deprivation paradigm already dominant. Eyer argues that the ‘guiding theoretical concept underlying bonding research is of course evolution — the ideal that animal models are pertinent to the study of human behaviour and the misconception that all biologically based behaviour is “good” because it is adaptive’ (1994:80). More importantly, the presupposition put forward by the attachment paradigm, was the need for mothers and babies to be in close proximity was a survival instinct that promoted the continuity of the species; therefore attachment behaviour was in fact ‘adaptive’ (Eyer 1994:80-81).

Attachment theorists’ biological view of attachment referred to instinct and innate behaviours, however as the technological advances in the 1990s entered the biomedical domain, a new call for understanding attachment as a neurobiological (brain) process was warranted (Insel 1997:726). In order to do this, animal models, specifically the prairie vole rodent, was first chosen in the first instance: like other animals chosen for attachment research, they were one of the few rodents that displayed monogamous pair bonding (Insel 1997:727). Since then, neuroscientific study of attachment has become an expanding field (see Coan 2008 for an overview; also Mayes, Swain & Leckman 2005).

Neurobiological research using animal models, a research practice referred to earlier by Oliveto’s Medical Unit Head, has more recently been used for understanding attachment. Neurobiological research attempts to identify specific hormones and neural structures, circuits, neurotransmitters and neuropeptides that are believed to contribute to attachment processes in the brain’s chemistry
Such a practice made the psychiatric (psychopharmaceutical) treatment of these brain processes possible. Research on the role these brain chemicals play in the activation of neurotransmitters’ pathways laid down in early childhood have also been conducted using animal models (Carter et al. 2005).

A number of theorists have discussed the inadequacy of animal models for understanding humans (Greek & Greek 2010; Miller & Costello 2001; Rice 2011; Shanks, Greek & Greek 2009; Udry 2001). Rice (2011) argues that the use of animal models for understanding humans is futile because of the considerable variability in humans therefore ‘expecting a different species to predict human response is naïve’ (Rice 2011:3). Despite this, the use of animal models for human research continues, arguably because the regulatory hurdle for working with animals is lower than working with humans (Rice 2011:4).

**Anthropological Critiques of Attachment**

The privileging of attachment behaviours as universal has been challenged by anthropologists and others who immerse themselves in the daily lives of people from other cultures, and observe childrearing and attachment models that do not correspond with the theory (Quinn & Mageo 2013:4-5). As such, anthropological critiques argue that assessing early infant-caregiver relationships through Attachment Theory is ethnocentric and therefore inadequate for capturing all cross-cultural variations in childrearing (Quinn & Mageo 2013). This is particularly so in relation to the measurement of attachment relationships through Ainsworth’s Strange Situation, which due to its prolific use over time has become synonymous with the theory (Bretherton 1993:25; see also Quinn & Mageo
2013:4). The Strange Situation Procedure, focuses primarily on reunion
behaviours and not on the natural context where interactions take place (LeVine &
Miller 1990:76-77 cited in Quinn & Mageo 2013:6). As such, attachment
relationships are 'decontextualised' and fail to taken into account important
information in the cultural structuring of childrearing practices (Quinn & Mageo
2013:17).

Questioning the Dyadic Focus

Traditional attachment assessment takes the view that attachment security is
dyadic, and the caregiver, usually assumed to be the child's mother, defines the
quality of the infant's security (Morelli & Henry 2013:244 my emphasis). Cross-
cultural evidence disputes the centrality of one secure base for young children,
instead it indicates that children develop multiple bases as sources of security
(Meehan & Hawks 2013). Ethnographic research has clearly demonstrated that
child-caregiver patterns can be communal, cooperative and diffuse. Infants and
young children have shown to exhibit a range of secure base relationships that
respond to: cultural values (Chapin 2010, 2013; Gaskins 2013; Gottlieb 2004;
Seymour 2013; Seymour 2004; Tronik, Morelli & Winn 1987); ecological
conditions (Barlow 2013; Crittenden & Marlowe 2013; Meehan & Hawks 2013;
Scheper-Hughes 1985, 1993; Tronik, Morelli & Winn 1987; Weisner 2005;
Weisner & Gallimore 1977); and maternal availability through competing
workloads (LeVine & Miller 1990; Quinn & Mageo 2013; Seymour 2013).

The prevalence of a wide range of secure base caregiver arrangements in the
cross-cultural literature prompted anthropologist Alma Gottlieb (Gottlieb,
2004:137) to refer to sole caregiving as a 'statistical anomaly'. Indeed,
evolutionary anthropologist Hrdy (2009: 84-85) points out that the exclusive dyadic mother-infant relationships viewed as the hallmark of Attachment Theory, is not a universal phenomenon. Through the study of alloparenting in the human species Hrdy concludes that ‘mother-only or even primarily maternal care...was more an impossible ideal projected onto traditional people by Western observers than a species-typical universal’ (2009: 128). Taking into account the numerous studies of attachment relationships in non-Western contexts that demonstrate the diversity of attachment relationships that contribute to an infant’s healthy psychological well-being, the practice of monotropic or dyadic caregiving relationships is in fact an exceptional phenomenon.

Western Values: Pathologising Non-Western Attachment

Anthropological critiques suggest ‘Attachment Theory is laden with Western values and meaning’ (Rothbaum et al. 2000:1093) that promote developmental outcomes reflecting the hegemonic ideals about the way that infants should be raised (Quinn & Mageo 2013:5). LeVine and Norman argue that the attachment paradigm was driven by a ‘child-centred freedom and equality against old-fashioned parentally imposed order of discipline’ (2001:101) and embody wider cultural values of autonomy and independence. The attachment paradigm therefore assumes that the socialisation goals of childrearing are to foster independence and autonomy in the child — characteristics valued in industrialised societies, however these values cannot be assumed to be the childrearing objectives of mothering style in all cultures (Quinn & Mageo 2013:7). In contrast, anthropologists offer alternative goals for child socialisation. For example, Barlow (2013) demonstrates the Murik of Papua New Guinea value both dependence and
interdependence: this is reflected in their attachment relationships which take 'at least two forms — one focused and person-specific, and another more diffuse and role oriented' (Barlow 2013:183). Similarly, Seymour (2013:131) describes how emotional interdependence and intergenerational trust are the culturally desired outcomes for children and young adults in Bhubaneswar. In this, and other Indian contexts, young adults are not expected to make their own decisions about education and life partners; instead these matters are considered family issues. Learning to depend on others, not just one carer, is therefore deeply engrained in their cultural practices, and is revealed in their childrearing and attachment relationships which include multiple adults, not just the child's mother. Samoan attachment relationships direct children away from dyadic bonds after six months of age, and towards group bonds (Mageo 2013:209). Under traditional attachment theorising this behaviour would be incorrectly labelled as 'insecure attachment' however Mageo argues it would more appropriately be referred to as 'interpersonal security' (Mageo 2013:193).

Another critique of attachment theorising is directed at the concept of 'maternal sensitivity' which assesses the 'quality' of a mother's interactions with her child and as such has become the hallmark of a healthy attachment relationship (Morelli & Henry 2013:245). 'Maternal sensitivity', measured within the attachment paradigm through a mother's responsiveness to her child's cues, and support in her child's exploration, are signs that the caregiver is 'attuned' to the child's developmental needs. Attunement is thus considered a 'precursor to the development of a strong and secure attachment' (Quinn & Mageo 2013:21). Through these interactions, the child is socialised to have their needs met by their
mother through vocalisation or ‘cuing’, and encouraged to independently explore their world. However anthropologists offer examples of caregiver sensitivity that under traditional attachment assessments would be misunderstood and inappropriately pathologised (Quinn & Mageo 2013:17). For example, Chapin (2013) demonstrates how caregivers in a Buddhist village in Sri Lanka are highly attuned to infants’ needs. Here, independence and communication are not culturally valued so infant elicitation and vocalisation is discouraged. Instead, the child’s needs are met before they are expressed, requiring a high level of attunement on the caregiver’s behalf.

Western models of attunement, characterised by eye gazing, skin touch and communication do not hold value in this context. Indeed, in Bhubaneswar, India the opposite is encouraged: here, eye gazing is considered to ‘attract the evil eye’ and ‘endanger the infant’s survival’ (Seymour 2013:127). It is therefore considered dangerous. In another example, Samoan caregivers use painful forms of skin and eye contact as ‘distancing practices’ to discourage dyadic relationships (Mageo 2013:193). In Samoan culture this is protective of the individual because it ‘helps direct children away from personal relationships towards group bonds’ (ibid). Attachment Theory is therefore inadequate for the assessment of these relationships as it can pathologise behaviours that are culturally considered protective and developmentally appropriate.

In all, anthropological critiques illuminate Attachment Theory’s failure to take into account the cultural context in which childrearing takes place: this includes the culture values; ecological conditions; and underlying beliefs about personhood, which could result in the inappropriate pathologising of caregiver behaviour.
Contemporary Uses of Attachment Theory

Notwithstanding evidence disputing universalist claims of attachment behaviour, the biological assumptions promoted through the use of animal models have helped maintain Attachment Theory’s popularity in biomedical culture. Bowlby’s initial theorising in the 1940s has been, and continues to be, expanded on and developed in numerous ways. Attachment Theory contends that the early parent-child relationship is central to personality development throughout the life cycle (Bowlby 1969, 1982). As such, the idea that social relationships can effect and be affected by developing psychopathology in childhood is fundamental to most modern theories of human development (DeKlyen & Greenberg 2008:637). For this reason, Attachment Theory continues to hold great relevance in contemporary psychological practices.

As a theory that refers to ‘lasting psychological connectedness between human beings’ (Bowlby 1971 [1969]:194), the application of the theory is not only applied to mother (parent or caregiver) — infant interactions, but is also used in therapeutic practice for the treatment of disrupted relationships throughout the human lifecycle. The availability of an attachment figure was one of the most fundamental appraisals in Bowlby’s conception of attachment, although the notion of availability changes as the individual advances in their life course. As an individual develops, proximity is no longer defined by the availability of an attachment figure, instead it is defined through the ability to communicate and reunite with an attachment figure. As such, Attachment Theory is used in contemporary psychology to address bereavement and loss, (Bowlby & Parkes 1970; Stroebe, Schut & Stroebe 2005), couples therapy (Davila & Kashy 2009;
Johnson & Whiffen 2003), family therapy (Liddle & Schwartz 2002), family therapy in relation to divorce, violence, trauma and maltreatment, child abuse, foster care and adoption (Cassidy & Shaver 2008:xv), caring for elderly parents (issues of aging, declining health and death, parental death), sexual abuse, binge eating disorder (Tasca et al, 2006), family therapy to address drug abuse (Liddle 1999), and depression in adolescence (Diamond & Lebow 2005). The extensive application of Attachment Theory demonstrates that it has not disappeared or become outdated. The theory has evolved, from its early beginnings related to ethology, to the latest developments in neurobiology (see for example Landers & Sullivan 2012; Sullivan 2012).

Attachment in Oliveto

The theorising and findings of attachment research conducted more than fifty years ago continued to have implications for the women in Oliveto. The biological assumptions inherent in attachment theorising contributed to the biological focus of the treatment of postnatal mental illness observed in Oliveto. In addition to this, the categorisations of attachment styles identified by Ainsworth were of particular significance as they were assigned to mother-infant dyads on a regular basis and used to determine the appropriate treatments.

In the first part of this thesis I have argued that psychiatric and attachment theories form the theoretical logic in Oliveto, used to justify hospitalisation and treatments. Through the process of a psychiatric diagnosis, constructed through a biomedical lens as an organic disease, women were constructed a mentally ‘sick’ and in need of medical treatment. However, it was by virtue of their social role as
‘mother’, which biologically linked them to their child and therefore placed their child at risk of the transgenerational transmission of poor attachment patterns, that their admission into the unit was confirmed. Mother-infant relationships as defined by Bowlby’s and Ainsworth’s attachment theorising, determined a significant criteria for Oliveto admissions, but more importantly defined the measures for progress and discharge from the unit. In the next chapter I ethnographically analyse attachment based therapies; in particular the use of a therapeutic tool referred to as the Circle of Security (COS).
THE CIRCLE OF SECURITY

Motherhood and infancy were once considered normal phases of human life. As medicine expanded and specialized, however, motherhood and infancy were increasingly reframed as pathological.

Diane E. Eyer (1992:129)

On my first day of fieldwork in Oliveto mother and baby unit, I was drawn to the blue circular diagrams I saw adhered to several walls and magnetically attached to filing cabinets. The diagram was entitled Circle of Security: Parent Attending to the Child’s Needs (Cooper, Hoffman Kent & Powell 1998; see below). This grabbed my attention as it was clear from the title of the diagram that the child’s needs were of significant importance in this context: prior to beginning fieldwork I had expected that the treatment focus in Oliveto was centred on the mother’s mental illness. However, the overt display of the Circle of Security (COS) diagram around the unit suggested that the needs of children were given primacy in this context.

When I first observed the diagram, I had not realised the importance that that the Circle of Security template would have to my understanding of the everyday practices in Oliveto. Over time, its significance became apparent. Its significance lay predominantly in that the COS described in pictorial form the basic principles of Attachment Theory, the psychological construct that underpinned all therapeutic work in Oliveto.
The COS template is a diagram, or ‘roadmap’ as it was referred to by its creators, designed for use in a psychotherapeutic context. It was created ten years prior to my time in Oliveto. While the COS was indeed used for this purpose, my observations in the field saw reference to the COS, and the language inspired by it, in numerous contexts both formal and informal. It was also used by a variety of Oliveto staff members from different disciplinary backgrounds. Indeed, it was through the COS that Attachment Theory was first brought to my attention.
Travelling the Circle of Security

As a therapeutic tool, the COS was designed to be used by professionals working in a therapeutic capacity, to assist with explaining the core elements of Attachment Theory in relation to the attachment relationship in question. To explain the COS, I draw on conversations with Oliveto’s staff members. The hands shown in the diagram diagrammatically refer to a child’s primary caregiver which was usually its mother. The top hand refers to the child’s support in exploration of their world through play and learning. In a healthy attachment relationship, mothers were viewed as a ‘secure base’ from where to explore the world. A child who has a secure attachment to its mother should be happy to leave their secure base and explore the world around them. In response to this, a mother who is understood to display a healthy attachment with her child will watch over her child by keeping them in their eye’s view (or for an infant, maintaining eye contact), keep them from physical danger, show delight in their exploration through facial expressions and responsiveness, help their child by assisting them (only) when they are not able do something on their own, and show enjoyment in them by joining in their play. The bottom half of the circle referred to the caregiver’s ability to be a ‘safe haven’ for their child — a place to return to when they have finished exploring the world, or needing comfort or protection. According to the COS, the concept of a ‘safe haven’ encompassed the idea of protecting and comforting the child when they were hurt or upset and being able to help their child manage their emotional distress. This is done through naming the emotion for the child, or staying with them while they are experiencing an emotional state. According to the COS roadmap, the role of the mother is to be ‘bigger, stronger, wiser and kind’, with the intention of following the child’s lead as much as possible, but taking charge when
necessary. One of Oliveto’s staff members described the secure base concept as follows:

*I’m your secure base and I care for you and I love you. Then you go off into the world and then when that’s a bit much or something goes wrong I, you know, help you sort it out, or at least be with you when you are sad and reassure you.*

Another staff member referred to the COS as being synonymous with the movement of an elastic band. Just as an elastic band can stretch and allow for movement, it will always return to its original form. Similarly, a child displaying a healthy attachment will always return to their ‘secure base’ or look to their mother as a ‘safe haven’ when feeling unsafe or unsure. No matter how far the elastic band is stretched, it will, by its very nature, always return to its original form and remain intact as a circle.

Central to the COS roadmap as it was described to me, was the primacy of the child in mother-infant relationships. In particular, the COS highlighted the commonly held view in biomedical cultural practices that the child’s physical and emotional needs were a domain to be managed by one primary caregiver — generally the biological mother. How was it then that the COS roadmap played such a significant role in my ethnographic observation of Oliveto’s therapeutic treatment for mothers with postnatal mental illness? In this chapter I explore the COS roadmap used as a therapeutic tool for deciphering a mother and child’s attachment relationship patterns and identifying psychopathology (or attachment disorders).
As a psychiatric unit for mothers and babies, the surveillance and monitoring of the mother-infant relationship was a primary focus. In this chapter I deconstruct how the COS was used as a symbolic framework, and a symbolic guide for identifying psychopathology within the mother-infant relationship and a preventative surveillance tool for what was understood as the inherent ‘risk’ in a mother’s relationship with her child.

This is explained primarily through a case analysis of a mother-infant therapeutic session, which provided ethnographically rich descriptions of the core assumptions the COS put forward. The COS will also be used to give context to the practices of Oliveto therapeutic unit as a whole. As a mother and baby unit, Oliveto’s underlying theoretical underpinnings combined elements of psychiatric and attachment principles (see Chapters Four and Five) to facilitate admission and justify treatment. Through the merging of the core principles of Attachment Theory combined with the assumptions produced through Oliveto’s psychiatric practice, the COS was used to highlight the transgenerational transmission of attachment patterns identified as psychopathological and therefore a potential ‘risk’ to the child’s future mental health and well-being.

Using anthropological analysis, I also argue that the COS revealed itself as a metaphor for Oliveto’s therapeutic environment. I draw ethnographically on Oliveto’s distinct appropriation of the COS roadmap as it was applied in formalised therapeutic encounters, which also filtered through to informal interactions that occurred in the everyday setting (discussed in more detail through the following chapters). Although the term ‘circle of security’ itself was rarely spoken, the
concept was well understood by Oliveto's staff as ‘just common sense really’, and I argue that its core principles were a lens for therapeutic practices in Oliveto.

Template Transmission and the Circle of Security

In Oliveto, Attachment Theory was applied in ways that were specific to the field site. In particular, the language and concepts highlighted in the COS informed discussion around the mother-infant relationship. Through participant observation and anthropological analysis, I came to understand the application of the COS roadmap as extending beyond its originally intended purpose. It was used therapeutically in Oliveto; yet it was also a visual educational tool to inform mothers about what were considered culturally appropriate patterns of behaviour towards their child(ren), and it infused Oliveto’s everyday practices.

The application of the COS as a tool for therapeutic treatment was used most obviously in mother-infant therapy sessions. In the therapeutic context, Kelly, the mother-infant therapist, used the COS roadmap to deconstruct where there may have been dysfunction in the women’s ‘internal working model’, or the template (the term used in Oliveto) of parenting patterns transmitted to them through their relationship with their mother. In accordance with principles of Attachment Theory, the transmission of attachment patterns was transgenerational; it was reasoned that attachment templates were transmitted from one generation to the next in a process likened to genetic transmission implicating biological processes. The transmission of attachment templates across generations followed a linear argument, whereby mothers admitted into Oliveto were asked to consider their

\[59\] A term used by Bowlby
\[60\] van Ijzendoorn (1995) referred to this as the ‘transmission model’.
own early attachment templates and reflect on the ways these patterns were being passed down to their own child(ren). Through observation of mother-infant interactions in relation to the COS attachment principles, judgments were made by Oliveto’s therapeutic staff about the dyad’s attachment styles. Failure for either the mother (or other caregivers in the therapeutic environment) or child to demonstrate adherence to these biomedically prescribed principles was indicative of pathological behaviour, raising concerns about the potential to cause either physical, emotional or long term psychological risk to the child, or a combination of these risks.

The COS diagram served as a metaphor for my analysis of Oliveto’s therapeutic treatment practice in terms of the continuity of the circle. Therapeutic case work therefore had temporal dimensions that projected back to the mother’s past and her early attachment relationship with her own mother (or primary caregiver), then projected forward to consider whether her own child’s future attachment template could be compromised. Treatment in the present was therefore justified as a preventative measure for the potential risk inherent in this relationship. Further to this, treatment practices involving the dyad were believed to be prevent the possibility of any future problems attributed to attachment deficiencies (for example emotional, behavioural, intellectual, physical, psychological and developmental problems in the child). The tensions inherent in this model were made evident through anthropological investigation that highlighted the belief of different modes of attachment transmission; on the one hand attachment was assumed to be akin to genetics, passed down from generation to the next, while the COS therapeutic intervention was a behavioural model implying that
attachment patterns were assumed to be changeable through therapeutic intervention. In this vein, the analogy offered by one of Oliveto’s staff members of the COS attachment roadmap similar to an elastic band, served to add depth to my COS metaphor. Through ethnography, the numerous tensions and contradictions inherent in the COS model were revealed, demonstrating its ability to be stretched, changed, made malleable yet always returning to the same basic form — the attachment relationship.

'At Risk'

In formalised staff meetings, routine assessments of a patient’s risk were conducted (appropriately called ‘risk assessments’), evaluating the patient’s risk of harm to self or suicidality, risk of harm to others, particularly the baby (infanticide or abuse), and risk of absconding from the treatment service. In Oliveto, the risk to the child was of particular significance as it was believed that the age of children admitted into Oliveto (between the ages of birth to three) was a time when a child’s brain was at its most formative developmental growth. Attachment templates formed at this time were believed to have lasting impacts on the child’s future; therefore addressing the mother-infant relationship during inpatient admissions was seen as a preventative measure for the potential risk to the child. Constructing the child ‘at risk’ in this context generally referred to the risk posed to the child through its relationship with its mother; the risk caused by the father-child relationship was a cursory concern in this context. A large part of Oliveto’s therapeutic work was therefore to assess this risk, and make decisions about ways to prevent this maternal risk from occurring.
Risk management in relation to children has been attributed to the developmental or socialisation paradigm in which children are constructed as future adults rather than children in the present (Jackson & Scott 1999:92-94). The tensions within this model reveal themselves in Oliveto’s everyday practices where children are simultaneously constructed as requiring a healthy attachment through dependence on their caregivers, yet are also encouraged to be autonomous through exploration and independent sleeping and self-soothing (see Chapter Seven for a detailed discussion). Jackson and Scott suggest that it is not surprising therefore for parents to seek ‘expert’ advice in relation to raising their children, as accessing external authority can lead to a sense of certainty that they are caring for their child in accordance to social and cultural norms (Jackson & Scott 1999:94). Failure to do so heightens the judgement that children are at risk.

Mother-Infant Therapy

To demonstrate how the COS was used in Oliveto’s therapeutic setting, I draw again on Helen and Javier’s case (introduced in Chapter Two). Helen and Javier, like a high percentage of dyads admitted in Oliveto, were involved in mother-infant therapy. Mother-infant therapy was described by many of my patient informants as a highly useful therapeutic process they underwent while admitted into Oliveto. At the time of the ethnographic data collection, Kelly, an occupational therapist (OT), managed the majority of mother-infant therapy work. Kelly described her work as an OT in the role of a mother-infant therapist as significant in Oliveto’s context. She viewed the role of mothering as an occupation that sometimes needed therapeutic work. Her expertise was in the area of mother and
infant relationships, with a specific focus on the attachment relationship between
the dyad. Kelly explained her role to me in the following way.

*I think OT is often misunderstood, even within the profession itself.... I mean
I'd sort of say that mother-infant probably is a core role of occupational
therapy in that occupational therapists should be interested in supporting
the occupational roles of people in the community, and one of the key
occupational roles is parenting. And so we should be incredibly interested
in supporting the parenting role which of course is the mother-infant or
father-mother-infant kind of relationships.*

Mother-infant therapy was chosen as a therapeutic option for women whom the
multidisciplinary staff identified as having problems in the attachment
relationship. These sessions occurred in a purpose built room in an area of the unit
that was not usually accessed by patients — it was away from the main living area.
The therapeutic room had a video camera installed on the wall which was a
significant feature of the therapy. All sessions were video recorded and played
back to the mother in a later therapeutic session. The mother and her child, and
sometimes other family members (fathers, grandparents, and other siblings)
would be asked to enter the room and interact with the child in the way that they
would normally interact, all the while knowing that their interactions were being
recorded. While this took place, the therapist, and quite often a student (medical
or OT) or other staff member, sat in a small room next to it watching the
interactions on a screen. Once satisfied that enough of the essence of the
relationship had been captured on video, the recording was shown back to the
mother and used a reference for psychological analysis. The frequency of these sessions was case dependant.

In Helen and Javier's case,\(^1\) a series of mother-infant therapy sessions were recorded and used the COS therapeutical tool to facilitate 'reflective functioning'. This was a term used by the mother-infant therapist, and is used by well-known attachment therapists (Fonagy & Target 1997) to refer to the individual's capacity to experience 'one's own and others' behaviour in terms of mental state constructs' (Fonagy & Target 1997:680). With Helen's consent, I watched her videos. Following this I spoke with the mother-infant therapist Kelly, and then with Helen about how they understood those sessions.\(^2\)

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### Helen's Perspective

Helen described her mother-infant sessions with Kelly as *more like a conversation* where she would meet with Kelly and *just talk*. She described how every now and then the therapist would stop her and say *see; look at what you said then. See what you said to Javier!* She would *catch* her on things that she had not noticed herself doing. In Helen's words: *...because when you're not well you're not as logical, you can't seem to process your thoughts through. You feel like you're in zombie land!*

Helen's perception of the mother-infant therapy sessions implied a relaxed tone, with a therapist whom she felt comfortable talking with. Yet these sessions were more than 'just talking'. Through observation and clinical logic, the therapist was

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\(^1\) Unfortunately, ethical restrictions at the time of my research prevented me from observing firsthand what happened in these therapy sessions, however from time to time patients would describe their experiences to me.

\(^2\) With Helen's permission, her mother-infant therapy videos were also used by Oliveto as an educational tool for mental health workers.
gathering information that would be translated, using the COS as a guide for interpretation. This was made clearer through the following discussion.

Helen explained that Kelly showed her how a few things kept re-surfacing for her, referring to recurrent themes that Kelly had identified as areas worthy of therapeutic investigation in Helen’s recalling of her childhood. She always tells me that I don’t give enough time to grieve or something. I asked her if she had had grief in her life, to which she dismissively responded I guess so, in my family... If Kelly was here she would say “See you always just pull your socks up and move on!”.

Following this I asked Helen about the ‘losses’ in her family, assuming that the grief related to death. She went on to explain that her entire family lived in another country; she had lost her father at the age of eight and now had an elderly mother with Alzheimer’s.

Helen had moved to Australia to study in her teens. When she was eighteen she learnt about what she described as a family secret from her then boyfriend (now husband). He told her that she had been adopted as a child and the parents she believed were biologically hers were in fact not. All of her siblings had known about this but had never spoken to her about it. Her sister in law was the first person to speak about it, though not directly to her, but through her partner. I asked if this was part of her grief: ...well to me now it’s fine. I’ve got a home and a family and it’s a second chance. And Kelly always said ‘see you didn’t grieve again, you just pull your socks up and carry on!’’. I understood that for Helen, picking her socks up and moving on was her way of processing her childhood experiences; she did not construct this as ‘grief’. Significantly, although Helen found mother-infant therapy sessions beneficial in hindsight, she still could not understand the benefit
of grieving something in the past that she could not change. Instead Helen’s rationalised this by saying: *It’s better than ending up being dead or a prostitute.*

Helen saw her attitude towards her childhood as a way of seeing the positive in a negative situation. When speaking about her adoption, she recalled it being *horrible* when she found out about her adoption, however what upset her most was that no-one had told her. She saw her adoption as fortuitous stating: *I’m very blessed because I’ve been rescued.* She felt this particularly because her adopted mother already had several children so an additional child could have been a burden. Helen went on to explain that she was happy to leave her adoption in the past and did not feel the need to ask her mother for details as she was worried that it would upset her — she was not looking for answers.

Helen recalled that Kelly told her that she needed to grieve and process those feelings, then move on. She spoke about her recollections of mother-infant therapy with some distance, as though she was almost dismissive of them, despite the fact that she thought her sessions with Kelly were useful. Helen described her inability to recognise grief as her *trait*, removing herself from the ability to control her actions, in favour of positioning it as something that was inherent in her personality or character. This was true for much of the way Helen constructed (in what was referred to in Oliveto as her *narrative* — her own way of *making sense* of what happened in her past. Using the term *narrative* implied to me, that her version of events was not understood as whole truth according to the psychological model, instead narrative implied Helen’s version of truth; the way she remembered her past. Her narrative was significant for the COS therapeutic model as it was through deconstructing her childhood narrative and translating it
to fit within the COS psychological model that dysfunction in her early attachment relationships could be identified, then be considered in the context of her present relationship with her son.

Searching for Helen’s ‘Nursery Ghosts’—The Biomedical Perspective

After watching Helen’s mother-infant therapy videos, I also met with Kelly who gave her perspective on what was happening in the therapeutic sessions. In our discussion, Kelly began by telling me the purpose of mother-infant therapy sessions and how they could be useful for someone like Helen who was struggling in her relationship with her son Javier. Kelly introduced me to the concept of ‘ghosts in the nursery’, a term used to describe the psychoanalytic exploration of a mother’s childhood traumas to explain difficulties in her present mother-infant relationship (Fraiberg, Adelson & Shapiro 1975). The concept of ‘ghosts in the nursery’ adhered with the COS as a model for identifying psychopathology in the transgenerational transmission of attachment relationships. In Kelly’s description of ‘ghosts in the nursery’ she stated: the reality of one’s childhood may be present without them being aware that they are present. Using this model therefore meant exploring the mother’s past —her childhood, to understand her presenting difficulties with her child(ren).

The concept of ‘ghosts in the nursery’ was a powerful metaphor that was descriptive of the therapeutic process that unravelled in mother-infant therapy. In Western popular culture, ghosts are portrayed as the spirit of people who have died, yet have a presence in the present day, the now. Ghosts are understood to conjure up reactions of fear and uncertainty of the unknown; they are portrayed as returning to the present to ‘haunt’ the living because of the traumas they
experienced in their past life. Returning to the present then becomes a way for the ghost to possibly resolve past traumas. The metaphorical use of the term 'ghosts in the nursery' therefore was presumed to allude to the trauma uncovered in this psychotherapeutic treatment; discovering 'ghosts in the nursery' suggested that the mother’s past had come back to haunt them.

As a mother-infant therapist, Kelly saw her role as encouraging Helen to think, be reflexive and become more awake to the ghosts from past relationships by helping her identify things from her upbringing that could be present in her relationship with Javier. She saw Helen as being damaged by her past and this damage was disrupting her relationship with Javier and causing him to have unusual behaviours —behaviours that were not in line with biomedical and cultural expectations for an infant of his age.

**Fitting Behaviour to the Circle of Security Model**

Through my analysis, it became apparent that mother-infant therapy was a process of exploration of the mother’s early attachment experiences which were then used to identify ways in which that experience was present in the mother-infant relationship in question. As such, the therapeutic process of mother-infant therapy meant that behaviour observed in the therapy room, then replayed again in the video playback, required fitting the behaviour to the model of the COS. Helen and Javier’s mother-infant sessions highlighted this. In Helen and Javier’s first video session, Kelly held a block up in front of Javier’s face; he looked straight past the block to Kelly’s smiling face behind it, cooing and babbling all the while. Kelly and Helen both recognised that he was much more interested in her face than he was in the object. In the mother-infant session, Kelly explained to Helen that
children are often more interested in faces than they are in objects and that there is nothing unusual about that. As mentioned previously, (see Chapter Two) Helen had been quite concerned about her son possibly having autism, however Kelly was able to calm these thoughts for her by saying that because Javier was so *transfixed* on faces it was unlikely that he had autism. In the video, Helen exclaimed: *I thought it was just a good thing, that he was just like...a people person* and then they start saying he’s not reaching for things or not doing the things that he should be doing, and I was thinking oh no, what’s going to happen? Javier’s behaviour had never been a concern for Helen until her admission into Oliveto. However, in this biomedical context his behaviour became a focus of attention which concerned her. Under a psychological model, the behaviour of young children was divided into expected time frames of developmental change referred to as ‘milestones’ by Oliveto’s staff but also widely accepted in the broader biomedical and developmental psychology literature. Helen had recognised that her son’s behaviour was different from her daughter’s, but did not understand it to be problematic until it was brought to her attention in the unit. She had never really spent a lot of time or energy focused on getting her daughter to grab a toy and had not understood the importance of doing so with Javier.

Kelly went on to explain to Helen that Javier’s development may be a bit *strange* but it was not unusual for children to develop and reach different milestones at different rates. She pointed out that Javier was quite *chatty* and perhaps he was developing his social skills first, then there *may be a big leap in his development where he catches up on grabbing objects*. Showing interest and grasping external objects was therefore considered an important milestone for young babies that
signified a developmental marker that, according to the developmental psychology model, can predict future outcomes or be indicative of underlying problems. This has been extensively researched in biomedical domains (see Thelen 2000 for an overview of the history and development of developmental milestones).

Developmental milestones are premised on a scientific model that assumes that the development of healthy children can be predicted according to a biological time-frame. These markers have been assumed by developmental psychologists to demonstrate universal norms and have been used in numerous studies in childhood observation in industrialised contexts and across cultures; however, anthropologists have demonstrated that these markers can be ‘significantly shaped by cultural emphasis’ (Gottlieb 2004:220; Lancy 1996; Super & Harkness 1982; Super & Harkness 1986).

In Oliveto’s biomedical context, the emphasis on Javier reaching the prescribed milestone of grabbing or reaching was given particular importance because of the biomedical belief that his lack of interest in doing so was indicative of an underlying concern arising within the mother-infant relationship. Failure to reach expected milestones was constructed as a potential risk to a child’s development and therefore was an area of concern for some of Oliveto’s multidisciplinary team.

For Helen, a far more important issue of concern was that Javier had begun to show a lack of interest in food. She had great difficulty in understanding why her son would not eat, and from her perspective, this was a source of great anxiety. This issue was also addressed in one of the video-recorded mother-infant therapy sessions when Helen was asked to feed her son in front of the therapist. In the recording, Helen persisted in trying to get food into her son’s mouth, but he kept
turning his head and denying her advances. Reflecting back on this session, Helen explained how Kelly taught her that she was pushing her son too hard to try to eat the food, and that meal times had become like a battle. She learnt that she needed to relax a bit more about her insistence for Javier to eat and let him lead their interactions. When she gave in to this battle and just let him eat when he wanted to, things started to improve, she reported.

Being Attuned & Reading Cues

Kelly and I spoke privately about Javier’s interest in faces over objects. It was through this conversation that the matching of behaviours observed during mother-infant therapy session to the COS was made explicit. Kelly described Javier as being hyper-vigilant to seeing what expressions his mother’s face would show. Throughout his young life he had many intrusive experiences where his mother (and others) had tried persistently to feed him, or more recently attract his attention to toys, however he was more concerned to see the face behind it and the intention behind the intrusion. Kelly described Helen as overbright in many of her interactions with Javier and not sensitively attuned. She also described Javier’s rejection of his mother and her intrusive behaviour as being caught between fight or flight, he not was sure whether he needed to put up his defences so was unsure how to manage interactions with his mother. Kelly referred to Javier as a stressed baby.

In the therapist’s description of Helen’s interactions with her son, Kelly described Helen as not being sensitively attuned to her son, and for this reason her son was

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63 This is a biomedical explanation about the sympathetic arousal of the autonomic nervous system, the ‘fight or flight response’.
rejecting her advances. According to the COS model, Helen was having difficulty in ‘supporting his exploration’ with food, and instead was insistent on him eating food when he was clearly rejecting it by turning his head. As Helen described, when she *gave in to the battle* and let him lead the interactions, the battle stopped and he started eating. According to the model when she was able to support his exploration, her son stopped rejecting her. Working with this model, the therapist was able to identify the attachment problem (avoidant); then consistent with the transgenerational argument of Attachment Theory and the COS, it was important for Kelly to locate Helen’s ‘ghosts’ from childhood and discover the origin of her familial attachment template.

Adhering to the COS model, the therapeutic interview then projected back through time to Helen’s childhood. From this, Kelly identified food as having a significant role in Helen’s life. Kelly described food as Helen’s way of connecting with Javier (and others). As a young girl, she was left at home alone for the majority of time: this was framed as neglect through a biomedical lens. Although Helen’s mother was rarely home, she would always make the same meal for her every day and leave it in the fridge for her to feed herself. The therapist’s interpretation (facilitated through the COS model) left no room for recognition for alternative cultural practices or socioeconomic necessities, despite the fact that Helen was raised in a foreign culture and her mother needed to work as a single parent with no welfare system. It was argued by Kelly that Helen’s mother taught her through this that food was a sign of caregiving. For Kelly, this was displayed through her insistence that Javier eat his food, despite the fact he was actively rejecting it. In Kelly’s home visits to Helen’s house, she also found that Helen would leave food
around the house to make sure that her daughter ate regularly. This supported her belief about the transmission of attachment behaviour in relation to food passed down from Helen’s mother, and now to her children. According to the COS model, the transgenerational pattern of attachment continued. Anthropological critiques of Attachment Theory have argued that ‘food, feeding and food sharing are central elements of care’ (Morelli & Henry 2013:245), prompting anthropologists to argue for a closer integration of food and feeding practices into the evaluation of attachment (Barlow 2013, Quinn 2013). A handful of ethnographic studies in diverse cultural settings are demonstrative of this (see Barlow 2004, 2010, 2013; Barlow & Chapin 2010; Chapin 2013; Seymour 2013).

Indeed, the therapist acknowledged food as a sign of caregiving, however in this biomedical context, food was used to highlight pathology in attachment behaviour. The therapist explained: Helen doesn’t see the child in front of her. She is not able to pick up on Javier’s nuances and overrides his cues with intensity because of her need for him to eat. Kelly’s reference to Helen’s needs overriding those of her son reflects assumptions about the primacy of the child inherent in the attachment model, that is, the requirement for the mother to identify the child’s needs through the child’s ‘cueing’ and respond sensitively to those needs, even if the child’s needs surpass her own. The assumption that these maternal-infant interactions should be universal was implied in Oliveto, whereby therapeutic approaches remained consistent with the COS model, despite mothers from several cultural backgrounds being admitted into the unit (see Chapter Seven for further discussion about cultural variability in maternal sensitivity and attunement). This idea was spoken about by Oliveto’s staff members in relation to a number of other mother-infant
interactions. Within the attachment model, mothers are expected to be attentive to their child’s cues, however the mother’s response to her child — her ‘maternal sensitivity’ was also used to assess problems in the mother’s own early attachment relationship (see Chapter Seven for further discussion). For example, mothers were reminded that their child’s vocalisations were not always a cue for the child to be picked up, but instead were constructed by staff as the mother’s need to hold the child close because of her own lack of a ‘secure base’ as a child.

Referring to the COS model, Helen was not able to ‘delight in’ her son because of her own frustrations. According to Kelly this sets up a negative cycle where Javier then rejects the food. Helen interprets this as rejecting her and becomes even more insistent on giving him food. Javier rejects her again. Here, Kelly again engages with the model of cyclical behaviour. In this cycle, food became traumatic for Javier; it was not caregiving as Helen interpreted it. Kelly explained that many women she encountered use food as a way of calming a distressed baby. Helen was considered to be a good example of this: she could not cope with distress and was quick to quieten her children with food. Kelly further described how food could be used for people who have emptiness in their lives as a way of filling up emotionally or filling up with good things. When describing Helen’s story, Kelly empathised with Helen as a child and imagined that she would have experienced many feelings of abandonment. This psychological technique used by Kelly, placed her in a metaphorical role of ‘secure base’, a person who was able to help her ‘organise her feelings’ described to Helen as grief and loss, but interpreted as abandonment through a psychological lens. Kelly used metaphor again to describe abandonment as an emptiness that needs filling in order for that person to manage those feelings.
The same biomedical beliefs also applied to the treatment of those with emotional eating, obesity and other emotional issues. Kelly believed that Helen’s intensity in forcing Javier to eat was her way of connecting with him while also managing her own feelings of abandonment.

‘Being with Them’ in Their Emotion States

Abandonment or neglect by a primary caregiver was commonly spoken about by staff in Oliveto when referring to mothers’ life histories. While Helen’s childhood neglect was viewed as a factor contributing to her mental illness and *intruding* on her relationship with her son, the same model was also used in relation to other patients with mental illness in Oliveto. The transgenerational cycle of neglect was described as making it difficult for mothers to be with their child. Another mother, Jenny, who was discussed as being severely neglected as a child, reflected on her reaction to watching her mother-infant therapy: she described it as *scary*. Through watching her mother-infant interactions on video, she realised that she and her daughter *didn’t interact very much*. Jenny then went on to explain: *she was learning from me, and she was looking to me to regulate her emotions when she was upset. And that’s when I need to be communicating with her and talking to her and just being with her...for her development.* Being with her was defined by Jenny as *sitting with her on the floor or being with her...where as I was just walking away, or looking away*. In my conversation with Jenny, she used the language and themes offered in the COS roadmap to describe her treatment experience in Oliveto.

*I was happy for [Amy] to explore, but not at participating and supporting her coming back or getting distressed, I would get really anxious and distressed and I wasn’t able to welcome her back. I would feel really
unnatural cuddling her...I’m not very good at regulating my emotions; I’m not very good at showing my emotion at all. And that was how I was brought up... to not show any emotion, so when Amy does [show her emotions], I can’t cope with that.

The assumed patterns of learnt behaviour promoted through the COS roadmap was made evident in Jenny’s explanation of her mental health difficulties. Her lack of emotion or emotional regulation was constructed as a result of upbringing. With the COS’s transgenerational premise, Jenny’s inability to comfort or be with her child were constructed as a result of her own childhood template of neglect and not having someone there to help organise her internal emotional state. In the COS biomedical model of attachment, the importance of having a primary caregiver to help organise a child’s feelings in a safe, non-judgemental environment was given emphasis by the mother-infant therapist, Kelly. She stressed the importance of recognising babies as feeling, human beings that needed to be heard. She explained that she asked clients to empathise with their children (although not explicitly) in order to better understand why their baby may act in particular ways. Kelly related this concept to Javier and Helen’s case: if Javier doesn’t have a chance to express distress, he ramps up his distress, and becomes more distressed. In trying to calm Javier’s distress with food, she argued, Helen was not allowing her son a voice. She explained the value in letting babies express distress, and sitting with them through different feelings states. Kelly explained in more detail:

Our culture ‘shushes’ babies but we need to understand the baby’s experience: Feeling it with them, being with them... Babies are people and
they actually need to have an experience of being heard, and being with, just the same as you and I.

In Kelly’s conceptualisation, Helen had no one with her in her feeling states when she was a child and, like Jenny, she learnt to quiet her emotions because no one had been there to help her with them. This was evident in one session where Kelly described Helen having incredible difficulty crying. Kelly believed that Helen became overwhelmed when her children show her their feelings; when they did Helen was very quick to quiet them. The connection again to COS attachment principles was made evident. Kelly spoke of a caregiver’s needs to comfort their children: rather than ignoring their emotion by quietening them, allow them to express emotions freely without question or judgment—a safe haven where their feeling could be organised and explained to them. The concept of recognising and being with someone in their emotional state was integral to the COS model as used in Oliveto for therapeutic intervention. This applied to the child involved in mother-infant therapy, but also to the mother retelling her experiences as a child where the therapist acted as a proxy attachment figure.

The Therapist: Providing a Safe Base

In Helen and Javier’s mother-infant therapy session, Kelly explained to Helen what she sensed were her big worries causing her anxiety. She sensed that Helen saw motherhood as a big responsibility: she had concerns for her children’s safety and well-being and saw these as major themes in her life. These ‘themes’ were the threads that held Helen’s circle of psychopathology intact. She described to Helen how her fear of not being safe was a result of not having her mother available to her during her childhood. This was believed to be playing out again in concerns for
her son's well-being. Helen agreed that she saw motherhood as a big responsibility and wanted to do the best for her children. She was also aware that she worried more than most people do. She went on to explain her fear of bugs (in particular, scorpions), comparing herself to her sister in-law who did not have the same worries about them as her. In my private conversation with Kelly, it was explained that Helen was not able to make sense of her fear of things that others did not fear.

In her role as therapist Kelly became a proxy attachment figure again in order to help Helen make sense of or organise her feelings about her mother’s neglect in childhood. In the mother-infant therapy video, Kelly suggested a narrative of Helen’s childhood to her that adhered to the COS model:

It sounds like, again you are a bit more vigilant that there could be nasty things out there in the world, hey? If you had to trace back to when you were a little girl, does it sort of ring true to how you grew up, that the world was a bit of a scary place and you needed someone to protect you? Was it like that for you? How do you make sense of this thing that...you’re different to [others] and the world is a bit of a scary place?

Helen responded in subtle defence, by offering that her mother was not home much and her siblings were rarely home because they were overseas studying. So it sounds like the world was a scary place for you. You didn’t have an adult looking out for you. Here Kelly again drew on empathy to help organise Helen’s childhood experience: she put into words the emotions she thought Helen may have been feeling as a child. In this example the therapist could be likened to the ‘hands’ depicted in the COS. In doing so she was also attempting to position herself as a ‘safe haven’ for Helen. Interestingly, Helen visibly (through her facial expressions)
rejected this idea, and stated: *No, I was happy actually, to stay home with my dog.*
She also elaborated that she liked being home on her own and maybe that was why she was finding it difficult. Kelly again tried to connect Helen’s own narrative with one that would fit into a psychological narrative of neglect. Kelly suggested now that Helen had two children, she could no longer have time to be by herself; she had a lot of responsibilities which included the care of others.

> *When you’ve had some trauma in your own history around being a child, it can bring up when you have your own children, like you said this feeling of lots of responsibility in being a parent hey, and you’re wanting to do this thing well I guess and ‘right’ (punches fist in air) if there is such a thing?*

At this point, Helen started to become emotional which was described by the therapist as a *good thing*, because it meant that she had *struck a chord* with her. She spoke about her desire to get better so she could be home with her kids.

> **KELLY:** So, can you see the parallel, why it is so painful? Your mum wasn’t really there for you and it’s a painful big thing for you if you feel like you are not there for your kids.

> **HELEN:** I think that’s normal for every mum.

> **KELLY:** Looks like its extra painful for you.

It was important for Kelly to have a childhood narrative about Helen that fit the mould of a ‘damaged’ child. According to the psychological theories underlying mother-infant therapy and COS attachment principles, a patient must discover their past childhood traumas and address them to be able to form a good and
‘healthy’ attachment with their child in the present, having implications for the child’s future well-being. If Helen’s childhood narrative did not match these expectations, there would not be possibility for repair. The primary focus for the therapist when working with Helen was Helen’s relationship with her mother. Concerns over the death (therefore absence) of Helen’s father at a young age, or Helen’s siblings being absent when she was a child were not issues raised.

In addition, the therapist was searching for Helen’s acceptance of the idea or ‘insight’ that her childhood attachment template was contributing to her mental illness. Kelly recognised that Helen was not able to hold the idea of her mother in that light and would quickly defend her mother’s actions. Kelly believed it was important for Helen to sit with the idea, or hold that her mother had been neglectful towards her and see how it made her feel. She explained how she would repeat the statement and asked Helen to hold the thought. Helen gave a little chuckle at this idea but went along with Kelly’s therapeutic advice. Kelly looked at Helen and stated in a gentle but direct voice: it sounds like you were neglected a bit. Helen sheepishly nodded. Kelly then encourages Helen to access the anger; suggesting it was a good thing to show it asserting that if anger was repressed it can come out as depression.

Through her words, Kelly alluded to a number of the core assumptions underpinning Oliveto’s everyday functioning. Depression, a mental illness defined ethnographically through Oliveto’s psychiatric practice as a biological disease, could result from her behaviour—repressing her emotions. This emotional response to her social and environmental upbringing was constructed as behavioural and managed though volition, yet had biological implications—
symptoms of mental illness. The permeability between different modes of transmission was also evident in the transmission of attachment templates. The belief of transgenerational transmission or ‘inheritable’ COS attachment templates, raised concerns that her son was also at risk of mental illness, yet through her behaviour, she had the ability to positively influence future outcomes. Kelly explained concerns over Javier’s behaviour to Helen in the following way:

Why there is extra worry is because you have been sort of sad yourself, and tearful yourself, and your ability to be with your baby has probably been a bit affected, even though you have been working really hard at it I reckon, hey...trying to make everything just so?

Kelly went on to explain through metaphor the belief that babies absorb the emotions of people around them which, consistent with the COS model, could have adverse effects on Javier’s future outcomes

Babies are sponges for emotions...that’s their big sense that they pick up...To begin with they pick up all the emotions of an environment, particularly when their mums are sad. That can really impact on them.

Here again, Kelly refers to the argument of transgenerational transmission presupposed by the COS attachment model. It was suggested that Helen’s emotional state could be passed to her son, causing his behaviour to divert from biomedicine’s prescribed milestones. Javier’s so called developmental strangeness arose in response to the environment provided through the mother-infant relationship. Adhering to the argument of continuity, treating Javier’s strange behaviour began by first exploring his mother’s ‘ghosts in the nursery’ to elucidate
where she may have had *struggles* in her own early attachment relationship. The importance of Helen addressing her own mental health for the benefit of her child was highlighted as motivation to encourage her to act in accordance with therapeutic processes. Helen was told how her own emotions could have an impact on her child’s emotional state, with the assumption that this could continue to create problems for him in the future; again drawing on the belief of a continuation of maladaptive attachment patterns across generations if this was not addressed. The assumptions highlighted through the COS attachment practiced in Oliveto was that the transgenerational transmission of attachment pathology was found through the maternal side — Javier’s father was not included in the therapy sessions so was not assumed to be as much of a risk to his child. As such, Helen was held responsible for Javier’s developmental difficulties, not Javier’s father.

**Searching for Insight**

For the therapeutic process to be successful, Helen was expected to show *insight* or agree with the model offered to her as an explanation for her symptoms of mental illness. In the psychiatric literature, the concept of insight in relation to mental health has been described as being ‘composed of three distinct, overlapping dimensions, namely, the recognition that one has a mental illness, compliance with treatment, and the ability to relabel unusual mental events ...as pathological’ (David 1990:798). Throughout the therapeutic process, therapist Kelly searched for Helen’s insight numerous times, repeatedly reframing Helen’s childhood recollections as *neglectful* resulting in her *grief* or sadness (a euphemism for depression). Again, Kelly attempted to search for Helen’s insight:
Can you look at that (childhood experience) now and see that that was a bit of a strange childhood to have?

The assumption that Helen could be reflexive was another contradiction recognised in Oliveto’s practices. By definition, her mental illness was constructed as a barrier to reflexivity—yet in order to progress in the therapeutic process, she was expected to agree with the psychological reframing of her childhood experiences. In addition, her attachment template constructed as fixed through early attachment models was assumed to be changeable through behavioural interventions.

Kelly felt that she had to be careful in her role as a therapist not to try to change the way families operated, but instead tried to encourage her clients to look and reflect on their family history and the roadmap this had imprinted in their current relationship struggles. She believed that Helen was very resistant to this idea in the beginning. Kelly claimed she was not trying to place blame on the individual’s history, but was trying to wake her up to the way history has a way of impacting in the here and now. Kelly claimed that Helen had a lot of difficulty coming to terms with this at first, but came back to her a few sessions later and admitted she was able to see its importance. Kelly believed that Helen did not want her mother demonised and at that point it appeared to Helen that this was what was happening. Kelly explained to Helen she was raised to believe you’re either a good girl or a bad girl. Helen’s defensive response was because she thought Kelly was going to separate her mother’s actions into the same primitive split that she was raised to believe. Kelly described Helen as unable to recognise and process the abandonment that she experienced as a child. Kelly's suggestion that her mother
did anything other than the best she could was met with defence. However Kelly was able to also empathise with this reaction.

_How do you make sense that someone has altruistically brought you in and then neglects you? That's a very complicated psychological thing to hold on to, but she'd never even contemplated the complexity of that as an adult looking back. So of course that's going to be rumbling around in her relationship._

Kelly spoke about how Helen could not make sense of her mother’s actions, and so constructed a narrative as a way of managing her confusion. Kelly saw that in Helen’s narrative she had an idealistic view of her parents as a wonderful couple who took her in, despite already having four older children of their own. Helen believed she should be grateful for her parents adopting her and giving her a better life. In contrast, Kelly felt that she was unable to see that she was severely neglected as a child. This was also reflected in Helen’s own words when she spoke to me. Although she could intellectualise what Kelly was trying to demonstrate to her, she claimed that she did not see things that way.

_HELEN: When I look back now, I just think it’s not her fault ‘cause she didn’t have parents of her own and she just did the best she could._

_KELLY: Every mother does the best they can...sometimes that isn’t necessarily enough. Sounds like your mother was in grief, hey? And she didn’t have parents of her own to look out for her._

Again, the COS therapeutical model of attachment was applied. Kelly engaged with the concept of transgenerational transmission, to ask Helen how her ‘ghost in the
nursery’ may have originated and then transferred through her mother’s own ‘nursery ghosts’. Her mother’s neglect of Helen as a child was a result of her own mother’s childhood neglect. The therapeutic process crosses temporal boundaries again as Helen was asked to empathise with her mother as a child. Through this, a link of transgenerational neglect was made over several generations, reinforcing the need for Helen to address her mental health problem in the present for her son’s (and potentially grandchildren’s) future.

Transgenerational Transmission: Justifying Treatments

As Helen and Kelly were concluding their therapeutic session, Helen looked to the therapist for acceptance that the session had gone according to therapeutic expectations.

    HELEN: Well what do you think of today then?

    KELLY: What do you think?

    HELEN: I don’t know, I guess I’m being analysed.

The therapist responded by seeking Helen’s insight about the session. Interestingly, Helen’s response failed to show that she had gained further insight into the roots of her mental health distress; she was more concerned about Kelly’s interpretation of events through her ‘analysis’ of her. In this therapeutic encounter, Helen agreed to the exploration of her childhood and observation of her interactions with her son — she did not actively resist the process. It could be argued that the power of psychiatric practice and the knowledges produced by it that highlight the risks of mental illness, were a factor of her submission to the
therapeutic process. The belief of transgenerational transmission suggested to her in the therapeutic process, could also have been used as motivation for agreeing to the process. Helen's concluding words in the therapy sessions were very telling. Helen was able to show that she understood conceptually the argument put forward about her childhood narratives, yet she was still resistant to agreeing with the therapeutic model.

*HELEN:* I don’t know. I thought it was just like if you had kids, you want to be with your kids. I didn’t really think because of my mum or whatever. I don’t know...

*KELLY:* Just think about that for a bit.

*HELEN:* So do you think it’s because of my upbringing and that for all of this?

*KELLY:* Can you look at that and see that was a strange childhood to have?

*HELEN:* Yeah my husband tells me that

Helen could express her husband’s acceptance of her strange childhood for understanding her emotional distress and difficulty with interacting with her son, but could not verbalise it herself.

Helen and Javier's case was chosen as an example to illustrate the core cultural values that infused Oliveto's everyday assumptions and functioning. With the diversity of biopsychosocial admission into Oliveto the range of therapeutic configurations were varied, yet the core assumptions of psychiatric and attachment principles inherent in this model, and the tensions within and between
them became apparent through ethnographic analysis. Within the COS therapeutic model, the thread of time projected backwards and forwards, joining the mother’s past early attachment relationship to her child’s probable future. Drawing attention to the transgenerational transmission of attachment patterns was used to prevent possible risk to the child’s future well-being and justify therapeutic treatment in the present.

The crossing over temporal boundaries in the therapeutic process echoed the argument presented by the COS attachment roadmap, and was therefore considered as a metaphoric model for identifying psychopathology and the source of transgenerational transmission. Oliveto’s use of the COS demonstrated how Attachment Theory was applied in practice in a contemporary psychiatric setting, highlighting a number of underlying assumptions inherent in the model that filtered into Oliveto’s everyday practice. In therapy, the COS model focused explicitly on maternal transmissions of pathological attachment templates through the exploration of transgenerational mother-infant relationships. As such the COS model focused explicitly on Helen’s mother and the perceived poor attachment between the two. There was less of an emphasis placed on other childhood traumas that arose through the therapeutic process, such as the death of Helen’s father at an early age, or the absence of her siblings. The belief of maternal transgenerational attachment pathology was highlighted particularly in reference to Javier’s difficulties. In the mother-infant therapeutic session, Helen was held responsible for Javier’s difficulties, while Javier’s father was not despite comments from staff about his mental health difficulties.
Treatment of the attachment relationship emphasised the emotional act of mothering through the provision of love and security, believed to have implications on the child’s future emotional well-being if not formed appropriately. In the following chapter, I discuss how the emotional act of mothering, although significant for the development of young children, was not the only element of mothering that was addressed in the Oliveto context. To be deemed a ‘good-enough’ mother, women in Oliveto also needed to learn the skill of *mothercraft* — that is the physical act of mothering with culturally orientated practices and techniques that were specific to the Oliveto fieldsite. Here I draw primarily on participant observation conducted with Oliveto’s nursing staff and their daily interactions with mothers and babies, training them in the *mothercraft*. The chapter gives emphasis to culturally specific mothering techniques used in this context, and considers how mothercraft practices relate to attachment and the woman’s ability to be considered a ‘good-enough’ mother.
‘MOTHERCRAFT’: TRAINING ‘GOOD-ENOUGH’ MOTHERS

There is no universal norm that dictates a standard for child rearing. What is universal however, is the existence of routines that facilitate the enculturation—the upbringing—of children.

David F. Lancy (1996:15)

What Makes a ‘Good-Enough’ Mother?

Before beginning fieldwork, I attended a conference organised and run by Oliveto. In the opening speech given by Dr Margaret (Oliveto’s Medical Unit head) I was introduced to the concept of the ‘good-enough’ parent, a concept I later learnt was created by psychoanalyst and paediatrician Donald Winnicott (1950). The concept of good-enough parenting appeared to be understood by most of the people who were attending the conference, the majority of whom worked in the area of infant and maternal mental health. They were asked to form small groups and discuss what would aid good mental health outcomes in infants when they become adults. After some conversation, the ideas generated from each group were shared. Some of these included: attachment, basic needs, stability, stimulation, love, connectedness through touch and eye contact, availability, physically and developmentally good-enough role models, sufficient finances, accommodation, extended family and community support, national policies and parenting support.
From that discussion, the complex construction of what was considered ‘good-enough’ in terms of parenting became apparent. During the fieldwork that followed, the concept of the good-enough parenting arose in staff conversations, however the term good-enough mother was used instead to reflect the gender of parents admitted. Oliveto staff reinforced my basic (at the time) understanding of what they expected from a good-enough mother: a mother who was able to provide what staff considered to be appropriate physical, emotional and psychological care for her infant or child in order to facilitate the growth of emotionally and psychologically healthy young adults in the future.

The expectations of good-enough mothering in Oliveto were complex and multi-layered and ultimately shaped decision-making around the woman’s ability to leave Oliveto with her child. This chapter addresses the assumptions of good-enough mothering as they were observed in Oliveto, with a particular focus on the social training of good-enough mothers, through mothering practices referred to as mothercraft. This portion of the therapeutic treatment offered for women was conducted primarily by psychiatric nursing staff, and aimed to normalise mothering skills in particular ways so as to reflect Oliveto’s core cultural assumptions about the practice of mothering, as well as to reproduce ideas about the role of mothers in Australian society and the cultural construction of infants and children. Through participant observation of everyday practices in Oliveto, these assumptions were made evident; particularly through the characteristic practices used to train mothers with mental illness in ways of managing their physical interactions with their child.
Within this chapter, I explore how the concept of being a good-enough mother in Oliveto went beyond providing a secure attachment to young children. Instead, being a good-enough mother included two interrelated but distinctly different features. The first being the *emotional* act of mothering by providing love and security to the child through the bond or attachment created (discussed earlier in Chapters Five and Six). The second feature of good-enough mothering, discussed in detail here, involved the *physical* act of mothering through *mothercraft*, that is, culturally orientated mothering practices and techniques that were specific to the Oliveto fieldsite.

**Winnicott’s ‘Good-Enough’ Mother**

Throughout the fieldwork period, it became clear that what some of the staff believed constituted a good-enough mother was derived from Winnicott’s theorising, however my ethnographic analysis revealed a much broader construction of the term than he had originally intended. A closer examination of Winnicott’s ‘good-enough mother’ concept (Winnicott 1953; Winnicott 1987a) will enable the reader to comprehend some of the key assumptions inherent in Winnicott’s theorising.

As a child psychoanalyst, Donald Winnicott was concerned with the psychological development of young children and the impact that a child’s early relationship with its primary carer (usually referred to as ‘mother’) could have throughout its adult life. He believed for a child to have ‘normal’ development, a mother did not have to be perfect or without failings, mistakes or frustrations, but simply be a good-enough mother, or alternatively an ‘ordinary devoted mother’ who ‘instinctively’ attends to her child’s basic needs in a ‘natural’ way because of her
ordinary devotion to her child (Winnicott 1950:4-6). In his writings he assumed that most ordinary mothers have a ‘natural devotion’ for their child, and because of this devotion, they ‘intuitively’ know what to do to provide the best possible outcomes for their child (Winnicott 1987b:16-18).

According to Winnicott, a mother's natural devotion can be identified in the way she attentively 'holds' her child. Holding for Winnicott is the physical act of holding the infant in a supportive, nurturing position where the child is held securely and closely, the mother adapting herself to suit her child’s needs. Winnicott believed that babies are extremely sensitive to the way they are held and that a good-enough mother is attuned to these sensitivities for her infant. Winnicott extended the use of the word holding in the physical sense to refer to providing the infant with a metaphorical 'hold': a ‘protective’, ‘safe’ and ‘secure’ space for babies to develop an autonomous ego (by which he meant, autonomous self) (Winnicott 1987a). He chose the term ‘hold’ to encapsulate ‘all that a mother is and does at this time’ (Winnicott 1987a:7), referring to the mother's role in this dependent relationship and the mother’s contribution to the child's self-development. Holding was a 'skilled job' that a good-enough mother has an 'intuitive understanding' for, that is ‘natural and unspoiled by learning’ (Winnicott 1987b:16-17). For Winnicott, his use of the term ‘holding’ was ‘the prototype of all infant care’ (1987a:37).

In his theorising, Winnicott described most mothers as having a ‘primary maternal preoccupation’; a state where they are ‘...able to put themselves into the infant’s shoes... [and] develop an amazing capacity for identification with the baby... this makes them able to meet the basic needs of the infant in a way that no machine can imitate, and no teaching can reach’ (1987a:36-37). He promoted naturalistic
assumptions about mothering and the mother’s role in facilitating her child’s development of self. However, he repeatedly reiterated that a mother’s ability to show a natural devotion to her child may be hindered in cases of psychiatric illness (Winnicott 1960; Winnicott 1987b). As part of psychoanalytic theory, Winnicott explained that women with mental illness are likely to have disorganised defences\textsuperscript{64} so therefore their sense of self is not fully functioning. For this reason, a woman with a psychiatric illness could not make a good-enough mother.

**Good-Enough Mothers and Oliveto**

The therapeutic work conducted in Oliveto assumed that mothers with mental illness lacked the capacity to identify with their child through the empathetic attitude that ‘primary maternal preoccupation’ required. In effect, Oliveto staff were attempting to repair the capacity for women with mental illness to be good-enough mothers through their daily work, a significant part of which involved assisting and training mothers in techniques thought to be helpful in the practical care of babies. The assumption could therefore be made that since women in Oliveto were taught how to care for their infants, mothering, for these women at least, was not intuitive or did not come naturally as Winnicott would suggest, precisely because of their mental illness. In his theorising Winnicott (1987a:6) engaged with the transgenerational argument put forward though Attachment Theory, stating:

> After all, she was a baby once, and she has in her the memory of being a baby; she also has memories of being cared for, and these

\textsuperscript{64}Mental illness is described in psychoanalytic theory as a disorganisation of defences. A detailed explanation of defences is outside the scope of this thesis; however it is of note that defences were not discussed in Oliveto.
memories either help or hinder her in her own experiences as a mother.

It is precisely at this juncture where attachment principles and the training of mothering practices collide. Without the influence of a positive maternal figure in a young woman’s life, the assumed socialisation of mothering or mothercraft skills transferred from a mother to her daughter were believed to be defective, impacting on her ability to provide good-enough mothering both physically and emotionally. These defects were caused, it was argued, by their own poor mothering and attachment in early childhood.

What the practices in Oliveto implied, was not that the woman was not able to be a good-enough mother, but that her mothering needed improvement through training in mothering skills. In Oliveto, psychiatric nursing staff worked daily to educate and train mothers in the cultural expectations for the physical care of babies to fit into regulated and scheduled patterns of behaviour that were considered predictable for the mother thereby easing the mother’s distress around caring for her child. Implicit in this training was the dual act of training infants and young children in the rules underpinning Australian and other Western cultures that promote individualism, regularity, autonomy, productivity and daily functioning that centres around time management (Oyserman, Coon & Kemmelmeier 2002). Through a process of normalisation, mothers in Oliveto were trained to care for their babies so as to achieve cultural norms in relation to child care practices.
Mothers were not discharged from Oliveto with their child(ren) unless they were able to achieve the expectations of good-enough mothering put forward by Oliveto. Unfortunately, for a handful of mothers, their inability to understand or to follow through with Oliveto’s both explicit and unspoken cultural rules resulted in consequences that were often unforseen by the mother, such as the temporary or permanent removal of the child into the custody of another. Mothers who were deemed not good-enough according to Oliveto’s standard, were thought to place the child ‘at risk’. In severe circumstances, the best solution for this was to remove the child either temporarily or permanently from that perceived risk.

What did this mean for mothers who had difficulty managing their early interactions with their child and had accepted (or were required to accept) treatment through an admission at Oliveto? As women with a diagnosed psychiatric illness, they had already been constructed as abnormal according to psychiatric practice; the assumption inherent in the treatments offered to women in Oliveto to create good-enough mothers through training of mothering skills further abnormalises their behaviour. Their devotion to their child was rarely questioned: Oliveto staff were generally optimistic about this because it was understood that accepting an admission into such a unit was a sign of devotion to the child. Oliveto staff were more concerned with measuring the quality of the mother’s devotion — was it normal or abnormal according to cultural standards? Were these women good-enough mothers? Or did the woman’s own experiences of being held by her mother, her template (as attachment discourse would label it), make the skill of holding her child defective?
The term ‘good-enough mother’ was rarely used by staff, however all of the key concepts of the good-enough mother as described by Winnicott (1950) were repeatedly inferred in the field in one form or another, particularly through the application of mothercraft.

The term mothercraft dates back to 1907 when paediatrician Sir Frederic Truby King introduced *mothercraft* as an educational process and intervention strategy to address high rates of infant mortality. In his later book, *Feeding and Care of Baby* (Truby King 1930) Truby King identified ‘Twelve Essentials’ for raising healthy infants which were thought to be revolutionary at the time. Truby King’s *mothercraft* message was to ‘[b]uild healthy babies rather than patch sick ones’ (Canadian Mothercraft Society 1918). This message still resonated in Oliveto. *Early intervention* as it was often referred to by Oliveto staff, relied on the same principles of building healthy babies, rather than ‘patching them up’. Children of parents with mental illness (referred to in Oliveto as COPMI kids) who were often constructed as not having received good-enough mothering themselves, were considered problematic. The belief was that if the transgenerational transmission of mental illness was not addressed early in the child’s life, COPMI kids may go on to drain mental health resources as they moved into adulthood. Yet, as has been demonstrated throughout this thesis, it was mothers and mothering that was the focus of the intervention.

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65 These twelve essentials were listed as: air, sunshine, water, food, clothing, bathing, muscular exercise and sensory stimulation, warmth, regularity, cleanliness, mothering, management, rest and sleep.

66 COPMI (Children of Parents with Mental Illness) is the name of an initiative funded by the Australian Government that aims to provide project materials, worker support information and links to information related to mental illness for parents, families, children and young people.
Mothercraft Skills

Truby King’s mothercraft was described in the Sydney Morning Herald as ‘part of the body of modern science’ (Anon. 1946). Mothercraft was an example of what Apple (2006) refers to as ‘scientific motherhood’ which applied scientific principles to justify the use of particular techniques used to educate mothers in child rearing practices believed to produce optimum outcomes. With the expansion of scientific and medical research, new knowledge about the best practices for raising healthy children also changed to reflect new findings (Apple 2006:1; Division of Rare and Manuscript Collections 2001). In a sense, the introduction of mothercraft education created a normalisation of mothering practices and techniques that became widespread and changed over time as new research influenced new trends (Apple 2006).

Implicit in the very term mothercraft, is the assumption that the ‘craft’ of mothering is not innate or natural, but a skill, trade or talent that is specific to mothers that must be learnt; that is, taught to an unexperienced person by someone with authoritative knowledge. More than a century on from Truby King’s original educational program which taught young women the skills for raising healthy babies, staff in Oliveto employed the term mothercraft when training mothers with mental illness in the basic skills that a good-enough mother was believed to require. Never were the terms parentcraft, fathercraft or carercraft used when describing these skills, positioning mothers as the primary architect of their child’s physical, psychological and social growth. Further to this, ethnography showed that being a mother was not a prerequisite for training good-enough mothers. The skills needed to become a good-enough mother were also taught by
women who had never been mothers, and by men, affirming Silva’s assertion that while motherhood is female, mothering need not be (1996:12).

Normalising through ‘Mothercraft’

Nursing staff commonly anticipated that a new mother and infant admission would mean the arrival of a mother who (in addition to the symptoms of her mental illness) would be exhausted from lack of sleep, beyond the expected sleep deprivation caused by newborn feeding patterns. In many cases, infants admitted were described as being unsettled. Unsettled babies in Oliveto referred to an infant that cried significantly, was irritable, had difficulty self-soothing or was difficult to soothe when distressed. In some cases, there may have been physiological reasons for the infant’s unsettled behaviour, and in others, the infant’s unsettled behaviour was considered to be a result of the mother’s poor mothercraft skills not meeting the individual infant’s needs. Whenever possible, mothers were encouraged to provide most of the physical care or holding of their children, however in many cases, particularly those with newborns, patients were given a night or two (or as many deemed necessary) of uninterrupted sleep. While the mothers slept, nursing staff managed the night care of their babies. Medications were usually administered to mothers at this point, if they had not been already, to alleviate the symptoms of the mother’s mental illness. In some cases, medication to assist with sleep was also administered. Maternal sleep was considered important for new admissions, and nursing staff believed it to be their role to take over the physical care of infants for mothers while they rested during their early admission. In Oliveto, the mother’s need for sleep was considered synonymous with oxygen as suggested by this psychiatric nurse:
When an aeroplane is going down and losing oxygen, what do the flight attendants tell you to do? First you fit the adult’s oxygen mask then you can help the child.

After an initial period of rest, nursing staff then continued to train mothers with the techniques they had used to physically manage their child during that time. After the first few days of admission, infants without underlying health problems were generally described by staff as becoming more settled.

In these circumstances, Oliveto psychiatric unit staff played the metaphoric good-enough mother for the mentally ill woman. On occasion, staff would describe an admission as holding the mother until her mental state had improved (see also Dolby, Ebert & Watson 2008). Within that time, the staff in the unit would begin to train mothers to fit within the specialised model of parenting assumed appropriate for an infant in this context. As was the case decades ago with Truby King, the mothercraft skills taught were informed by new research formulated from scientific principles. When staff perceived that the mother had begun to embody the attributes of a good-enough mother, then weekend leave from the unit was considered.

In many instances, mothers with mental illness found the basic skills of physically caring for their child challenging. Poor mothercraft skills (in addition to a mental illness diagnosis) were viewed as risk factors for children of mothers with mental illness; this was because the primary biological needs of the child may not have been met to a standard that was considered good-enough. The average age for infant admissions was approximately four months. According to staff, during that time the mother would have spent four months trying to establish her own
patterns with her child, and may have inadvertently created the unsettled behaviour that her child was displaying. Nursing staff often commented on the *bad habits* that mothers had created in order to alleviate their child’s unsettled behaviour. They worked with mothers (and on rare occasions fathers) to break these habits, by teaching them new patterns of behaviour that encouraged predictability. By observing the everyday practices that occurred in Oliveto, particularly in relation to mothering and mothercraft practices, I was able to identify what those working in the context valued as important for establishing good-enough mother-infant interactions. Through observation, and analysis of the assumptions staff made about babies when instructing mothers to care for them, a clearer image of the construction of babies emerged.

During early admission, nursing staff observed the infant’s behaviour, and surveilled the quality of the mother’s mothercraft skills for managing her infant’s behaviour — intervening when necessary. Daily physical care, such as feeding and sleeping activities, were significant for infants who were entirely reliant on their caregiver. Cultural trends and beliefs about the best ways to provide these needs for an infant fluctuate and change over time. Smart (1996:46) referred to the changes in rules and guidelines that determined the evaluation of good or bad mothering practices as ‘the calibrations of good motherhood’. My fieldwork allowed me to observe the calibrations of motherhood current at the time of this research in an intensified environment where mothering practices were under constant biomedical scrutiny and subject to instruction. These practices were often unfamiliar to mothers admitted to Oliveto, with several mothers admitting that they had never held an infant before having their own. Later in the fieldwork
period, the practices were often intentionally brought to my attention by both nursing staff and mothers because of my pregnant state as a means of preparing me for my future interactions with own child.

**Getting into a Routine**

During initial admission, nursing staff used specific techniques to help develop or stretch out routines for the infant, then tried to educate mothers in the techniques they used. There was flexibility in the techniques used, and they were adapted differently to suit individual situations. However, the underlying structure in each routine was to regulate feeding and sleep patterns, allowing for play or interaction time in between which was thought to facilitate physical and emotional development and foster early communication skills. While mothers were being trained in mothercraft and the act of holding their infant, infants were simultaneously being trained to be good-enough babies. The assumption put forward by these practices was that an infant also had to behave in particular ways for the mother to manage their relationship — the infant therefore must also be taught how to be a good-enough baby, so that the mother could cope.

The normalisation of mothering techniques created through mothercraft training was a significant focus of Oliveto’s daily practice. For this reason, infants and babies consumed most of the working day for nursing staff. The majority of their work involved regulating infants into more predictable patterns for their mothers to manage. Oliveto, under the guidance of Healthy Women and Children (HWC), the state’s governing medical body for women and children, recommended

67 See Chapter Two for more information about the role that Healthy Women and Children (HWC) played in Oliveto’s operation and management.
settling techniques that fit within a cyclic routine of feed-play-sleep. Establishing this routine was considered a high priority so that predictability or regulation was created in the child's behaviour. This was considered beneficial for both the mother and the infant. Predictability in child behaviour meant that mothers were then able to anticipate what would happen next, while also fostering security for the child. When caring for an infant, time schedules for sleep and feeding patterns were encouraged. A significant focus was placed on this practice in Oliveto; in some instances mothers were encouraged to keep a record or chart their child's behaviour so as to maintain a good routine.

The cultural belief of routines and regularity in infant behaviour is a distinctly Western notion reflecting cultural values of independence and self-management. The regulation of infant behaviour patterns was first encouraged during the infant welfare movement (between 1880 and 1950) where concerns with eugenics sought to improve the care of infants. In the socio-political environment, the advice offered by medical and scientific 'experts' was thought to be the safest and healthiest way to raise children (Silva 1996:27). The conventional medical advice given at this time was to adhere to a rigid feeding and sleeping schedule (Apple 2006; Ehrenreich & English 1979; Riley 1983), with limited contact, including no kissing: kissing was feared to spread contagions and create an emotional dependence. This advice was advocated and promoted as 'the way to protect the child' with the assertion that 'regularity in infancy would produce a well-adjusted adult' (Apple 2006:65-66). The disciplining of infant behaviour to fit within adult patterns of behaviour has been a continuing trend in industrialised societies such as Australia. Viewed through a Foucauldian framework (Foucault 1977) the
disciplining of young children’s bodily behaviour made them more ‘docile’, productive and useful (Blunden, Thompson & Dawson 2011:330). The scheduled patterns have been described metaphorically as ‘imitating the rhythm of industrial life…evoking] the efficiency, power and modernity and progress of…industry’ (Eyer 1992:95).

Perhaps the most notable inclusion to the training of infant behaviour in the last century was the widespread publication of Dr Spock’s ‘The Common Sense Book of Baby and Child Care’ (1946). Influenced by the work of Freud, Dr Spock urged women to use their ‘common sense’ and trust their intuition in regard to child care (McInnis 1985:13). He introduced psychological principles in his advice to mothers (Apple 2006:124). He continued the advocacy for adherence to schedules in child care, yet encouraged flexibility in schedules, catering for the individual baby within the context of family life (Graebner 1980). Although somewhat outdated, Dr Spock’s advice to mothers still held relevance in the Oliveto fieldsite. Mothers were encouraged to create regularity and predictability in their child’s behaviour while simultaneously attending to the attachment relationship with their child.

Inherent in the thinking of infant schedules and routines was the partition and observation of time; allocating specific parts of the day to particular behaviours and differentiating between day and night time. In Oliveto this was reinforced by having the child sleep in a cot in a dark bedroom at night time, while day time sleeps would occur in pushers or cots (depending on the situation), however daylight was not necessarily masked. The underlying principles in such behaviour prepare the young child for life in their social and cultural worlds, where time
determines acceptable behaviours. For example, in Western industrialised contexts, social institutions such as school and work set the standards for regulating sleep patterns. The organisation of time in these institutions tends to fit within 9am-5pm time frames (Jenni & O'Connor 2005:206). Meals also tend to follow a pattern of three standard meals a day and sleep generally is expected to occur when it is dark and for a significant stretch of time. Regulated feed-play-sleep patterns for babies are therefore culturally constructed definitions and expectations (Blunden, Thompson & Dawson 2011:329). Regulating sleep patterns in babies therefore enculturates them into the broader cultural values and social demands of their society (Jenni & O'Connor 2005:206). These cultural rules of behaviour are so engrained in our daily functioning that we rarely question them. Within Oliveto's model of mothercraft, the mother, with the assistance of nursing staff, had to learn to train her baby to mould its functioning to fit within these culturally constructed cycles. The expectation that infants could fit easily within these time frames is paradoxical, as they may not be responsive to the child’s innate behaviour as argued by McKenna, Ball and Gettler (2007).

Training infants to fit within these cycles was difficult for some mothers and sometimes exacerbated symptoms of mental illness as observed with Ally in her interactions with her newborn son Simon. She appeared to be highly agitated, constantly checking the clock and looking confused. She explained to me that her confusion and anxiety around time had begun since the birth of her son. When she was discharged from hospital after Simon’s birth she received help from midwives who came to her house daily, giving her advice on a schedule for her baby which organised her time around feeding, keeping her son awake for a certain amount of
time for play, then sleep time. Because of this, she had become fixated on time and watching the clock, constantly wondering what she had to do next for her son. She found that she could not relax in between caring for him as she had been advised to do. Ally explained that before Simon was born, the only occasions she felt she had to observe time was to make sure she got to work on time or for knowing when the time of her favourite television programs were on. Now, for Ally, all of a sudden time had taken on a whole new meaning and was highly regulated.

Reading Baby’s Cues

When an infant was healthy, nursing staff generally managed to create a routine in the infant’s feed-play-sleep patterns, described as a loose schedule, with minimal difficulty. However, mothers often found this task difficult. A significant part of nursing work was to educate mothers on the mothercraft skills they needed to use to regulate their infant’s behaviour, however the biggest difficulties these mothers faced was in interpreting their child’s communication of their needs through their cries, verbalisations and bodily movements — referred to as cues. A baby’s cues were believed to indicate hunger, tiredness, discomfort (for example from a soiled nappy or being too hot/cold), distress and enjoyment. A good-enough mother understood how to read her child’s cues and respond in a way that was considered appropriate according to Oliveto’s mothercraft philosophy.

The agency of the infant for the elicitation of mothercraft skills was significant. A newborn infant was often described as helpless and dependent on its caregiver for basic biological survival. Babies of this age (0-3 months) were said to be in their

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68 Mothers were often advised to rest while their child was sleeping.
fourth trimester, indicating the child’s physical dependence on their mother for survival, similar to being in the womb. Infants were also understood to play a powerful role in eliciting their mother’s responses in meeting their basic physical needs through cueing. It was believed that babies were programmed, or designed to cue their caregiver to fulfil their basic needs. These ideas link back to Bowlby’s (1958) earlier theories of attachment where these behaviours in babies were understood to elicit responses from primary caregivers. The child’s experience of the caregiver’s response influenced their attachment formation and hence was considered a key part of the attachment relationship. In Oliveto, a good-enough mother was expected to be able to recognise her child’s cues, and respond with culturally appropriate practices. Gaskins argues that responsiveness in the attachment paradigm is assumed to hold universal relevance, however this can only be applicable if ‘responsiveness’ is defined in local terms (2013:51). The locally defined terms of maternal responsiveness through mothercraft, were precisely what women in Oliveto were being trained in, and what this chapter aims to convey. Many mothers, especially first time mothers, had considerable difficulty recognising and responding to their child in accordance with biomedically set norms. The expectation that a mother could read her child’s cues was so important that when, through observation, it became apparent that the mother was not succeeding in this, nursing staff would instruct mothers how to recognise these cues, or attend to the child’s needs for them. For many mothers, this was an extremely difficult task, as they had never been taught or had prior experience in recognising a baby’s cues, but were still expected to understand them.
Learning to read a child’s cues was considered a skill of good-enough mothering. Mothers with mental health disturbances were often described by Oliveto’s staff as misinterpreting their child’s cues and not recognising what their child really needed from them. For many mothers, their first response to their crying infant was to hold or feed their child, however in many cases, nursing staff described this as creating bad habits that become difficult to sustain as the child grows. One afternoon, I observed a nurse explaining to a mother that she needed to be the boss in the relationship with her child. Instead of responding to every noise her child made, she needed to listen and observe carefully and learn to understand what her child’s sounds and movements indicated. The nurse went on to explain that when a child cries, the child is attempting to communicate a need to the mother: their need for sleep, food or their need to be made comfortable. However, this did not necessarily mean that they needed to be held. The nurse explained to me privately that a lot of babies have their mothers wrapped around their little finger and have their parent doing everything for them. This nurse did not see this as beneficial behaviour because the child then becomes too reliant on the parent to help them, particularly with sleep and soothing, as this can create bad sleep habits. Bad sleep habits in this context referred to patterns of sleep that would be disruptive to the mother’s daily life such as short sleep intervals, referred to as napping (approximately 20-40 minutes at a time) during the day and wakeful sleeps overnight. Good babies slept for longer stretches of time: for example, newborns would have two to three sleeps lasting approximately two or more hours per day, or older babies would be expected to have one sleep lasting between two to three hours. Following this a good sleep would sleep through the night for a stretch of five hours or more.
Mothers’ confusion around babies’ sleep patterns is perhaps not surprising given the contradiction in cultural understandings of infancy, and the child’s developmental needs. As noted earlier, a newborn infant described as being in their 4th trimester suggests that the child was considered as dependent on its mother outside of utero as it was in utero. However, the discourse in Oliveto around infant behaviour and sleep suggests that in fact babies were imbued with agency and volition. While mothers in Oliveto were expected to attend to their child’s needs, infants were simultaneously described as being manipulative in their elicitation of their needs.

**Sleeping Like a Baby?**

The most salient examples of structured behaviour in babies was observed though sleep routines. Sleep was generally one of the greatest concerns for mothers with new infants as sleep deprivation interfered with their daily functioning, particularly when dealing with symptoms of mental illness. Wrapping and swaddling techniques were strongly advocated for young infants, and infants were wrapped particularly firmly; this was believed to emulate the enclosed feeling of being in the womb. The practice of swaddling is an ancient technique that has fluctuated in popularity in Australia and other industrialised societies. At the time of this research, staff in Oliveto believed that swaddling was conducive to better sleep patterns (particularly in infants) because it prevented them from being roused from their sleep by their involuntary arm and leg movements, also referred to as the *startle reflex*. During the day, babies were wrapped firmly, then placed lying on their back in a stroller that reclined into a flat position. The practice of laying the baby on their back (or occasionally on their side) was following
directives of scientific research for the prevention of Sudden Infant Death Syndrome (SIDS) and was recommended by Oliveto’s governing body. This form of sleeping was considered an issue of biomedical safety.

Portable bassinets were used so that the child could stay with the mother or nursing staff, or the child was moved into a cot in the nursery room (a room dedicated for babies to sleep in). If babies began to rouse after a short period of sleep (forty minutes or less), mothers were encouraged not to pick the child up but instead soothe the child back to sleep by engaging in other techniques. In doing so, the mother was teaching the child to self-soothe meaning to independently soothe themselves back to sleep without the aid of his or her mother. One nurse went so far as to place a note across a sleeping baby that read do not pick me up so that when the mother responded to her child’s rousing, she would be reminded that this was not a recommended practice. Again we see cultural values of autonomy and independence incorporated in mothercraft training practices. Paradoxically, babies were expected and taught to become separate from their mother at a very early age in contrast to attachment principles which highlighted the innate nature for infants to seek closeness and proximity in their first year.

Rather than holding the babies, distance and rhythmic patterns such as patting, stroking or rocking the bassinet back and forth were used to encourage babies to sleep. A common sight on arrival to the Oliveto unit was to see mothers or nursing staff standing between the space separating the dining area from the lounge area. Here a strip of plastic covering the connection between carpet and linoleum created a slight bump which was used to roll bassinets backwards and forwards (sometimes quite rigorously), creating a rhythmic movement for the baby. Using
the *bump* as it was referred to, was advocated in Oliveto, with some mothers amazed at the simplicity of the idea and its ability to soothe their child to sleep. Some proclaimed they wanted to create their own *bump* with discussion of making one by placing an electric cable on the floor to imitate this.

Although holding and rocking infants to sleep was not an advocated practice, it was acknowledged that the rhythmic movement created by rocking was soothing for babies and was commonly observed among Oliveto’s nursing staff and mothers. It was not unusual to see a group of two to four women standing together chatting and rocking rhythmically in unison. Ironically, they were not always holding a baby; standing alongside another who was doing this movement was enough to encourage others around them to fall into the same rhythm. One nurse joked that she would often find herself rocking in the supermarket while looking for something on the shelf.

Many of the infants in Oliveto were believed to have developed *bad habits of napping* for short periods of time (20-40 minutes) during the day and/or relatively short sleep patterns (one to two hours) overnight. *Stretching out* infant sleep patterns, particularly overnight, meant allowing the child to cry without the mother attending to the child. Nursing staff took responsibility for doing this in early admission, while mothers were given rest. Staff felt they were better equipped to do this than the mothers, whose emotional response to their child, they argued, made it difficult to deal with their infant’s cries. Research by biological anthropologists McKenna, Ball and Gettler (2007) has demonstrated that the prevalence of SIDS is a culture bound syndrome that could actually be attributed to Western societies’ tendency to ‘stretch out’ sleeping patterns in
young infants who are biologically hard wired to wake frequently (generally for feeding).

Night sleeps were expected to occur in the mother’s room so that the mother could respond quickly to her child’s needs and would not rely on the assistance of staff. There were of course staff available should the mother require assistance, however as much as possible, night time care was expected to be conducted by the mother. Having the child room-in with her was also believed to assist with promoting the attachment relationship. Babies were expected to be close to their mothers at night time, but not too close. Co-sleeping, that is the mother sharing a bed with her child, was forbidden in this context, even if this was normal practice for the mother and her child at home. As part of Oliveto’s policy, co-sleeping was viewed as a possible biomedical risk to the child, particularly when mothers were medicated and may not be aware of their child’s presence in the bed. The risk of SIDS or the children suffocating under the weight of a medicated mother were the primary concerns. The only time babies were actively removed from a mother’s room was when a mother had been detained or there were concerns of risk to the child’s safety. Where a child slept was therefore considered a medical issue.

Cultural Construction of Sleep

Despite the explicit normalisation of independent sleeping, where the baby spent long periods of sleep on their back, sleep practices in Oliveto were distinctly cultural rather than purely based on biomedical necessity. Anthropology has offered insights about the interplay of culture and the biological experience of sleep (Crawford 1994; Gottlieb 2004; McKenna, Ball & Gettler 2007; Morelli et al. 1992; Super & Harkness 1982; Super & Harkness 1982 ). By examining
expectations and definitions of sleep in the context of wider cultural values, the cultural construction of sleep is made evident (Blunden, Thompson & Dawson 2011:329). For example Beng babies in West Africa always slept attached to another person exhibiting sporadic sleep intervals and lengths of time (Gottlieb 2004:167). Gottlieb argues that for the Beng people, the importance of promoting social bonds with a variety of people therefore underpinned ideas around sleep behaviour. This made ‘cultural sense’ for a people who viewed infants as reincarnations of ancestral spirits who needed to be lured into this world. They also believed that babies should choose their own schedule for sleeping and therefore there was little patterning in their sleep behaviour (Gottlieb 2004:169). This was consistent with the Beng belief of infant volition. Being close to people becomes a way to convince them into an ‘inviting hospitable world’ which is ‘worth separating from the other world’ (Gottlieb 2004:183). Similarly, Balinese babies are held close to a variety of people of all ages all of the time (Mead 1970). For Balinese babies, being alone, particularly when sleeping, is considered a risk leaving them vulnerable to the spirit world. In contrast to infant sleeping arrangements in Oliveto which were considered a medical issue, the above examples demonstrate how infant sleep arrangements were determined by cultural beliefs and maintaining social relations (McKenna & McDade 2005:137). Cross-cultural research demonstrates that although babies sleeping independently from others is considered the norm in Anglophone societies, there is significant evidence to suggest that in fact co-sleeping is normal in numerous countries.

Sleep patterns and sleep behaviour in babies has therefore been shown to be a cultural shaping of biological behaviour to fit within cultural and social demands.
This belief was particularly highlighted in the Oliveto context where the unpredictable nature of an infant behaviour, particularly in relation to sleep, was constructed as a significant concern for a mother with mental illness. Adhering to these values, nursing staff would sometimes use what was described by a nurse as active settling.69 Active settling referred to nursing staff training babies to settle themselves. It could be otherwise understood as a diluted form of a baby sleep training program known as ‘controlled crying’ where parents respond to the child’s needs on a basis of time rather than the child’s cues. In active settling, the child was never left alone but was still left to cry until an acceptable amount of time was reached.70 The policy of Oliveto’s governing body (HWC) did not condone active settling techniques because it was thought to compromise the development of a secure relationship. However, the distress caused to some mothers by their child’s irregular routines was considered more of a risk to the child because of the mother’s inability to cope with this stress. For babies who did not sleep for very long stretches of time, or in older children who had difficulty sleeping for hours at a time, sleep patterns were treated as abnormal as they interrupted the adult’s sleep patterns (Blunden, Thompson & Dawson 2011:329).

**Feeding**

Upon admission into Oliveto, all mothers had already established some kind of feeding routine with their child (either formula fed or breastfed). The overwhelming majority of mothers in Oliveto bottle-fed their infants, despite the significant promotion of breastfeeding by its governing body for optimum

69 This was otherwise referred to as ‘controlled comforting’.
70 Or if the baby was becoming overly distressed.
nutrition and for bonding with their child. Infant nutrition was important, and nursing staff worked at creating feeding routines that ensured the infant received enough nutrition to aid what was considered appropriate growth. The height and weight of infants was measured to evaluate the achievement of growth according to scientific benchmarks. All nutrition provided to the infant was recorded and when formula was used, measurements of formula intake were also documented and surveilled (as discussed previously in Chapter Three). An integral part of being a good-enough mother was recognising the child’s nutritional needs and responding to them in culturally acceptable ways. Infants were expected to be fed approximately every two to three hours with time intervals stretching as the child grew. Knowing exactly when it was time to feed the child was assessed through a combination of time evaluation (for example, had it been more than three hours since a feed?) or as a response to the child’s cues. Cues for feeding were referred to as the rooting reflex, where the baby turned its head towards the mother’s chest and cried. Hungry cries were differentiated from cries of distress by the tone and pitch. Nursing staff would often teach mothers the difference between these sounds as they occurred. In some cases, babies had difficulty sucking. In these circumstances, mothers were taught to place their thumb in the soft spot under the child’s chin to induce the sucking reflex.

Feeding & ‘Unsettled’ Babies

Mothers dealing with what was described as an unsettled baby were often anxious or concerned about their infant’s physical health. Upon admission, each child’s

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71 See Chapter Three for a discussion about why this practice occurred.
physical health was examined by a medical practitioner or paediatrician\textsuperscript{72} (if there was one available) for any underlying health problems and was treated accordingly. Doing this enabled staff to rule out underlying health problems in the infant as the cause of unsettled behaviour. In many cases, mothers explained their child’s unsettled behaviour as due to reflux, colic or some other kind of medical concern.

During my fieldwork, there were several mothers who had babies that staff described as having reflux\textsuperscript{73}. These infants were quite often \textit{unsettled} and cried a lot, interpreted by these mothers as hunger, to which the response was to feed the child again. It was commonly believed by nursing staff that the cause of the child’s reflux was not physiological at all, but instead was a result of the mother overfeeding the child by misreading cues and interpreting the child’s cries of protest as cries of hunger. These mothers were constructed as mothers who \textit{could not read their child’s cues}. Staff in Oliveto generally conducted their own investigation of these mothers’ claims rather than automatically assuming a medical problem with the baby. An example of this was with a mother named Alexis who was admitted into Oliveto after having panic attacks. These occurred shortly after the birth of her daughter Laura; she immediately knew something was wrong so sought help. She believed the mental health difficulties she was experiencing were around settling Laura — she found this very difficult. Alexis believed her daughter had

\textsuperscript{72} Oliveto had a paediatrician who would visit the unit once a week to attend to any health concerns. I had almost contact with her. She only appeared in multidisciplinary meetings twice.

\textsuperscript{73} Reflux is the lay term for the medical condition Gastroesophageal reflux. Reflux occurs when the contents of the stomach pass back up into the oesophagus: this will sometimes spill out of the baby’s mouth, cause vomiting or regurgitating. In most cases, reflux will resolve itself and does not require treatment, yet it can cause irritability and discomfort in the child until resolved (Australian Breastfeeding Association 2014).
reflux and upon admission requested to have a paediatrician look at her. Staff in Oliveto recognised that Laura was indeed unsettled and experiencing discomfort around feed time but decided that before requesting the paediatrician they would play around with her formula to see whether this was what was actually causing the problem. Nursing staff also taught Alexis a number of techniques that helped when trying to settle Laura.

In the first ward round following Alexis’ admission the following conversation took place.

*NURSE:* Alexis is a lot more confident looking after Laura than when we first saw her. She is growing in confidence with the baby.

*PSYCHIATRIST:* On the day she was admitted, she wanted an urgent visit with the paediatric doctor. We were reluctant to do this; perhaps we were concerned that we didn’t medicalise or pathologise her daughter’s reflux and settling problems.

*NURSE:* We have been playing around with her formula. She is definitely a reflux baby.

*PSYCHIATRIST:* OK, we’ll organise for the paediatrician to see her on Friday, also for holding mum and grandma. They are driven to have this looked at. She needs to understand though that it’s not only about reflux; it’s about emotional stuff too. At eight weeks will be the peak of her irritability.
Staff in Oliveto were not convinced that Laura’s reflux was solely a medical condition; they questioned Alexis’ explanation of her child’s behaviour as a medical pathology and needed to rule this possibility out. In this biomedical context, staff were concerned that if a medical reason for her child’s behaviour was found, Alexis might disengage from Oliveto’s therapeutic process. Staff therefore had to balance physiological and psychological assessments and treatments for conditions seen in Oliveto, while trying to train women in culturally acceptable mothercraft techniques.

Staff appeared to convey a sense that mothercraft techniques and reading a child’s cues was simple and common sense. The following account offered by a nurse clarified this idea.

_The reason babies chuck a lot is because they are simply overfed. Mothers are giving them more than they need and they don’t have room in their stomach for any more so it comes back up, it’s as simple as that. Women are generally told 10-15 minutes on each side (breast). There is no need to measure, for example 290mls, and become concerned that the child isn’t getting enough. You can tell just by the way they look. If they look healthy, they are._

For the nurse, understanding how much to feed a baby was _simple_. With a time guide offered for breastfeeding or a measured amount offered in bottle feeding there should be no confusion. According to this nurse, knowing if the baby had consumed enough was evident in the child’s appearance. The underlying assumption therefore was that a good-enough mother should understand this.
Yet there were numerous women who experienced a lot of confusion and relied on the expertise of nursing staff to guide them in understanding their baby and the cues they were being given. Indeed, understanding their infants was the biggest concern for many mothers. This encompassed a wide range of factors including: recognising their baby's cues, knowing if their child had had enough sleep or milk, recognising if their child was comfortable or not, and identifying the difference between a smile through happiness or a smile as an involuntary response to wind. In addition, mothers were trained to use mothercraft techniques that were specific to their child's individual needs — recognising and understanding these needs was facilitated through the nursing staffs' guidance.

The following acrostic poem written collectively by a group of mothers during a psychology group session alludes to some of the guidance the mothercraft practices women received training in while in Oliveto, as well as their experiences of providing physical care to their infant in the context of their mental health treatment.

THE THINGS I WISH THAT I HAD KNOWN

Ten minutes sleep is not enough
How to comfort you when you cry
Experience charting

Tell my partner and my family that I love them and I'm sorry
I'm going through this. Tell me it's going to be OK ('cause it
doesn't feel like it.) Telling me doesn't fix it.
Holding a finger with slight pressure when feeding to stimulate
sucking..
I wouldn't always know what you were wanting.
Night time feeds can be stressful!
Good night's sleep may disappear but will be back again!
Surprised and slowly going crazy.

74It was then made into a song and performed, along with a guitar by the psychologist.
I wish I’d known to wrap you as tight as possible so your arms and legs can’t get out to wake you up.

Wind pain can be eased by heat pack (firmly) pressed down on your (babies) stomach.

It really hurts when you are sad.

Settling me works if you wrap me and just put me down.

Having you has brought many challenging but rewarding experiences.

Tap me on the bum when I am lying on your knees with pressure on the stomach (to help with wind).

Help me sleep! I never knew it would be this hard. Why didn’t anyone tell me? Help me, I can’t do this. I don’t have the energy for anything.

Ask for help if you need it.

Taught things I wouldn’t dream of.

I wish I’d known to stimulate you as much as possible in the day (looking at you). Using eye contact and talking to you to wear you out so you can sleep at night.

Help someone to help yourself

Another baby could be as cool as long as you don’t throw them in the pool [written by a nurse]

Days could seem to last a lifetime.

Kindness to you calms us down

Night time means something completely different

Our lives would never be the same again.

When and how to comfort, crying can mean different things

Night time sleeping patterns and when to comfort and sleep during the night.

The poem was written by each mother randomly choosing one, two or three letters from a hat and writing a sentence about something they wish they had known before becoming a mother starting with the letter that was chosen. Some of the responses were indicative of the training they had received while in Oliveto: one mother wrote about how she was taught things she would never have dreamed of. This is demonstrative of how the cultural rules that these women were being
taught did not always make *common sense* to them as Winnicott’s or Dr Spock’s theorising would suggest.

What is interesting is that these *things* made up part of the cultural rules by which the women’s mothercraft skills were judged. Many of the things these mothers wished they had learnt only became evident during their admission, implying that the training they had received was indeed new information. The poem also demonstrates that these mothers were accepting of things they were taught. There was no resistance from these mothers in this poem about their experiences and treatments while in Oliveto. The mothers’ compliance with and acceptance of mothercraft training (as well as other issues raised in the poem) demonstrates explicit agreement with the views of the health care professionals who offered them treatment. In biomedical terms, they were demonstrating *insight*. Yet, these women were not free to write their own song without assistance or surveillance from staff — instead the song reflected the assumptions of good-enough mothering in which they had been trained throughout their admission in Oliveto. This, I argue, shows that these women were being trained in ways to manage their relationship with their child through a process of enculturation that was specific to the Oliveto context yet fit within wider Western cultural patterns of childrearing. This process of enculturation allowed women to demonstrate they were good-enough mothers, a process critical to their eventual release from Oliveto with their child.

While the examples of mothercraft practices discussed in the poem suggest that the women who wrote it were compliant with the processes offered during their time in Oliveto, there was a particular grouping of women, referred to as
borderlines, who were positioned by staff as being non-compliant, and therefore difficult to manage and treat. In the next chapter women described as borderline, a term used to refer to characteristic belonging to the diagnosis of borderline personality disorder (BPD) will be discussed. The difficulties of working with BPD are analysed through the merging of psychiatric labelling and the attachment model. The complexities of treating borderlines highlighted tensions between biological, psychological and practical approaches to treatment.
On numerous occasions I heard women referred to as being *borderline* by members of Oliveto’s staff, a colloquial term used to refer to women diagnosed with borderline personality disorder (BPD). The use of the term *borderline* was constant, but not consistent. It was applied in situations where the patient’s behaviour was referred to as *borderline*, yet the patient was not formally diagnosed as having the psychiatric illness of BPD.\(^7\) This gave rise to numerous analytical questions about the function of the *borderline* label which are examined in this chapter. Drawing on ethnographic data, I explore how the term *borderline* was understood and applied in Oliveto’s context, and the consequences this had for those involved. The many tensions and contradictions that surrounded the term made it difficult to define, and I will argue, contributed to the pejorative opinions that staff held about those who were spoken about as being *borderline*. BPD allows for an analysis of the relationship between mental illness and attachment models as practiced and managed in Oliveto, a relationship of overlap, tension and sometimes contradiction.

Despite the frequent use of the term *borderline*, I was surprised to find that in Oliveto’s admission register (official documentation), those spoken about as being *borderline* had diagnoses that differed; more often than not a diagnosis of depression or anxiety disorder was recorded in its place. I was confused by this

\(^7\) In this chapter, women referred to as *borderline* were not necessarily diagnosed with BPD. Oliveto staff, in particular nursing staff, referred to women as *borderlines* because of the behaviours these patients displayed which were understood as being characteristic to patients diagnosed with BPD.
and asked Oliveto’s Medical Unit Head for clarification. In her lengthy explanation she described how she felt that not all referral sources had the expertise to make a diagnosis of BPD, however once admitted into the unit, *borderline* diagnoses were *made evident* through the particular behaviours these women displayed. In an ethnographic study of medical students learning to become psychiatrists, Luhrmann described the processes whereby students were taught to diagnose personality disorders through an interaction model, rather than a disease model (2000:112). Within this model, students were taught to use their responses to how the patient makes them ‘feel’ (also referred to as countertransference) as a diagnostic tool for identifying personality disorders instead of the usual emphasis of ‘meeting the criteria’ (Luhrmann 2000:112). In the Oliveto fieldsite, I also observed the process of informally diagnosing women as *borderline* in this manner. However, the use of this method extended beyond mental health workers who were trained in the areas of psychiatric diagnosis, to include other mental health workers, in particular psychiatric nurses would often describe women as *borderline*.

Through an anthropological lens, I began to view the *borderline* category as a complex diagnosis category. I questioned the function of the BPD label; if it was not a diagnosis that was required for admission, and only made evident once the patient was in the unit, what was the objective of assigning BPD diagnosis for mothers already admitted into Oliveto? If BPD was made evident through an interaction model, then what emotions and feelings were aroused in staff.

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76 The medical unit head also described how diagnoses were often linked to government funding for treatment, however Oliveto was a unit that had atypical admissions and their funding operated differently.
members that led them to categorise women as *borderline*? Furthermore, what was it about these women’s behaviour that defined them as *borderline*? This chapter offers a contextual analysis of the group of women in Oliveto collectively referred to as *borderlines*. Despite no apparent formal diagnosis of BPD, these women were defined as *borderline* through the behaviour they exhibited in their interactions with staff and others, based on assumptions embedded in psychiatric knowledge that was context specific.

**A History of Borderlines: In Between Social Categories**

In Oliveto, the term *borderline* referred to the BPD diagnosis category and behaviours associated with it, however the term *borderline* has a long history dating back to the early 1900s. Historically the term *borderline* has been used for labelling individuals who were placed on the border of social categories. In Barrett and Parker’s (2006a)77 unpublished manuscript, they describe how the term *borderline* was first used in the United States in the field of criminology. In the *Journal of the American Institute of Criminal Law and Criminology*, Anderson described ‘borderline mental cases which belong neither to the feeble minded nor the insane, and yet are clearly abnormal in mentality’ (1916:689). Anderson further suggested that this category of people had histories of ‘vicious social environments, early immoral teachings and practices’ (691), and as such they were considered ‘unable to profit...from any sort of treatment’ (689). Other language used to describe people in the *borderline* category were; ‘moral imbeciles’, ‘emotionally defective’ and ‘morally insane’ (Anderson 1916:689). The same journal published a paper by Meken in 1924, referring to this grouping of so

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77 Professor Robert J. Barrett’s work was not published due to his untimely death.
called ‘moral imbeciles’ (ibid). Menken referred to 300 women who repeatedly appeared before magistrates in Manhattan for solicitation and other crimes. She wrote that these women had ‘a warped or undeveloped personality’ (Menken 1924:147), and that they were distinctively ‘emotional and unstable’ (148). Both of these authors at different points in history described people who did not fit into existing categories of bad (the ‘common criminal’), or mad (the ‘psychotic’). Instead they appeared to have features of both categories and because of this were considered beyond reform (Parker & Barrett 2006a:7).

A number of in-between categories also appeared in psychoanalytic literature. Manning (2000:630) suggests that the term *borderline* was first ‘discovered’ by Stern in 1938 to describe patients who were neither psychotic nor neurotic and who also had disregard for the usual therapeutic boundaries (see also Gunderson 2009:1). During the World War II period, other references to people in between categories appeared: for example Zilboorg (1941) identified the ‘ambulatory schizophrenic’, Deutsch (1942:75) wrote about the ‘as-if personality’ and Hoch and Polatin (1949) discussed the ‘pseudoneurotic schizophrenic’. Decades later Kernberg (1967:641-642) synthesised this material and used the term ‘borderline personality organisation’ to describe patients who had permanent ‘pathological personality organisation... their personality organization is not a transitory state fluctuating between neurosis and psychosis’ (ibid). It was further characterised by a weak or failed identity formation (ibid).

Borderline personality disorder (BPD) as it is recognised and used today first appeared in the DSM-III in 1980. BPD sits within a wider group of personality disorders that first appeared in the DSM-III in 1980 with a separate axis, Axis II
diagnoses, that differentiated them from other psychiatric disorders (Manning 2000:622). At the time of research the DSM-IV-TR listed ten personality disorders of which BPD was one.

The term ‘personality’ is deeply rooted in Western thought about human individuality (Caprara 1999:129). It is a psychological term that integrates the terms ‘temperament’ used to describe emotional and biologically rooted components of the person, ‘character’ to define moral and interpersonal components of the individual, along with ‘intelligence’ to describe cognitive components (Caprara 1999:129 see also Berrios 1993). Personality first appeared in the psychiatric literature in the 1920s and 1930s to ‘represent the psychological values that made the individual unique’ (Lombardo & Foschi 2002:138). However it was in 1923 that Schneider defined abnormal personality as ‘a state or divergence from the average.... [their personalities are] not pathological in a medical sense and fall outside of the disease model’ (cited by Huber & Gross 2009:63). Personality disorders were therefore considered a permanent condition that affected emotional, moral, interpersonal and cognitive aspects of the individual that could not be treated medically. The category of BPD was brought into prominence during the deinstitutionalisation movement which saw mentally ill patients removed from hospitals in favour of treatment in the community. Patients, more often than not women, who were considered difficult to treat in either the community or hospital therefore did not fit comfortably within any treatment category — hence they were referred to as borderline. Since its introduction BPD has become both an accepted, and highly disputed and controversial psychiatric label (Manning 2000; Rohleder 2012).
Diagnosing *Borderlines*

As a formal psychiatric category, the criteria for diagnosis offered by the DSM-IV-TR\(^{78}\) were as follows:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment.

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).

5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness.

8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

*American Psychiatric Association (2000:710)*

\(^{78}\) Current at the time of my fieldwork.
In order for women to be diagnosed with BPD in Oliveto, a clinician had to make a medical judgment about the patient that included five or more of these criteria. The DSM-IV-TR offered a script for expected behaviours and the potential underlying causes of *borderline* behaviours. Over my time in the field, the mismatch between formal diagnoses and staff constructions of patients’ behaviour attributed to psychiatric illness, repeatedly reminded me that diagnoses are social constructs. The diagnostic labels used by the psychiatric profession to categorise and treat mental illness are deeply embedded in a complex socio-historical matrix, reliant on the judgments of clinicians specifically trained to identify these categories using DSM criteria. The *borderline* diagnosis was tied to, and justified treatment, yet unlike depression and anxiety, which may be implied in the criteria of a BPD diagnosis, the disorder itself has no targeted, short term treatment. Yet according to the Medical Unit Head, the only treatment that had been shown to be effective for BPD at that time was dialectical behaviour therapy\(^79\) (see also Linehan et al. 2006). Throughout my fieldwork I only heard about this therapy being offered once by referring the patient to an external treatment provider,\(^80\) yet discussions about *borderline* patients were recurrent indicating that there were numerous women defined as *borderline* receiving inpatient care.

This chapter engages with DSM criteria for BPD, and offers a different perspective of *borderline* criteria uncovered through ethnographic exploration. Some of the assumptions made about *borderline* behaviour clearly corresponded to the diagnostic criteria described in the DSM-IV-TR, yet staff definitions of *borderline*

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\(^79\) Dialectical Behaviour Therapy was created by Marsha Linehan (1993)

\(^80\) The Medical Unit Head has since told me that they have been referring women to this service more often. There are very few therapists in the state who do this work so the waiting list is long and it is a long therapeutic process
aetiology and behaviour revealed dialectical tensions that were difficult to synthesise. These tensions were played out in Oliveto’s everyday practices, through conflicting understandings of *borderline* behaviour as a result of the biological substrate in the individual versus behaviour as an act of volition and agency.

**A Medical or Moral Judgement?**

Perhaps the clearest example of the tensions inherent in understanding of *borderline* patients came about through a conversation I had with three Oliveto staff members. Janet, a psychiatric nurse, engaged me in a conversation she initiated with two staff members that were arriving for the day. After their initial salutations, the women sat down sideways on the office chairs provided in the room while Janet sat on the desk. Janet told us about the admissions expected for that week, three of whom were *borderlines*. Their sarcastic responses of *oh great* and *fantastic* suggested an unspoken knowledge about these patients inherent in the diagnostic label that I did not understand. I asked what it was about *borderline* patients that made them respond in this way. All three women took turns to explain.

The first thing I was told was that these patients were more difficult to work with than patients with *biologically determined mental illnesses* because they had the ability to control the symptoms of their mental illness and instead chose not to. Intrigued by this suggestion, I asked for a more detailed description of what they were referring to. I was told that *borderlines* displayed polarised behaviours and often tried to *play the staff off against each other*. Janet suggested I was probably likely to get *pulled into* the matrix of their polarised behaviour (a behaviour
otherwise referred to as *splitting*), and that I needed to protect myself from it, not physically but mentally. Obviously sensing my sudden concern, I was told not to take their behaviour personally and that I probably would not even realise it was happening. It was then suggested that what was most likely to happen would be that a *borderline* woman would probably say she liked talking to me and tell me that I am the only one that would listen to her, suggesting that because of my position as researcher I would listen to *borderline* patients when no one else was willing to.

In addition to this, I was also told that the reason these women behaved in this way was because they had probably had poor attachment relationships in early childhood; they were explained as having experienced abandonment or trauma as children and as such had *no secure base*, no one that they felt they could trust. Because of this, their relationships were always a *mess* and they were not able to form secure relationships with others in their adult life because they had no *template* for understanding a secure relationship. It was generally accepted that because of this, their child would also experience the same problems as them, so unless they chose to help themselves the situation was a *lost cause*.

I was confused by the staff members’ explanation of the BPD psychiatric category. Their reasoning for aetiology of *borderline* symptoms seemed contradictory. I was told that *borderline* behaviour was more than likely a result of a dysfunctional attachment template from early childhood, leaving the woman with no template for understanding how a functional relationship operated. If this was the case, then why were these women constructed as *choosing* their illness behaviour? The diagnosis of BDP was described to me as *not biologically determined* but instead
brought about by environmental influences that were beyond the individual's control. In this capacity there appeared to be little sympathy for the expression of illness behaviour. Women described as *borderline* were being evaluated through moral rather than medical judgements (see also Bowers 2003; Charland 2006; Zachar & Potter 2010).

This conversation with staff triggered questions for me about the relationship between BPD and attachment as well as issues of trust and manipulation between patients and staff. As staff definitions of what made a patient *borderline* began to emerge through the ethnographic process, the assumptions the label evoked highlighted the moral evaluations made by staff who worked with these women. Based on perceived deviance, *borderline* diagnoses were used to explain staff reactions to behaviour that aroused feelings of discomfort in their working environment, and to legitimise decisions made for controlling women and making assumptions informing therapeutic decisions about their relationship with their child.

**Borderline Control**

Borderline is a countertransference diagnosis. It tells you more about the therapist than about the patient. We give the diagnosis to people we don’t like. It tells you nothing about what to do. Other diagnoses tell you what to do, what to look for. It’s more a sociological diagnosis than a psychiatric one, since it involves people doing things… which upset people.

*Phil Brown (1987: 41-42)*

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A deconstruction of borderline labelling in Oliveto demonstrates the moral evaluations that occurred in the inpatient setting. If we consider the Medical Unit Head’s assertion that BPD was made evident through the patient’s behaviour in the unit, in addition to Luhrmann’s (2000) ethnographic example of psychiatry students being taught to diagnose patients with personality disorders through an interactional model, implicit in these examples was the assumption of an interaction between two or more people — the patient and mental health workers. However, despite two (or more) people involved in this process, it was only the patient’s behaviour that was constructed as deviant and subject to disciplinary power. Assigning a woman the borderline label created opportunities to control the individual’s behaviour, by using the diagnosis to make decisions about keeping her in the mother and baby unit, and also to ask her to leave the unit. Although generally referred to the unit as patients with depression or anxiety issues around parenting, the emergent borderline category given in Oliveto reframed their depression or anxiety in the context of a borderline diagnosis.81 As the DSM-IV-TR clearly states, one of the criteria for a BPD diagnosis is difficulties with interpersonal relationships: it is no surprise then a BPD diagnosis fits within Oliveto’s explanatory model for a woman’s inability to form a culturally acceptable relationship with her child.

Borderlines and Attachment

Throughout my research, the staff I spoke with described BPD as having no obvious biological underpinnings (unlike depression or schizophrenia for example). Instead it was understood to be located in the individual’s interpersonal

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81 DSM-IV-TR indicates a mood component in the nine criteria for diagnosis.
functioning. In the Oliveto context, this meant it was through the behaviour they displayed; primarily in relation to staff, but also to their child and other patients in the unit, and supported by their history of relationship dysfunction. In Oliveto, the psychological framework used for conceptualising interpersonal relationships was Attachment Theory, and as such staff discussions about borderlines and their difficulties in interpersonal relationships were filtered through an attachment lens. Indeed, a review of the psychological literature points to dysfunction in the early attachment relationship as key to BPD (Fonagy & Bateman 2007; Fonagy, Target & Gergely 2000; Steele & Siever 2010). For women discussed by Oliveto staff as being borderline, childhood attachment templates were believed to be passed down in a transgenerational transaction, and hence attachment templates were therefore viewed as the primary cause of illness behaviour. Despite staff recognising through their own definitions, that borderline patients had ‘inherited’ characteristics that informed their mental illness behaviour, their behaviour was still viewed as a choice rather than beyond their control.

‘Choosing’ Borderline Behaviour

The belief that borderlines chose the behaviour associated with the BPD diagnosis was seen as a key part of their mental illness and became a recurrent theme in Oliveto. The difficulties of working with borderlines in a therapeutic context arose in numerous conversations with Oliveto’s multidisciplinary team. They were repeatedly spoken about as causing chaos or difficulties in the unit and elicited feelings of frustration and discomfort among staff as well as the patients admitted. It was therefore my observation that the term borderline was generally used as a pejorative term that encapsulated many of these ideas. Borderlines were often
discussed as *not really needing to be here* and if there were several *borderlines* admitted for long periods of time I would hear *it's borderline month again*, suggesting they were unnecessarily taking up too much therapeutic time. Oliveto was also sometimes described as a *boarding house* or I would hear *she's moved in* implying that patients with BPD were taking advantage of the inpatient service. The underlying assumption in these comments was that these women were not considered *sick enough* for an admission. Comments such as these, particularly by nursing staff, constructed *borderlines* as lazy and wanting staff to help them beyond what was required. This was particularly the case because *borderlines* were not thought of as being genuinely unwell, but instead were performing their illness behaviours to get the desired response or care and help from Oliveto’s team.

However, despite suggestions by nursing staff that *borderline* women were not sick enough to be admitted into Oliveto, an admission into this acute service was only made possible if a psychiatric staff member believed that the woman was in need of psychiatric treatment. The nuances in understandings of *borderline* behaviour from a psychiatric staff who had limited contact with these women, to that of the nurses who had significantly more daily contact, were highlighted through the ethnographic process.

This belief that *borderlines* were not sick enough for psychiatric treatment also extended to family members of women with BPD. In a staff meeting discussing Jessica’s case, a patient described as *borderline with a capital B*, one of Oliveto’s nursing staff gave an account of Jessica’s behaviour in the ward. Referring to her as

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82 Mothers were expected to take responsibility for the care of their child whenever possible.
a slack arse, the nurse told the team that Jessica thinks she's only here for a rest. Jessica's husband was also brought into the discussion when the nurse told others about Jessica's disbelief that her husband doesn't think she has anything wrong with her while simultaneously nodding his head in agreement. In this example, both the nurse and Jessica's husband made suggestions that Jessica was able to be more actively engaged with her child, yet was choosing not to by adopting the sick role and claiming that she was unwell. Themes of laziness and misuse of the inpatient system were common for women spoken about as being borderline, particularly in relation to the care and interactions with their child.

Considering this analytically, defining borderlines as lazy sat in contradiction to the attachment aetiology of borderline behaviour described by staff. By definition, borderline women had no template for understanding how to interact with their child so were therefore not choosing not to interact or care for them; they simply were not able to produce what was expected from them as mothers. The belief that patients with personality disorders chose their illness behaviour was a similar finding recognised by Luhrmann (2000) in her ethnography of psychiatrists in training. She argued that the use of an interaction model for identifying psychiatric illness was inherently dangerous, because it led to the belief that the patient has the capacity to change their behaviour, so therefore, the patient was to blame for the way they behaved (2000:115).

Moral Evaluations

Another common assumption made about borderlines was their helpless attitude, a term used by Oliveto's staff to describe help-seeking behaviour. Staff used the term helplessness to describe help seeking behaviour that was considered overstated
and unhelpful to the individual. Again, helplessness was considered to be an overreaction to circumstances, which in the staff's view, were not significant; instead it gave the *borderline* person an opportunity to seek attention and help from anyone who was willing to get dragged into their *game playing*. This was made particularly evident when two or more *borderline* patients developed friendships in the unit, and supported each other with difficulties they were experiencing. The interpersonal exchanges between *borderlines* were referred to as *shovel therapy*, where it was joked that they could *all go and dig a hole for themselves*.

The value judgments made about *borderline* patients not only questioned the validity of their illness but also highlighted behaviour that in other contexts may have gone unnoticed, and would not have been discussed with the same intensity of moral evaluation. There was significant ambiguity in the behaviours attributed to those labelled as *borderline* ranging from *back chatting* to staff, inability to make eye contact with their child, dressing in perceived inappropriate ways, attention seeking, poor eating habits, disagreeing with therapeutic decisions, self-harming, neediness, self-pity, *splitting*\(^3\) and suicidal ideation. While some of the behaviours attributed to *borderlines* corresponded with diagnostic criteria, ethnography revealed the staff assumptions evoked by the term *borderline* went beyond the clearly defined diagnostic categories of the DSM-IV-TR. The common thread in all of these behaviours were feelings of discomfort aroused in staff when dealing with patients who were considered bothersome, annoying or threatening to them in one way or another.

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\(^3\) This will be explored in more detail later in this chapter
As I have already flagged, anthropologist T.M. Luhrmann (2000) pointed out the complexities of diagnosing with the interaction model, where psychiatrists in training were taught to use psychodynamic principles to recognise how the patient makes them 'feel'. Students were taught to pay less attention to the diagnostic criteria, and more attention to their internal responses to the patient (Luhrmann 2000:113). If they began to feel the need to protect themselves, not the patient, they were advised that it was probably a personality disorder (Luhrmann 2000:118). However Luhrmann (2000:115) also critiqued the difficulties inherent in this model, which could lead clinicians to believe:

...a patient's symptoms are much more part of him, much more a part of his intentions, and hard to conceptualise as disease. It is easy for a resident to skip from this complexity to the irritated sense that the person is intentionally creating havoc.

Luhrmann’s ethnographic findings resonated with my own, in that women defined as *borderline* were imbued with volition and control over their behaviour; choosing to behave in ways synonymous with the psychiatric category. Yet this particular construction of *borderlines* viewed BPD as an illness that was not biological so therefore could be controlled. This was in contradiction to the alternative construction of *borderline* behaviour as a result of attachment templates.

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### Attachment Templates

The ideological underpinnings of Attachment Theory were ever present in Oliveto’s daily practices, and pervasive in staff's understanding of, and attributions
to *borderline* behaviour. *Borderline* behaviour was often spoken about in relation to the women’s attachment template, that is, her understanding of what attachment relationships are, and how they should be conducted, through her experience with her primary caregiver. The woman’s attachment template was viewed as a significant contributor to her *borderline* behaviour in the Oliveto context and further legitimised her admission and therapeutic intervention, with the underlying belief that early intervention could stop the transgenerational cycle of psychopathology. In contrast with the belief that *borderline* patients chose their behaviour, explanations of *borderline* behaviour as a result of template dysfunction suggested that these patients were in fact victims of poor childhood attachment experiences, invariably constructed in this context as a result of various forms of child abuse: sexual, physical and emotional abuse, neglect, grief, loss or abandonment. Viewed through an attachment lens, these forms of abuse meant that the woman had difficulty trusting those around her which was consequently reflected in her behaviour towards others. The *borderline* patient’s fear of abandonment (either real or imagined) was described as being *central to their functioning* and resulted in their inability to trust others. Oliveto’s Medical Unit Head (Dr Margaret) explained how many mothers when admitted into the unit showed considerable improvement in the first few days, and then deteriorated quite rapidly because *by and large* they received *kindly care* from Oliveto’s staff. This was described as being *not compatible with who they are* because in their first years of life they had learnt that they could not trust others or expect others to be there for them — defined in psychological terms as abandonment. In her own words, Dr Margaret described *borderline* behaviour during inpatient treatment in the following way:
It arouses a sense of... so this is what it’s like to have help, but I don’t have it 

a) because I can’t trust you and b) I know you’re going to throw me out and 

c) I’m not worthy so... you know I can see that so I’m just going to act out

so you can see just exactly how desperate I am.

Other staff members also agreed with the notion that *borderlines* deteriorated after admission because they experienced what it was like to be cared for, when in their everyday lives this was generally not a reality. When talking to staff about this, they again referred to the *Circle of Security*, describing Oliveto as a safe haven. *Borderline* women were believed to like, and yet feel uncomfortable with, staff attention because their relationship templates had repeatedly proven to them that they would probably be rejected or abandoned. It was believed that through their difficulty in trusting others, they created relationship patterns that made it difficult for others to be close to them, including staff. The patient’s inability to trust made them appear untrustworthy to staff, who would often be heard to refer to *borderline* patients as being manipulative. The acting out behaviour referred to in Dr Margaret’s comment referred to many of the attributes and behaviours that have become synonymous with the *borderline* category, for example self-harm (particularly mutilation/cutting), suicidal ideation, intense anger or aggression, manipulation, ‘splitting’, being over sexualised, unstable, emotional, difficult and demanding (Potter 2006, 2009).

Many of Oliveto’s staff also articulated what has been commonly discussed in the field of mental health about people working with BPD patients. For example, the difficulties of working with *borderline* patients in a clinical capacity have also been noted by a number of authors (see for example Feldman-Barrett & Bliss-Moreau
Manipulation in particular was an adjective commonly used to describe borderlines, so much so that Bowers suggests it could easily be mistaken as a ‘major defining criteria of their disorder’ (2003:232). Adjectives such as these have been argued to have a social basis in defining appropriate gender roles — with borderline behaviours viewed as atypically feminine therefore deviant (see for example Wirth-Cauchon 2001). Men who may display the same behaviours are more likely to be diagnosed with narcissistic personality disorder (NPD), if diagnosed at all, confirming the highly discussed gender bias in the diagnosing of BPD (see for example Bjorklund 2006a; Luhrmann 2000; Millon 2000; Paris & Lis 2012; Sargent 2003; Skodol & Bender 2003; Ussher 2011; Widiger & Frances 1989; Wirth-Cauchon 2001).

Approximately 75 percent of BPD diagnoses are given to women (American Psychiatric Association 2000). Numerous theories have been offered for this phenomenon ranging from the social control of women’s behaviour and femininity (Akhtar 1995) to the assumptions made about gender ‘embedded in psychiatric knowledge’ (Horsfall 2001:421). BPD is also a diagnosis that has been strongly associated with early abuse and trauma, particularly traumas that are associated with gendered experiences such as sexual abuse and domestic violence (Rohleder 2012:143). The BPD diagnosis has therefore been argued to be pathologising the effects of trauma as mental ‘illness’ rather than a response to trauma and abuse (144). Indeed it was my understanding that a significant number of women described as borderline in Oliveto had been victims of gendered violence, predominantly in their childhood. In particular, the assumption that women with BPD had experienced sexual abuse
was a wide-spread belief among the mental health professionals, even those in training. In an Oliveto ward round, I was present when a medical student was discussing a patient with so-called **borderline features**. In his description of the woman, he proclaimed that she **denied sexual abuse**, suggesting that the woman had indeed experienced sexual trauma but was not admitting it.

### ‘Splitting’: The Circle of Insecurity

Talk of **borderlines** causing chaos through difficult behaviours was common in Oliveto. The chaos that **borderlines** were seen to cause was characterised by a phenomenon referred to by those working in mental health services as ‘splitting’. I was warned about splitting behaviour at my first meeting with the Medical Unit Head of Oliveto, and I was reminded on several occasions of the difficulties I may experience with this during my fieldwork. Splitting has been defined in psychological literature as including ‘a switch between idealizing and demonizing others... [This] combined with mood disturbances, has the ability to undermine relationships’ (Borg Jr & Miyamoto-Borg 2012:5). Indeed, this is how it was explained to me in my first briefing about splitting that was intended to prepare me for this behaviour. I found this explanation unsatisfactory as I failed to understand how this was unique to **borderlines**. I had experienced this behaviour in my everyday life with people who did not have this label. Over my time in the field, the disruption that splitting behaviour caused for staff, and occasionally patients in Oliveto became more evident when **borderlines** were admitted. The difficulties they created in the unit were not constructed as problems for the patient, but instead problems that disrupted staff and interfered with their ability to work with them. Because of **borderlines’** perceived splitting behaviour, I would
often hear about how one staff member who had been working closely with a patient and had formed a good working relationship with them, was positioned against another staff member, idealising one, then demonising the next. The details of each splitting episode were continually varied, however the common thread was the disruption of this behaviour to therapeutic dynamics, particularly for staff. Splitting behaviour was seen as manipulative and impaired working relationships. This was particularly the case when a patient favoured one staff member and refused to engage with another. In discussions with one of Oliveto’s nurses, I was told that a patient’s refusal to engage, especially when their engagement with another staff member had been good, brought up feelings of powerlessness and incompetence in her abilities as mental health worker. She went on to describe how splitting by borderlines had the ability to activate staff’s own templates recognising the role of staff members’ own psychodynamic involvement in the construction of splitting behaviour. In Oliveto, splitting was a behaviour attributed to the borderline woman, however ethnography demonstrated its relational characteristics. This construction of borderline behaviour engaged attachment discourse and the pathological model proposed by psychiatry to explain not only borderline behaviour but also the effect that working with borderlines had on Oliveto’s multidisciplinary team.84

Despite the fact that I had been warned repeatedly about the difficulties I could expect from borderlines and the need to protect myself against their splitting behaviours, the only time I personally experienced splitting behaviour was through my interactions with Julia, a patient with a diagnosis of schizophrenia (See

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84 The term ‘countertransference’ is used in the psychological literature to describe this phenomenon.
Chapter Four). After a long time of building trust with Julia, I accompanied her one
day on an outing to the bank. Before leaving, the nurse who was working with her
that day was reluctant to give her permission to go, but as she was not a detained
patient, she allowed us to leave together with the promise we would be back
within one hour for an appointment Julia had scheduled. I waited outside for Julia
to complete her banking and after twenty minutes she had still not emerged. I
went into the bank to let her know I was still waiting for her but she was nowhere
to be seen: the staff in the bank had no recollection of her. I began to panic. Was
she looking for me? Did I miss her somehow? Would she be upset that I had lost
her? Furthermore, would staff at Oliveto be upset with me for losing track of her? I
searched the surrounding shopping centre for some time then decided I needed to
return and let staff know what had happened. Perhaps she had returned there
without me?

I was very surprised when I returned to find that the staff were not upset with me,
instead they just laughed at me and told me I had been duped. Julia had wanted to
go out all day, and when she encountered me, she finally found someone who
would give her what she wanted. They described her as manipulative and
resourceful, and warned me to be careful of getting too close to her because she
would use me for all it was worth. They also told me that I had been recruited by
her: that she had me wrapped around her little finger and I needed to watch out for
that. I was told: That’s what patients who split do. They make you feel all important
and special and make others out to be the ‘bad’ ones (referring to themselves). The
nurses tried calling her on her mobile to see if she was on her way back. She had
an appointment at a hospital in the city that afternoon and had promised that she
would return. They also wanted her back to care for her daughter once she had woken from her sleep. I was concerned that Julia may have been upset with me for losing her and potentially getting her into trouble with nursing staff. After they spoke to her, I asked if she had sounded distressed because she could not find me. I was told that she was not thinking about me at all and had gone off and done her own thing: probably shopping, because she had been increasingly manic recently.

When Julia returned she seemed unfazed about what had just happened. She apologised to me in front of all of the nurses and said that she understood that I left because I had been waiting too long for her. She then told us that the banking staff had taken her into one of the booths to discuss her banking issue and I obviously had not seen her. I knew that this was untrue as I had asked the banking staff about her. I find it noteworthy that the only time I experienced the behaviours described by Oliveto staff as characteristic to a *borderline* patient was with a patient who was not diagnosed or labelled as such. This again made me question the assumptions inherent in the *borderline* label and the construction of their splitting behaviour. Was it that these women behaved as a result of their dysfunction in their parenting template, or was the behaviour constructed through the combined moral judgements made by staff about patients’ behaviour as ‘bad’, annoying, difficult or bothersome and not fitting within the commonly understood categories of ‘sad’, referring to the depressed, or ‘mad’ referring to the psychotic? The construction of behaviours attributed to *borderline* patients in Oliveto positioned them as between these two categories, not sad, not mad but bad and difficult to treat.
As mentioned earlier, the commonly understood deterioration of *borderlines* when admitted into inpatient wards followed by difficult behaviour meant that staff in Oliveto were keen to discharge patients when their behaviour reached this point. It was believed that the best treatment for *borderline* patients when they reached this point in their admission (which appeared to be at approximately three weeks), was to discharge them with a treatment plan that allowed access to treatment and support services in the community. Although believing that discharge from the unit would trigger feelings of abandonment, Oliveto’s staff explained that *borderlines* did not benefit from further inpatient treatment and needed to accept the responsibility of caring for themselves and their child(ren) again. With a handful of patients, part of their discharge plan included an offer of what was called *the bank of fourteen days*. The bank of fourteen days offered *borderline* patients the option to be readmitted for up to fourteen days if they felt that they needed support. It was described by Dr Margaret, the Head of the Unit, as a *tactic* for asking *borderline* patients to leave while giving them a promise to be able to access the service again when they needed to, thereby giving the *borderline* patient something within their control. Dr Margaret believed that by offering the bank of fourteen days, *borderlines* were not being abandoned, instead they were encouraging the woman to manage on her own in the community.

When discussing the bank of fourteen days, staff often referred to Oliveto as a *safe haven* or *secure base* for patients who had *borderline* diagnoses. Again, engaging the language used in the Circle of Security model, staff in Oliveto constructed themselves as the positive caregivers for women whose template experience with
their primary caregiver had been negative. Asking borderline patients to leave was constructed metaphorically as supporting the woman’s exploration (top half of the Circle of Security), with Oliveto staff ready to welcome them back if needed.

Indeed, the women I spoke with who had accessed the bank of fourteen days tended to agree that they felt secure when they were cared for in Oliveto and that this gave them comfort. For Emma, a borderline whose experiences with staff had been tumultuous, the comfort she experienced in the unit (despite being discharged and having her child removed), meant that she still spoke to me about wanting to return after discharge — much to her own confusion.

What became evident over time was Oliveto’s adoption of the COS as a model for explaining patients’ behaviour, particularly in relation to borderline patients. As a psychodynamic tool, it seemed an appropriate fit particularly for explaining interactions with borderline patients as it allowed space for both the patient (through her attachment template) and Oliveto’s mental health workers (through countertransference) to engage in intersubjective experiences. The language informing the COS model of attachment constructed the borderline women’s template as the cause of her disruptive behaviour: it simultaneously provided a model for a therapeutic working relationship with these women that took into account the ideas that Oliveto was a secure base, and also the need for exploration.

**Tensions in Oliveto**

The exploration of the borderline category as it was observed in Oliveto demonstrated the tensions inherent in this fieldsite — tensions in diagnosis and labelling of mental illness, between biological treatments for mental illness, and psychological and practical attempts to improve mothering and the mother-child
Through ethnography, the multiple ways that attachment templates were conceptualised in Oliveto underpinned the complexities of working with this grouping of women. BPD is a personality disorder rather than a biological illness, driven by poor attachment experiences leading to a template for abandonment, and yet behaviour was viewed as partially volitional. Attachment templates could be activated through countertransference, changed through psychotherapeutic interventions, or learned as the previous chapter analysed. These tensions become most clearly apparent in the case of borderline patients who staff respond to with some discomfort, and a sense of difficulty in appropriately treating their illness. These women raise issues about when and how to properly discharge a woman and her child from the institution. The outcomes for women with borderline diagnoses at discharge from Oliveto and beyond were varied and will be discussed further in the concluding chapter along with other discharge outcomes.
CONCLUSION

TREATING MOTHERS WITH MENTAL ILLNESS: FROM DIAGNOSIS TO ATTACHMENT

Discharge Outcomes: Where Attachment Takes Precedence

The measure of an effective outcome for dyadic admissions was the discharge of the mother and baby together from Oliveto, where neither the mother nor child were considered to be at physical or psychological risk. The mother’s mental illness, although a defining criteria for admission, was given less focus than her attachment relationship with her child at the time of discharge. As one of Oliveto’s multidisciplinary team members explained, a woman’s mental illness was never cured during her admission in Oliveto: curing the mother’s mental illness was not the measure of successful treatment. Success was measured through the management of mental illness symptoms, primarily with pharmaceutical treatments, consistent with Oliveto’s biological treatment focus. Most women and children did leave the unit together after an average stay of three weeks, with extreme cases discharged after six weeks or more. However for a small proportion of dyads the outcome was the temporary or permanent removal of children.

Before discharge was permitted, Oliveto’s team would discuss the patient’s progress within the unit, both in terms of the woman’s mental illness and her relationship with her child, then assess any concerns about the mother and her child returning home together. Although this was usually a team discussion, it was ultimately one of Oliveto’s psychiatrists who made the final decision. Theories of
medical dominance and hierarchical power inherent in Oliveto's psychiatric practice remain relevant here.

Once it was decided that a dyad was ready for discharge, a discharge plan was devised, linking the mother, and in some instances the child and other family members, with access to various services in the community. The services offered were case dependent and included: ongoing outpatient therapies with Oliveto staff, referrals to external psychiatrists and psychologists, referrals to attend mother's groups designed specifically for mothers with PND, services that offered assistance with practical household duties (for example meal planning) and playgroups specifically for mothers with PND that encouraged ‘play’ interactions with their children, maternal sensitivity through eye contact and touch, journaling for self-reflection and ‘therapeutic’ craft activities. The majority of mothers also left the unit with medication supplied in a small paper bag. The biological bias for the treatment of mental illness symptoms continued into discharge practices. The management of symptoms in this way reaffirmed underlying assumptions of the woman’s biology as the source of mental illness.

Throughout this thesis, the case studies of women such as Helen, Jenny, Emma, Julia and their children, were used to highlight various areas of analysis and the ways in which the interplay of attachment and psychiatric theories were engaged. The discharge outcomes of these cases will be used here to highlight the tensions and contradiction inherent in the interplay of psy theories identified throughout the thesis, as will the consequences of such an approach.
Transgenerational Attachment: Mothers Linked to Child Risk

Helen and Javier were first introduced when discussing the admission process into Oliveto (Chapter Two), and then later when discussing the application of the COS attachment model in mother-infant therapy (Chapter Six). This mother-infant dyad was considered to have had a successful treatment outcome. After a lengthy seven week admission period, in which time Helen underwent several mother-infant therapy interventions and her son Javier was admitted into the State’s children’s hospital for assessment of his developmental delay, the dyad was discharged and returned to their family home. The interplay of psychiatric and attachment theories in the treatment process were made explicit in Helen and Javier’s case. The COS attachment model was used to identify psychopathology in the mother-infant relationship though the observation, surveillance and therapeutic investigation, joining Helen’s experience of attachment in the past to her own mother, to her son’s probable future well-being. The primacy of the mother, central to Oliveto’s conceptualisation of attachment security, was made particularly evident through analytic exploration of the COS psychotherapeutic tool, whereby pathological attachment behaviour was intrinsically linked to maternal relationships through time. It highlighted the crossing over of temporal boundaries for identifying psychopathology and the source of transgenerational transmission.

However tensions within this model were also recognised. Attachment templates were viewed as fixed or ‘hard wired’ in early childhood, having long term implications into adulthood if not formed in culturally appropriate ways. Yet therapeutic practices sat in contradiction to this. Mother-infant therapy, which drew heavily on dyadic attachment ideals, aimed at transforming attachment
pathology in ways that would better support the child’s mental health, through a focus on the child’s developmental needs. Again drawing on transgenerational theories, Helen was asked to reflect on her childhood attachment experiences and the traumas she experienced, and consider how these experiences may be present in her relationship with her son. This further highlighted Oliveto’s child centred approach central to ethnocentric views of attachment. Mother-infant therapeutic practices also assumed that attachment templates could be transformed, counteracting beliefs about attachment as being ‘hard wired’ through early attachment interactions. The tensions and permeability between biological and learned models emphasises the complexities of treating mental illness in the context of the mother-infant relationship.

After her discharge, Helen spoke about significant improvement in the symptoms of her mental illness which she largely attributed to the medication she was prescribed. Reflecting back on her relationship with her son before her admission, she also felt that this had improved. Helen described how she learnt that her over-protective nature was a result of her childhood, and that she was prohibiting Javier’s development. According to Oliveto’s underpinning beliefs, Helen’s acceptance of the COS model as an explanation for her illness symptoms and her son’s delays, described as insight, was a reflection of her success in treatment. She was able to articulate how her over-protectiveness prohibited her son’s exploration and subsequently his developmental delays — beliefs consistent with the COS model of attachment. Since leaving Oliveto, Helen described Javier’s development as having caught up. She largely accredited Javier’s developmental improvement as her son learning through play with his older sister. Despite taking
responsibility for his developmental delays, Helen demonstrated an underlying belief that others, not just mothers, can affect attachment behaviour and child development.

Showing Acceptance of the COS Model through Insight

The COS attachment model was also pertinent to Jenny's case, a patient referred to as borderline. The previous chapter described how patients diagnosed with BPD were offered a bank of fourteen days, a discharge tactic (as described by the Medical Unit Head) when discharged from Oliveto. The bank of fourteen days sought to give borderline patients a sense of security, and appease feelings of rejection recognised as common to BPD. Many of the borderlines who were offered the bank of fourteen days did not return to the unit, however during time in the field, there were four patients who had repeat admissions. Jenny was one of these patients. Throughout the fieldwork period, Jenny returned three times. As a borderline, Jenny's mental illness pathology was defined as sick but not really sick. As demonstrated above, borderline behaviour was considered volitional and within the patient's control, yet simultaneously believed to be hard wired and fixed. Despite recognition that the attachment relationship was fixed through early mother-infant interactions, the assumption that these women could control their illness behaviour, but chose not to, was implied.

Bank of fourteen days practices responded to underlying beliefs about borderline attachment templates. Women diagnosed as BPD were believed to have lacked attachment security in childhood as a result of childhood trauma (maternal neglect, physical and sexual abuse, domestic violence, drug addicted mother and so on). As a result their ability to form trusting interpersonal relationships had been
damaged. By offering the *bank of fourteen days*, the security of knowing that there was help if needed was thought to satisfy the *borderline’s* fear of rejection, knowing that although they were asked to leave, they could return. Referring back to the earlier analysis of the COS attachment model as metaphor for Oliveto’s practice (Chapter Six), Jenny used Oliveto as a *safe haven* to return to, and Oliveto staff continued to play the metaphoric *secure base attachment figures* during these admissions.

In an interview conducted after Jenny’s final discharge, the influence of mother-infant therapy sessions was evident in the language she used to describe her relationship with her child. She repeatedly engaged in attachment discourse, referring to her difficulties in *regulating her own emotions* and subsequently having difficulties in doing this for her child. In her reflections about her treatment, she engaged with the belief of transgenerational transmission of attachment pathology. She spoke about these challenges and about the processes she had learned to manage them. She was able to show *insight*, and therefore was considered a *good-enough* mother to be discharged from Oliveto with her child.

**Psychiatric Practice and Power in Oliveto**

The power inherent in psychiatric practice was exemplified in Julia’s case. Earlier in this thesis, Julia’s diagnosis of schizophrenia was demonstrated to be flexible and changeable. This raised questions about the stability and subjective nature of DSM diagnoses, as well as the power inherent in the medical model which authorised a select few to make decisions.
Julia’s admission during fieldwork was the last of several repeat admissions for her into Oliveto. As the result of previous admissions, her daughter had been placed into foster care with another family. Her admission at the time of fieldwork was part of a final attempt for Julia’s attachment relationship with her child to be observed and assess whether there was risk to the child through this relationship. However, despite an awareness that her parenting was under review, Julia did conform to the biomedically informed expectations analysed throughout this thesis and her child was not returned to her custody. The symptoms of Julia’s mental illness were believed to *interfere* with her ability to form a healthy attachment relationship with her child. The severity of her mental illness symptoms justified a court ordered depot injection that overrode agency in relation to acceptance of biological treatments. As the multidisciplinary team discussion (Chapter Four) highlighted, Julia’s parenting could not be assessed until her symptoms were *sorted*. In Julia’s case, the attachment relationship was used to justify hierarchical power to coerce Julia to take medication, despite her claiming that the medication did not agree with her. Even though these measures were taken, Oliveto’s surveillance and observation discerned that Julia’s mothering was not considered safe enough for her daughter to be returned to her care. Her child was considered ‘at risk’ through the attachment relationship with her mother. Julia’s mental illness symptoms were seen to interfere with her ability to put her child’s needs before her own.

After numerous consultations with Oliveto’s team and external state child welfare services, the decision was made to permanently remove Julia’s daughter from her care. Her daughter was placed with a foster family that had previously cared for
her: they had requested to adopt her. As Julia no longer had her daughter in her custody, and the symptoms of her mental illness continued to interfere with her daily functioning, she was moved to an adult mental health hospital to continue psychiatric treatment. As a patient diagnosed with a chronic mental illness, her psychiatric treatment drew heavily on psychiatric discourse, however as her discharge outcome demonstrated, her attachment relationship with her daughter determined the dyad's discharge outcome.

The four case studies of discharge demonstrate the range of outcomes for those women and children admitted to Oliveto, and what constitute a successful outcome. In what follows I unpack the key conclusions about mothering and mental illness in a biomedical context.

**Key Findings from Fieldwork in Oliveto**

Mother-love in infancy and childhood is as important for mental health as are vitamins and proteins for physical health.

*John Bowlby (1952 [1951])*

*I just gave birth to him, I have no rights...I'm too much of a psycho!*

*Michelle, patient participant*

The above statements were chosen to highlight two key findings of this ethnographic project. Firstly, Bowlby’s quote exemplifies the long standing belief about the centrality of mothers for infant and child mental health, integral to Attachment Theory's dyadic focus. In contrast, Michelle's statement points to the tensions and contradictions that arose in Oliveto's institutional context where
attachment principles intertwined with psychiatric theories. As the patient’s quote indicates, in cases of women with severe mental illness, the attachment relationship can also be viewed as a risk to the child’s mental health. This thesis has demonstrated how the treatment practices in Oliveto were filtered through an attachment lens which highlights the importance of what is seen as the key dynamic relationship, yet also identifies this relationship as a risk. Knowledge arising from the attachment paradigm determined the institution’s admission, treatment, management and discharge practices for mothers with mental illness. It also justified governmentality through surveillance, hierarchical observation, and the coercive assertion of power to minimise what was understood to be a risk to the child’s mental health.

Although a diagnosis of mental illness in the postpartum period was a fundamental prerequisite for admission, it was the woman’s attachment relationship with her child that confirmed admission and ultimately determined the dyad’s discharge from the unit. Through an ethnographic approach, a critical analysis of the interplay of psychiatric and attachment treatments offered in this context was made possible, and the consequences of such an approach for mental health practitioners, mothers and babies were brought to the fore. This thesis critically analysed how the interplay of psychiatric and attachment theories informed knowledge for speaking about and acting upon maternal subjectivities. Within the boundaries of psy knowledge, ideas for determining what could be said, who had the authority to make decisions based on disciplinary knowledge, and what disciplinary techniques could be applied were defined. However within these bodies of knowledge, tensions and contradictions were also evident, particularly...
between understandings of biologically driven attributes, and features that were learnt through the women's environment. Inherent to Oliveto's psychiatric practice, power dynamics meant that hierarchical dominance was a prominent feature of the unit, whereby a select few with psychiatric training had the power to make transformative decisions about the treatment of mothers and babies. Although a multidisciplinary team approach was taken, medical dominance still remained.

Women, as patients of the institution, held the least power, and were subjected to observation and surveillance practices justified as 'in the best interests' of both mother and child. Within the biopsychosocial model of treatment service offered, the biological was given precedence. Despite this biological emphasis in diagnosis and medication, the practice of treating the woman's mental illness in Oliveto was conducted in the context of the mother and child attachment relationship. Such an approach was demonstrated through ethnography to be replete with tensions and contradictions, contributing to the complexities of treating mothers with mental illness. Gendered assumptions about childrearing were reconfirmed through these practices, which saw women primarily responsible for the physical and emotional health of their child. As Bowlby's quote above clearly delineates, the belief that mothers are responsible for their child's future psychological well-being justified dyadic admissions. The belief of transgenerational transmission through mother-child relationships inherent in the attachment model, exemplified though Oliveto's use of the COS, further validated treatment practices by identifying pathology and the potential for risk to the child's mental health through time.
Implications for Mothering in the Context of Mental Illness

In questioning the taken for granted assumption of biomedical constructions of mothering and mental illness, a medical anthropological perspective attempts to deconstruct the entanglement of human biological factors from the socio-cultural context that shapes illness experiences. The ethnographic study of Oliveto mother and baby unit therefore offers new insights into the biomedical treatment of maternal mental illness as practiced in Australia in 2008-2009.

In the socio-historic context where this fieldwork took place, a woman’s mental distress in the postnatal period was viewed as a medical problem requiring biomedical interventions by experts in the field of Perinatal and Infant Psychiatric knowledge. Through anthropological analysis, this thesis explored how the merging of psychiatric and attachment theories (Oliveto’s Perinatal and Infant Psychiatric practice) assumed that the woman’s biology was central to her treatment, both through the targeting of medication to treat symptoms of mental illness, and supporting the mother’s biological link to her child through mother-infant attachment therapies. In the Oliveto context, the psychiatric treatment of postnatal mental illness in women was linked to caregiving: as biological mothers, the women’s mental illness was viewed as inextricably linked to her social role as mother. Oliveto’s mother-infant psychiatric admissions were therefore founded on gendered assumptions about parenting and childrearing inherent in the attachment model.

This thesis offers a critical analysis of Oliveto’s translation of Attachment Theory through the COS model which held mothers primarily responsible for their child’s well-being while simultaneously viewing her as a risk to her child’s mental health.
Through the COS model, the emphasis on mothers as a factor for risk to the child’s future psychological well-being raises questions about the absence of male parents in the institutional context. Such an approach reduces the possibility of integrating a wider social network of attachment relationships for the child and increases the responsibility on the mother to be primarily responsible for her child’s future well-being. The biomedical emphasis of dyadic mother-infant attachment relationships above all others, minimises the father’s genetic and parenting contributions in the conceptualisation of the child’s future mental health outcomes. The existence of a psychiatric unit that specifically treated maternal mental illness in the context of her attachment relationship with her child is demonstrative of the underlying cultural beliefs of childrearing in Australia. Despite recognition that the unit does facilitate the treatment of any primary caregiver suffering acute mental health symptoms, fathers or other caregivers were not admitted during the time of my fieldwork. If the emphasis on father-infant attachment was given equal cultural emphasis then options would be available for fathers with mental health issues to be admitted for dyadic treatment too. During the time when this fieldwork was conducted, no treatment options were available that specifically catered for this — for example a father and baby psychiatric unit. The existence of Oliveto mother and baby unit and the treatments that were conducted within the institutional space, therefore perpetuate the cultural belief that mothers are primarily responsible for their child’s future well-being yet are a threat to the psychological health of the child and potential future generations. It also perpetuates an emphasis on attachment as based in a single dyadic bond.
The findings of this thesis have also illuminated the power held by health professionals to shape the experiences of women under their care. Through technologies of power, governmentality through surveillance and hierarchical observation, women were coerced to conform to biomedical norms of good-enough mothering. Oliveto’s biopsychosocial model assumed that caregiving was primarily the mother’s responsibility and as such treatment practices, in particular through mothercraft were considered an important part of the treatment during her admission. Training women in cultural techniques for regulating a baby’s feed-play-sleep patterns also drew attention to wider cultural values of autonomy, independence and order. Power played a significant role in establishing these norms of mothering that women were expected to follow. Mothers who failed to accept the model of treatment offered, or self-regulate according to norms of mothering set by the institution, risked being separated from their child, either into temporary care by another adult (staff or family member), or more permanently.

The analysis of the institution’s enactment of power offers insights for mental health practitioners operating within institutional contexts. Through ethnographic exploration, this thesis illuminates underlying factors that drive social interactions and decision making that arises from biomedical cultural beliefs.

Oliveto’s biological focus for the treatment of mental illness facilitated through a DSM-IV-TR diagnosis, was believed to ameliorate symptoms for many women and create compliance with other treatment models that followed. The treating of symptoms through a disease model mapped mental illness onto the female body, specifically her brain. Such an approach creates the belief that mental illness
symptoms are organic and therefore potentially beyond the individual’s capacity to self-manage. This is particularly relevant for women diagnosed with BPD who were simultaneously viewed as ‘sick’ and therefore unable to control their symptoms, and yet also ‘not sick’ but instead choosing to behave in ways that were difficult to manage. The split between moral and medical judgments when discussing the behaviour of borderlines was made explicit through ethnographic detail. Such an approach illuminates the tensions and contradictions that surround the BPD diagnosis and offers new insights about the complexities of treating borderline women. The moral evaluations made by staff working with patients with mental health diagnoses have the potential to have significant impact on the patient’s future outcome. An awareness of the ways in which morality and medicine intertwine in the treatment of mental illness may improve the delivery of health care to patients.

Strengths and Limitations of Ethnography in Oliveto

Strengths of the Ethnographic Method

As a qualitative technique, the ethnographic method, a hallmark of anthropological research, is recognised for the rich, in-depth data it produces for analysis. Medical anthropology acknowledges that human experiences are shaped by social and historical factors, and that the people who inhabit any cultural framework, in this case Oliveto, have a tacit knowledge and awareness of a shared cultural beliefs and expectations (Atkinson and Pugsley, 2005:229). In order to explore this in detail, the ethnographer spends prolonged periods of time with the people they are studying, and gather detailed data about the seemingly ‘mundane’ everyday world that their informants inhabit. Unlike other forms of qualitative research, which for
example, focus on the collection of interviews for evidence to create a perceptional account of what people think and feel about a given domain, ethnography can provide an account of *what actually happens* (Reeves et al. 2013:1365e). The detailed descriptions produced through ethnography capture the informants’ expertise of their social domain, and explores how the cultural context where actions take place are informed by their informants’ tacit knowledge of that world (Atkinson and Pugsley, 2005:230).

A strength of the ethnographic method is the length of time it enabled me to spend gathering data. The long periods of time spent in the research context serve multiple functions that include conducting participant observation, asking in-depth questions that can be explored further as areas of interest arise, and building rapport with research informants. Once rapport is established, the researcher is better positioned to observe informants’ naturalistic interactions in their everyday context. It also enables the ethnographer to observe how social phenomena can shift over time. The benefit of this approach is that it yields qualitative data that reveal what is meaningful to the people who inhabit that space. This is particularly important in the medical context where understandings of biomedical treatments are largely produced and reproduced within the scientific paradigm and are taken for granted as ‘truths’ of the discipline. Whilst scientific knowledge is important to the production of biomedical understanding, an anthropologist recognises that biomedical knowledge and illness experience is embedded in and shaped by cultural contexts (Kleinman, Eisenbruch & Good, 1978). Ethnography contextualises the experience of illness and health care treatment in the wider cultural and social environment where the meanings arise.
Limitations

Due to the highly regulated nature of Oliveto’s medical context research, I was restricted from spending extended periods of time in the unit. For example, I was not able to stay in the unit over night or spend time in the unit akin to a psychiatric admission. It is possible that there were valuable insights that I missed as a result of this, however this limitation was largely out of my control. As discussed earlier in the thesis, ethical requirements, of the medical bodies were limiting in terms of the ethnographic data that was approved for collection. The participation and observation of naturalistic behaviour characteristic of ethnographic research, was limited by ethical concerns to protect the anonymity and safety of my research informants. From a data collection perspective, this meant that I was also limited in the types of interactions in which I could observe and participate. My ethnographic involvement was framed by ethical boundaries and therefore limited my scope.

The highly regulated ethical boundaries of the psychiatric context also meant that all data when presented in written or oral forms used ‘thick disguise’. All identifying information about my informants was changed in order to protect the confidentiality of the people I spoke with and spent time with over the fieldwork period. Unlike some other forms of qualitative research, the findings of my ethnographic project were not discussed with my informants. This was partly due to ethical concerns about protecting the anonymity of patient informants through confidentiality of their cases — exposing too much identifying information about the patient could lead to their identification. By the use of thick disguise, the findings of my fieldwork can be shared in publications so that people working in
Oliveto or similar treatment facilities can learn from the findings of an ethnographic project that has never been produced before.

Ethnography and participant observation techniques are by their very nature grounded in personal experience (Pope, 2005:1180). For this reason, a reflexive approach was imperative to consider my position within the field, and how this influenced my interpretation of data. As an individual living in a society where biomedical beliefs are dominant, I was an insider of the cultural beliefs under investigation. This may have limited my ability to question phenomena because I did not recognise them as noteworthy of investigation (Pierano, 1998).

Becoming pregnant during my fieldwork also added a new dimension to my fieldwork that I had not anticipated. Although arguably it allowed me to collect data from informants that might not otherwise have been shared if I was not a ‘mother-to-be’, my pregnant state may have also been limiting. As discussed earlier, my strong matriarchal upbringing generated internal views about the mother-infant relationship that I had not realised prior to my research. These deeply engrained beliefs became more prominent when I became pregnant. Despite identifying the influence this may have had on my data collection, it may still be viewed as a limitation to my data collection. In a similar way to my cultural blindness of biomedical assumptions, being pregnant in the field may have restricted my ability to follow paths of investigation because I could not recognise the cultural influence of my beliefs.
Contributions and Future Directions

This thesis adds to the vast body of literature that exists in the field of maternal mental illness yet offers a unique perspective not yet explored before in the academic literature. As a cross-disciplinary thesis, the ethnographic study of mothering and mental illness in a psychiatric context contributes to the academic literature across a number of disciplinary fields. The findings identified add to the field of medical anthropology, the critical analyses of the ‘psy’ disciplines, attachment research, and institutional ethnographies. It also contributes to the study of gender and mothering, in particular the anthropology of mothering.

The findings from this thesis could be used to better inform mental health practitioners working in related fields by raising awareness of the influence that cultural and social factors have on the everyday context of mental health treatment delivery. The nuanced details made available through ethnographic research are valuable insights for medical educators and people working, or intending to work in the area of mental health treatment delivery also. The use of ethnography for medical teaching and learning has provided many new insights that contribute a greater understanding to the field of medical education (Reeves et al. 2013:1375e). The study of mental health treatments in the context where knowledge is established, generated, enacted and taught to emerging mental health practitioners would be a valuable way forward.

As this thesis demonstrates, the multiple and complex realities that arise in the context of mental health treatment can be more fully explored through the ethnographic method. This thesis gives context to the complexities of navigating
the multiple, often contradictory processes that occurred in the institutional psychiatric space for the treatment of mothers with mental illness.
APPENDICES
Introduction
I am inviting you to help me with a research study. Before you agree it is important that you read and understand the following explanation of the study. If you do not wish to participate, your medical care will not be affected in any way.

What is the study about?
This main aim of the project is to understand what it feels like to be a mother with mental health difficulties in the months after childbirth. I am trying to understand what your day-to-day life is like: what sort of experiences you have and how you cope with them. In order to understand your life in hospital, I will also be talking to the staff that care for you and other women with mental health difficulties.

Who will be carrying out the study?
I (Sonia Masciantonio) am the main researcher for this project. I am an anthropologist and I am studying a PhD at the University of Adelaide. An anthropologist is a person who is interested in groups of people and what makes those groups different from other groups. I am not a psychiatrist, psychologist, psychiatric nurse or social worker, and I do not work for any of the psychiatric hospitals or their community teams.

How does the study work?
To do this study, I plan to ask a number of postnatal mothers who are experiencing mental health issues to share their experiences with me so that I can learn from them. This will involve spending some time with you; observing your life with your baby, other family members and staff, and talking with you about your daily life. It will be largely up to you what we talk about and what we do, although I may want to ask you certain specific questions as we go along. I will be interested to know how you cope with your illness, how it makes you feel mentally, physically and emotionally, how it impacts on you close relationships and what strategies have been most helpful for you to improve. With your permission, I would like to record some of the things you tell me in my notebook and occasionally, if you are happy to do this, on a digital recorder. If you are agree, I may also want to talk to you away from the hospital as well as during the time you are admitted to This may be at your house if you find this acceptable or maybe at a coffee shop or some other place where you feel comfortable and safe.

What are the risks of participating in the study?
There are no physical risks involved in the study. However, some people may find particular questions upsetting. If there are any questions you are uncomfortable with, you can choose not to answer them.

What will you get out of the study?
There will be little to no immediate benefit to you personally, and I am unable to pay you anything for helping with this project. The aim of this study is to improve the understanding of women experiencing mental health difficulties in the postpartum period.

What happens to the information I give?
Any information you give to me will be strictly private and confidential. However, I am also guided by a duty of care to participants in this study, which means that if you tell
me something that indicates that your life or the life of others is directly at risk, this information will be passed on to the relevant professionals. Generally, the information that you give me will be stored securely at the University of Adelaide. I will put together what I have learnt from you and others, and analyse it for inclusion in my PhD thesis. A PhD thesis is what someone writes after studying a particular issue in great depth for several years and then submits it to people through a University. One day the information may appear in a journal or book. When I publish in these ways, I will be careful to write the results in such a way that no reader could identify who you are.

What if I do not want to participate in the study?
It is not a problem if you choose not to be involved in the study. Your medical care will not be affected in any way. If you agree to take part but later change your mind that is also not a problem. I will remove the information you have given me from my records and from the final analysis if you would like me to do so. You can withdraw your involvement from the study at any time without question before the publication of results of the study.

What if I have any questions about the study?
If you have any questions about the study, feel free to contact me. I can be contacted through the Discipline of Psychiatry at the University of Adelaide, ph: 8222 4207, or via email: sonia.masciantonio@adelaide.edu.au. Alternatively, you can contact the supervisor of this project Associate Professor Anna Chur-Hansen through the Discipline of Psychiatry at the University of Adelaide, ph: 8222 5785, or via email anna.churhansen@adelaide.edu.au, or the co-supervisor Dr Susan Hemer in the Discipline of Anthropology, ph: 8303 5732 or email susan.hemer@adelaide.edu.au. If you wish to discuss aspects of the study with someone not directly involved, you may also contact the Chairman of the Human Research Ethics Committee at the University of Adelaide on ph: (08) 8303 6028 or through the submission of the attached Independent Complaints form.

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1. I, …………………………………………………………………………..(please print name)
   consent to take part in the research project entitled: An Ethnographic Study of Postnatal Mental Illness

2. I acknowledge that I have read the attached Information Sheet entitled: Staff Information Sheet: A Study of Postnatal Mental Illness

3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.

4. Although I understand that the purpose of this research project is to improve the quality of medical care, it has also been explained that my involvement may not be of any benefit to me.

5. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.

6. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.

7. I agree that interviews may be audio recorded. YES / NO

8. I want a copy of the transcript from my interview YES / NO

9. I understand that I am free to withdraw from the project at any time and that this will not affect medical advice in the management of my health, now or in the future.

10. I am aware that I should retain a copy of this Consent Form, when completed, and the attached Information Sheet.

   ………………………………………………………………………………………………………………………………………………………………………
   (signature)  (date)

WITNESS

I have described to ……………………………………………………………(name of participant) the nature of the research to be carried out. In my opinion she/he understood the explanation.

Status in Project: ………………………………………………………………………

Name: …………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………
   (signature)  (date)
A Study of Postnatal Mental Illness in Helen Mayo House

Introduction
I am inviting you to help me with a research study. Before you agree it is important that you read and understand the following information.

What is the study about?
This main aim of the project is to understand what it feels like to be a mother with mental health difficulties in the postpartum period. I am trying to understand what their day-to-day life is like: what sort of experiences they have, how they cope with these experiences and how medical treatment shapes their experiences.

Who will be carrying out the study?
I (Sonia Masciantonio) am the main researcher for this project. I am an anthropologist and I am studying a PhD at the University of Adelaide. I am not a psychiatrist, psychologist, psychiatric nurse or social worker, and therefore am not qualified to participate in any clinical work. The supervisor for this project is Associate Professor Anna Chur-Hansen of the Discipline of Psychiatry at the University of Adelaide and the co-supervisor is Dr Susan Hemer of the Discipline of Anthropology at the University of Adelaide.

How does the study work?
The research I am conducting is an ethnographic project. Ethnography is a research technique which requires that I take into account all characteristics of the research community under study; for this reason I will be observing all aspects of what happens at Helen Mayo House.

As a researcher I am interested in the day-to-day practices that happen within the facility and the best way for me to gather this type of information is to spend large amounts of time with the people concerned, observing their interactions and talking with them about their life and the things they do daily. The research is primarily interested in the experiences of mental illness in postnatal mothers, however an integral part of their experiences while receiving psychiatric care is the interactions they have with staff. For this reason I will also be spending a significant amount of time observing your day-to-day work, speaking to you about your workplace practices, professional knowledge and personal understanding and beliefs of mental illness in the postpartum period. I will be in Helen Mayo House most days, and will be spending approximately 5-6 hours per day there. I will be there mostly during the day, but I will occasionally be there at night time and early morning too. During my time talking to you and observing your daily interactions, I will record what I learn from you in my notebook. Our conversations will be largely guided by your responses to my questions, although I may want to ask you certain specific questions as we go along. With your permission, I may occasionally ask you to be part of a semi-structured interview which I will ask to digitally record.

Please be advised that as I am not clinically trained so will not be assisting in any clinical or other skilled work.

What are the risks of participating in the study?
There are no physical risks involved in the study. However, some people may not like being asked certain questions. If there are any questions you are uncomfortable with, you can choose not to answer them.
What will I get out of the study?
There will be little to no immediate benefit to you personally, and I am unable to pay you anything for helping with this project. The aim of this study is to improve the understanding of women experiencing mental health difficulties in the postpartum period.

What happens to the information I give?
You are under no obligation to participate in the study. Any information you choose to share with me is private and confidential. The information you give me will be recorded in my field notes. It will be kept securely and will only be made accessible to myself (and on occasions my supervisors). The data will then be analysed for inclusion in a PhD dissertation and may later appear as journal articles and conference papers in the fields of anthropology and psychiatry. When I publish in these ways, I will be careful to write the results in such a way that no reader could identify who you are.

Your information will remain confidential except in the case of a legal requirement to pass on personal information to authorised third parties. This requirement is standard and applies to information collected both in research and non-research situations. Such requests to access information are rare; however we have an obligation to inform you of this possibility.

What if I do not want to participate in the study?
It is not a problem if you chose not to be involved in the study. If you agree to take part but later change your mind that is also not a problem. I will remove the information you have given me from my records and from the final analysis if you would like me to do so. You can withdraw your involvement from the study at any time without question before the publication of results of the study.

What if I have any questions about the study?
If you have any questions about the study, feel free to contact me. I can be contacted through the Discipline of Psychiatry at the University of Adelaide, ph: 8222 5636, or via email: sonia.masciantonio@adelaide.edu.au. Alternatively, you can contact the supervisor of this project Associate Professor Anna Chur-Hansen through the Discipline of Psychiatry at the University of Adelaide, ph: 8222 5785, or via email anna.churhansen@adelaide.edu.au, or the co-supervisor Dr Susan Hemer in the Discipline of Anthropology, ph: 8303 5732 or email susan.hemer@adelaide.edu.au. If you wish to discuss aspects of the study with someone not directly involved, you may also contact the Chairman of the Human Research Ethics Committee at the University of Adelaide on ph: (08) 8303 6028 or through the submission of the attached Independent Complaints form.

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Email: sonia.masciantonio@adelaide.edu.au
Staff Consent Form

1. I, .................................................................(please print name) consent to take part in the research project entitled: An Ethnographic Study of Postnatal Mental Illness.

2. I acknowledge that I have read the attached Information Sheet entitled: Staff Information Sheet: A Study of Postnatal Mental Illness.

3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.

4. Although I understand that the purpose of this research project is to improve the quality of medical care, it has also been explained that my involvement may not be of any benefit to me.

5. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.

6. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.

7. I agree that interviews may be audio recorded. YES / NO

8. I want a copy of the transcript from my interview YES / NO

9. I understand that I am free to withdraw from the project at any time and that this will not affect medical advice in the management of my health, now or in the future.

10. I am aware that I should retain a copy of this Consent Form, when completed, and the attached Information Sheet.

................................................................. (signature) ................................................................. (date)

WITNESS

I have described to .................................................................(name of participant) the nature of the research to be carried out. In my opinion she/he understood the explanation.

Status in Project: .................................................................

Name: .................................................................

................................................................. (signature) ................................................................. (date)

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Independent Complaint Form

Document for people who are participants in a research project

CONTACTS FOR INFORMATION ON PROJECT AND INDEPENDENT COMPLAINTS PROCEDURE

The Human Research Ethics Committee is obliged to monitor approved research projects. In conjunction with other forms of monitoring it is necessary to provide an independent and confidential reporting mechanism to assure quality assurance of the institutional ethics committee system. This is done by providing research participants with an additional avenue for raising concerns regarding the conduct of any research in which they are involved.

The following study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee:

Project title: An Ethnographic Study of Postnatal Mental Illness in

1. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the project co-ordinator:

   Name: Associate Professor Anna Chur-Hansen / Dr Susan Hemer

   Telephone: 8222 5785 / 8303 5732

2. If you wish to discuss with an independent person matters related to

   • making a complaint, or
   • raising concerns on the conduct of the project, or
   • the University policy on research involving human participants, or
   • your rights as a participant

   contact the Human Research Ethics Committee’s Secretary on phone (08) 8303 6028


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