JYU DISSERTATIONS 643

Mirjam Raudasoja

Transition to Motherhood

Childbirth Experiences, Psychological Well-Being, and Discourses of Childbirth and Mothering

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Esitetään Jyväskylän yliopiston kasvatustieteiden ja psykologian tiedekunnan suostumuksella
julkisesti tarkastettavaksi Ruusupuiston Helena -salissa
kesäkuun 6. päivänä 2023 kello 12.

Academic dissertation to be publicly discussed, by permission of
the Faculty of Education and Psychology of the University of Jyväskylä,
in building Ruusupuisto, lecture hall Helena, on June 6, 2023, at 12 o'clock.

JYVÄSKYLÄN YLIOPISTO
UNIVERSITY OF JYVÄSKYLÄ

JYVÄSKYLÄ 2023

Editors
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ISBN 978-951-39-9567-6 (PDF)
URN:ISBN:978-951-39-9567-6
ISSN 2489-9003

Permanent link to this publication: http://urn.fi/URN:ISBN:978-951-39-9567-6

ABSTRACT

Raudasoja, Mirjam
Transition to motherhood: Childbirth experiences, psychological well-being, and discourses of childbirth and mothering
Jyväskylä: University of Jyväskylä, 2023, 97 p.
(JYU Dissertations
ISSN 2489-9003; 643)
ISBN 978-951-39-9567-6 (PDF)

The aim of this dissertation is to examine mothers' psychological well-being and discourses of childbirth and mothering in the transition to motherhood. In Studies I and II, fear of childbirth (FOC), birth experience and self-esteem were assessed in a longitudinal study following women (*n* = 125) from pregnancy to one year after childbirth. Study I examined the interaction of FOC and self-esteem in predicting birth experience. High self-esteem was found to protect from the detrimental effect of FOC on birth experience. Study II examined self-esteem development in the transition to motherhood and its relation to birth experiences. This mixed-methods study showed that positive birth experience predicted increased self-esteem and negative birth experience predicted decreased self-esteem during the year after childbirth. Qualitative analysis showed that this finding applied only for very satisfying or traumatic experiences. In mothers' answers, childbirth experiences were described through three main themes: childbirth as a lived experience, childbirth as a relational event, and childbirth as a medical event. In Studies III and IV, infants' mothers (*n* = 479) were studied. Study III examined the relationship between mothers' self-esteem, socially prescribed perfectionism (SPP), and parental burnout. High self-esteem was found to buffer the detrimental effect of SPP on parental burnout. Finally, Study IV examined mothers' mothering discourses and their interplay. Four mothering discourses were found: the Equality discourse, the Familistic discourse, the Intensive Mothering discourse, and the Balance discourse. The four discourses were in counterpoint relation to one another, and the responses were mainly centered around traditional conceptions of motherhood. Overall, the results of this dissertation suggest that transition to motherhood is an identity-organizing event where self-esteem serves as an important resource. Expectations for motherhood produce stress that some mothers can buffer with their high self-esteem and by reframing mothering ideals. The results suggest that mothers would benefit from more varying conceptions of childbirth and motherhood and support for their self-esteem throughout the transition to motherhood.

Keywords: childbirth, mothering, self-esteem, well-being, fear of childbirth, transition to motherhood

TIIVISTELMÄ (ABSTRACT IN FINNISH)

Raudasoja, Mirjam
Siirtymä äitiyteen: Synnytyskokemukset, psyykkinen hyvinvointi ja synnytys- ja äitiysdiskurssit
Jyväskylä: Jyväskylän yliopisto, 2023, 97 s.
(JYU Dissertations
ISSN 2489-9003; 643)
ISBN 978-951-39-9567-6 (PDF)

Tämän väitöstutkimuksen tarkoituksena oli tutkia äitien psyykkistä hyvinvointia sekä synnytys- ja äitiyskokemuksia siirtymässä äitiyteen. Väitöskirjan kaksi ensimmäistä osatutkimusta perustuivat pitkittäistutkimukseen, jossa äitien (n = 125) synnytyspelkoa, synnytyskokemusta ja itsetuntoa tutkittiin loppuraskaudesta synnytyksen jälkeisen vuoden loppuun. Tutkimuksessa 1 selvitettiin synnytyspelon ja itsetunnon yhteisvaikutuksia synnytyskokemukseen ja havaittiin, että hyvä itsetunto suojasi synnytyspelon negatiiviselta vaikutukselta synnytyskokemukseen, mutta heikko itsetunto vahvisti vaikutusta entisestään. Tutkimuksessa 2 selvitettiin monimenetelmäisesti itsetunnon kehitystä siirtymässä äitiyteen ja sen yhteyttä synnytyskokemukseen. Hyvä synnytyskokemus ennusti tilastollisesti itsetunnon kohentumista ja huono synnytyskokemus itsetunnon heikkenemistä synnytystä seuraavan vuoden aikana, mutta laadullisen analyysin perusteella tämä piti paikkansa ainoastaan hyvin myönteisten tai traumaattisten kokemusten kohdalla. Synnytyskokemuksia kuvattiin kolmen teeman kautta: synnytys elettynä kokemuksena, synnytys ihmissuhdekokemuksena sekä synnytys lääketieteellisenä tapahtumana. Osatutkimuksissa 3 ja 4 tutkittiin vauvojen äitejä (n = 479). Tutkimuksessa 3 selvitettiin äidin itsetunnon, sosiaalisesti määräytyvän perfektionismin sekä vanhemmuuden uupumuksen välisiä yhteyksiä. Äidin hyvä itsetunto suojasi sosiaalisesti määräytyvän perfektionismin negatiiviselta vaikutukselta vanhemmuuden uupumukseen. Tutkimuksessa 4 tutkittiin äitien äitiysdiskursseja ja niiden keskinäisiä suhteita. Äitien kuvauksista löydettiin neljä erilaista äitiysdiskurssia: tasa-arvodiskurssi, familistinen diskurssi, intensiivisen äitiyden diskurssi sekä tasapainodiskurssi. Eri diskurssit olivat jännitteisessä suhteessa keskenään, ja useimmiten äitien vastaukset keskittyivät perinteisiin äitiyden malleihin. Väitöstutkimuksen tulokset viittaavat siihen, että siirtymä äitiyteen on identiteettiä organisoiva tapahtuma, jossa hyvä itsetunto toimii keskeisenä voimavaratekijänä. Äitiyteen liittyvät odotukset näyttävät tuottavan äideille stressiä, jota osa heistä pystyy kuitenkin torjumaan hyvän itsetunnon avulla sekä uudelleenmäärittelemällä ihanteita. Tutkimuksen perusteella äidit hyötyisivät synnytykseen ja äitiyteen liittyvien kulttuuristen käsitysten monipuolistamisesta sekä itsetunnon tukemisesta siirtymässä äitiyteen.

Keywords: synnytys, äitiys, itsetunto, hyvinvointi, synnytyspelko, siirtymä äitiyteen

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FOREWORD

I have received immense support, encouragement, and guidance from many people during this work and I would like to express my sincere gratitude to all of you. First, Prof. Kaisa Aunola, I was lucky to find you as my supervisor. You have been a real star, always encouraging, and a supportive supervisor and colleague, as well as a friend and role model for me. Thank you for everything. You always made my day. Docent Matilda Sorkkila, you have been a brilliant supervisor, always making things clear and guiding me forward. I am thankful for all the guidance, kindness, and friendship that I have received from you. Without you, my texts would not have been as well articulated as they are. Prof. Katri Vehviläinen-Julkunen, thank you for your supervising and all the good advice, as well as your kindness and good humor. You always reminded me to include the context, which made my texts more complete.

I also would like to warmly thank my co-authors Asko Tolvanen and Aarno Laitila. Asko, you answered my endless questions patiently and reassured me when I was sure that something had gone horribly wrong with the analyses. Aarno, you taught me how to write qualitative results without putting my own attitudes in the text, which was one of the most important things to learn during my doctoral journey. Thank you.

I am grateful for all the wonderful people who participated in the studies. You shared your experiences in one of the most intimate processes in human life, and that is courageous and valuable. I admire you all and want to thank you from the bottom of my heart. Without you, this work would not have been possible.

I wish to thank the Department of Psychology for funding my research.

I dedicate this work to my children Edith and Joel, my darlings. I am grateful to have two wonderful children, so different but equally dear. Your births inspired me to do research, and when learning to be a mother, I also started to learn to research. You are the stars in my sky.

I thank my husband Aleksi for all the encouragement, love, support, laughing, and discussions we have had throughout the way. We have had a special kind of humor and numerous discussions during these years. You encouraged me to dream of doing research, and to apply for doctoral school in the first place. I would not be in this position without you. Thank you for being there for me.

I am grateful for all my friends and family members who have supported me during this doctoral journey. On many occasions, when you had no idea what I was speaking of, you let me share what was on my mind. To my sisters Pauliina and Johanna, thank you for offering a place to stay in Jyväskylä.

Finally, thank you to all the nice, kind, funny, and compassionate people in the doctoral studies program with whom I met regularly. It has been a real support and much needed connection for me.

Kangasala April 6, 2023
Mirjam Raudasoja

LIST OF ORIGINAL PUBLICATIONS

The thesis is based on the following publications. In the text, they are referred to as Studies I–IV.

I Raudasoja, M., Sorkkila, M., Vehviläinen-Julkunen, K., Tolvanen, A. & Aunola, K. (2022). The role of self-esteem on fear of childbirth and birth experience. *Journal of Reproductive and Infant Psychology, (online first) 1–9*. https://doi.org/10.1080/02646838.2022.2115989

II Raudasoja, M., Vehviläinen-Julkunen, K., & Tolvanen, A. (2022). Passing the test of motherhood? Self-esteem development and birth experience in the transition to motherhood: A longitudinal mixed methods study in Finland. *Journal of Advanced Nursing, 78*(12), 1–15. https://doi.org/10.1111/jan.15468

III Raudasoja, M., Sorkkila, M. & Aunola, K. (2022). Self-Esteem, Socially Prescribed Perfectionism, and Parental Burnout. *Journal of Child and Family Studies, 6*(1). https://doi.org/10.1007/s10826-022-02324-y

IV Raudasoja, M., Sorkkila, M., Laitila, A., & Aunola, K. (2022). "I feel many contradictory emotions": Finnish mothers' discursive struggles with motherhood. *Journal of Marriage and Family, 84*(3), 752–772. https://doi.org/10.1111/jomf.12828

Considering the instructions given and the comments made by the co-authors, the author of this thesis contributed to the original publications as follows: designing (Studies I and II), collecting the data (Studies I and II), analyzing the qualitative data (Studies II and IV), interpreting the results (all studies), and writing the manuscripts (all studies).

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ORIGINAL PAPERS

1 INTRODUCTION

In life course psychology, life transitions refer to developmental stages characterized by uncertainty and change between two stable periods (see, for example, Levinson & Darrow, 1978; Levinson & Levinson, 1996; Sherman, 1987). Transition to motherhood, including pregnancy, childbirth, and early mothering (also referred to as the perinatal period), is one of the major life transitions (Taubman-Ben-Ari, 2009). It is an individual and unique experience (Larkin et al., 2009) that happens in specific sociocultural contexts. Women enter this life stage with different dispositions and beliefs, surrounded by different societal systems and cultures. The transition is significant and life-changing every time, not only the first time of giving birth (Prinds et al., 2014). The successful processing of the transition may be affected by women's well-being, such as self-esteem and fear of childbirth, and by sociocultural contexts such as care systems, parental leave policies, gendered expectations, and motherhood discourses. Well-being and sociocultural contexts are closely intertwined. For example, the increase in prevalence of fear of childbirth that has been recognized in many Western countries in the new millennium (O'Connell et al., 2017) is likely affected by changes in societies and cultures, such as the decreases in fertility rates and increases in medicalization of childbirth (Betrán et al., 2016; Kennedy et al., 2015; Preis et al., 2019a). Similarly, women's own dispositions, such as their level of self-esteem (i.e., the sense of their own value or self-worth; Jordan et al., 2015) or perfectionism (e.g., having high standards and concern for mistakes; Curran & Hill, 2019), are likely to function reciprocally with expectations in the culture. For example, someone with a low self-esteem may feel their self-worth threatened by high performance expectations that many women experience in pregnancy (Copelton, 2007; Neiterman, 2013), childbirth (Chadwick & Foster, 2013; Martin, 2003; Reisz et al., 2015; Zadorosnyj, 1999), and motherhood (Hays, 1996; Henderson et al., 2016; Liss et al., 2013) and special requirements in the immediate postpartum period (Neiterman, 2013; Upton & Han, 2003), and being confronted with these expectations may further lower self-esteem. The other way round, women with low self-esteem and high perfectionism may be more likely to feel the need to succeed perfectly or even outperform others in the transition,

and this may contribute to perfectionist standards of motherhood that women also produce and reinforce themselves (Abetz & Moore, 2018; Chadwick & Foster, 2013). The balance of various risk and protective or supportive factors is crucial for well-being (see, e.g., Antonovsky, 1979; 1996; Mikolajczak & Roskam, 2018). In this dissertation, I will concentrate on maternal experiences and psychological well-being in the transition to motherhood, with particular emphasis on self-esteem development and cultural discourses of childbirth and mothering. The term "psychological well-being" is used to refer to individual's general sense of well-being, as balance of positive and negative aspects, including cognitive and emotional components (Alderdice & Gargan, 2019; Jomeen, 2004; see also Antonovsky, 1979). The main aim of this dissertation is to examine how individual and sociocultural influences jointly affect the experiences in the transition to motherhood. The aims of this thesis are, first, to study the role of childbirth experiences in the transition to motherhood; second, to examine the role of self-esteem in the transition to motherhood, and third, to describe mothers' own childbirth and mothering discourses. The results will build knowledge on how individual and cultural processes intertwine and affect mothers' psychological well-being in the transition to motherhood.

In this dissertation, I mainly use "women" and "mothers" to refer to persons who are pregnant and give birth. While it is important to acknowledge that not all pregnant/birthing people identify as women, using gender-neutral terms is also problematic and undermines gendered identities and social roles. Indeed, it also makes it impossible to identify restrictive practices and violations directed specifically at women (see Gribble et al., 2022). In some cases, when these structures are not relevant, I occasionally use "pregnant people" or "birthing parents" to include minority gender identities. While experiences of fathers are also very important and increasingly recognized in scientific research (see O'Brien et al., 2017), the present research is restricted to mothers due to sex- and gender-based differences in childbearing. The transition to parenthood includes important qualitative differences for mothers and fathers (Hollway, 2016), and for this reason, mothers and fathers should be studied separately. The scope of the present research is on mothers only.

1.1 Transition to motherhood as a life transition

Life course psychology generally posits that psychological development includes several developmental or life transitions (see Erikson, 1950; Levinson & Darrow, 1978; Levinson & Levinson, 1996) such as transition to school, adolescence, transition to adulthood, transition to parenthood, and transition from working life to pension. Characteristic of life transitions are changes in physiology (such as puberty, aging), cognition, emotions, and/or social contexts and roles. Transition to motherhood can be understood as such a developmental transition or a developmental crisis (Mercer, 2004). The term "crisis" follows from the life transitions theory, and it means a state of psychological disequilibrium that is

characteristic of transitional periods (Levinson & Darrow, 1978). According to Erikson's (1950) theory of psychosocial development, people need to resolve different developmental tasks in different stages of development, and successful resolution creates "virtues," that is, new psychological structures. The theory focuses on identity development, which comprises an individual's experience of self, including beliefs about others' expectations and perceptions (Laney et al., 2014). This way identity can be seen as closely connected to the society where the individual lives.

Erikson (1950) distinguished eight stages that all people need to navigate in their developmental paths. He proposed that developmental crises occur in a certain order and that successful resolution of previous crises creates a basis for healthy development. An unresolved crisis at any stage affects the "integration of the whole ensemble" (Erikson, 1997, p. 29). His theory especially centers around changes before adulthood, and it is somewhat limited in adult years when biological change is not so apparent and connecting psychosocial development to biological roots is more difficult (Sorell & Montgomery, 2009, p. 109). However, childbearing is one of the few processes that profoundly changes the physical body in a short time, which supports the idea that this period would be of urgent importance to women's identity development. Moreover, social changes are usually profound in this period, including changing social status and roles, as well as everyday life and responsibilities (see Laney et al., 2014). Erikson's theory was male-biased (Laney et al., 2014; Sorell & Montgomery, 2009) and did not always reflect women's experiences (see, e.g., Chodorow, 1978; Gilligan, 1982), but as an extension of his thinking, we can assume that childbearing can be understood as one of the most important transitional crises in adult life.

Particularly interesting is that even though Erikson placed emphasis on marrying the biological and social aspects of development (Schachter, 2018), he reduced women's reproductive capacities in a certain kind of biological determinism to explain gender differences (Sorell & Montgomery, 2009) and women's identity was assumed to be primarily focused on the roles of wife and mother (Laney et al., 2014). However, Erikson's basic assumptions that warn against universalization of experience support studying the experiences in their unique contexts, including within populations that have not been previously studied (Sorell & Montgomery, 2009). Indeed, the content of Erikson's mid-life crisis, generativity versus stagnation, directly encompasses caring for others and is particularly relevant to the transition to motherhood. Generativity refers to establishing and guiding the next generation, while stagnation means failing to establish this caring relationship (Erikson, 1950). Generative adults strive to care for and nurture the next generation. Generativity can also be depicted as a typical feature of women's psyche throughout development, developing earlier than in men and continuing longer; however, it can of course include different meaning in the transition to motherhood. Gilligan (1982) argued that "ethics of care" is a framework for moral reasoning that is more typical for women than for men and that it is not restricted to middle age, but women develop this form of moral

reasoning throughout their development. Gilligan (1982) proposed that ethics of care develop through three stages, the first being concern for one's own survival, the second responsibility for others, and the third responsibility for both oneself and others. Generativity would thus be represented already at the second stage of development of ethics of care.

I propose that despite the shortcomings of Erikson's theory, it is a useful tool in understanding psychological development in the transition to motherhood. Transition to motherhood represents a developmental crisis that often challenges women to develop a new sense of responsibility (see Hays, 1996; Miller, 2007). I argue that when becoming mothers, women are directly exposed to the need for generativity or a moral conflict that can be described with the concept of ethics of care (Gilligan, 1982), and that this developmental need is not restricted to middle age in women (see also Sorell & Montgomery, 2009). Because this transitional stage includes moral reasoning, women may be particularly vulnerable to external expectations during this period.

Modern developmental theories may be seen as a variation and enlargement of Erikson's (and other classic developmental psychologists' and psychoanalytical theorists') thinking. Psychoanalytically oriented researchers and practitioners have in recent decades explained the perinatal period as a developmental event (see Brodén & Kivirauma, 2006; Hall, 2016; Holmes, 2000; Raphael-Leff, 2001). They have proposed that childbearing itself is an imagined aspect of female psychosexual development (Hall, 2016) and that in the perinatal period, early experiences with one's own caregivers and intimate partners are activated (Brodén & Kivirauma, 2006; Holmes, 2000; Raphael-Leff, 2001). The psychological tasks that mothers must work through in pregnancy are proposed to include accepting pregnancy, re-evaluating one's own childhood experiences and the mothering one has received, and forming a sense of self-as-mother (Brodén & Kivirauma, 2006; Raphael-Leff, 2001). Of urgent importance is the mother's relationship with her own mother, her ability to evaluate the quality of motherhood she has been subjected to, and the preservation of both separation and identification with her own mother (Raphael-Leff, 2001).

In empirical studies, it has been proposed that becoming a mother includes changes in and enlargement of identity (Laney et al., 2014; Mercer, 2004; Ulriko, 2018). Laney and colleagues (2014) found as a result of their grounded theory study of 30 university faculty women that when becoming mothers, women expanded their selves to include new aspects, such as personal qualities, increasing relational capacities, caring for others, and nurturing younger generations (on generativity, see also Erikson, 1950), but also engaging with their careers in new ways. Similarly, Mercer described maternal identity changes as transformation and a growth of self that results in enlargement of identity (Mercer, 2004, p. 231). Although recognizing a large variability in the phase of this development, Mercer proposed that maternal identity is often achieved around four months after the birth.

Hollway calls for a psychology which takes into theoretical consideration "the psychological implications of women's capacity to create life for their

changing subjectivities over a life course" (2016, p. 150). In the transition to motherhood, this theme is apparent. However, the effects of pregnancy-related psychological tasks have not been explained in detail in relation to many psychological structures. For example, if becoming pregnant activates the woman's resolutions for the very early developmental conflicts such as receiving care, feeling worthy, and trusting others, this might affect her capabilities to mentally work through the themes that successful psychological processing in pregnancy requires (see, e.g., Brodén & Kivirauma, 2006). Specifically, if a person has developed low self-esteem in infancy, this may impair her ability to process the impending childbirth and, ultimately, motherhood. However, previous research is generally vague about how self-esteem is developed in the transition to motherhood in connection with influences in the prevailing society and culture, such as normative femininity and motherhood discourses. Moreover, although childbearing and becoming a mother have been theorized in academic psychology, childbirth experiences have been granted much less attention. Indeed, Saxbe (2017) calls for research that integrates modern psychological theories into studies of childbirth.

1.2 Childbirth experience and its significance in the transition to motherhood

Childbirth is often described as a pivotal event for most women and part of their psychosexual development (Hall, 2016; see also Hollway, 2016). Hall writes that pregnancy and childbirth in a woman's mind are accompanied by "fantasies, fears, and excitements about her body" (2016; p. 43). In her framing, childbirth represents a developmental task that challenges inner representations and specifically affects one's body image.

Childbirth experiences are not "everyday" experiences; they are something that will be remembered for decades, if not a lifetime (Bossano et al., 2017; Simkin, 1991). They are unique events (Larkin et al., 2009), consisting of mutually related physiological and psychological processes and affected by the surrounding culture, environment, and organizations (Larkin et al., 2009). Childbirth experiences have been identified as consisting of several core experiences or domains, such as feelings of capacity, perceived safety and security, perceptions of professional support, and feelings of participation or exclusion (Dencker et al., 2020). Indeed, most research suggests that birth experiences are multifaceted (see Dencker et al., 2020; Viirman et al., 2023).

1.2.1 The meaning of childbirth experiences

In empirical studies in the field of nursing and health sciences, childbirth experiences have been studied from the viewpoint of mothers' lived experiences through their own words and meaning-making (see Dixon et al., 2014; Olza et al., 2018). The meaning of childbirth experiences for the mother has been depicted in

many ways. Childbirth is described as a life-changing experience that mothers will remember in detail for the rest of their lives (Bossano et al., 2017; Simkin, 1991). This life event is proposed to include individual and sociocultural meanings (Larkin et al., 2007).

Psychologically, giving birth seems to represent a culmination point in the transition to motherhood, being anticipated in pregnancy (Goutaudier et al., 2019; Malacrida & Boulton, 2014; Preis et al., 2019a; van Bussel et al., 2010) and affecting woman's well-being (Ayers et al., 2006; Dikmen-Yildiz et al., 2018) and her functioning as a mother (Holopainen et al., 2020; McDonald et al., 2011) afterwards. It has also been described as a test of womanhood (Coleman & Coleman, 1971) and the first task of motherhood (Deutscher, 1970), a peak experience (Simkin, 1991; Thomson, 2010), and a transformative experience (Olza et al., 2018). An emotional flow in spontaneous physiological labor has also been discovered from the point of view of laboring women as opposed to male-biased and mechanistic understandings of birth (Dixon et al., 2014). Moreover, some researchers propose that childbirth encompasses existential themes, such as personal value systems and spirituality (Prinds et al., 2014) or mythical aspects, including the hero myth (Thomson & Downe, 2013).

The characteristics of birth experiences and their consequences for women have also been researched. For example, the essential components of the experiences (Dencker et al., 2020) and antecedents and consequences of different experiences (Chabbert et al., 2021) have been studied. Women's birth beliefs and their relation to actual experiences have been examined (Preis et al., 2018; 2019a; 2019b). Women's experiences of different caring systems have been studied and components of good care and different caring models have been differentiated; for example, the role of positive interpersonal relationships in caring systems (Rubashkin et al., 2018), continuous support (Rubashkin et al., 2018), and continuity of care (Sandall et al., 2016) have been proposed as caring models that enable and promote positive experiences. What is common to these different perspectives is the understanding that childbirth experiences are multifaceted and intense and that women need good support.

Indeed, childbirth has been theorized to include physical, psychological, and social changes that are all apparent in the transition to motherhood (Saxbe, 2017). Giving birth is a challenging physical task that includes peak hormonal levels, usually intense pain, and in the case of vaginal birth, the baby fitting through the mother's pelvis (Saxbe, 2017). When childbirth happens via a caesarean section, a major surgical operation, it is sometimes experienced as traumatic, especially if a medical emergency is involved (Ayers, 2004); however, obstetrically uncomplicated birth can also be experienced as traumatic (Beck, 2004). The experience, including pain, stress, and anxiety during labor, is dependent on many psychosocial aspects, such as expectations, perceived ability, and control, as well as culture and environment (Saxbe, 2017). Childbirth challenges personal resources and coping means and activates vulnerabilities (Hamelin-Brabant et al., 2015). Social aspects seem to be very important for childbirth experiences; for example, the crucial role of social support has been

indicated in many studies (Downe et al., 2018; Kurtz et al., 2022; Lundgren & Berg, 2007; Rubashkin et al., 2018; Saxbe, 2017). A successful transition also forms a strong basis for motherhood (Raphael-Leff, 2001). However, it is important to study the transition from the perspective of mothers without justifying it with the benefits for children.

Childbearing includes elements such as identity development (becoming a mother; Laney et al., 2014; Mercer, 2004) that cannot be reduced to maternal functions of caring for children. Most studies on the significance of birth experiences concentrate on negative or traumatic experiences (McKelvin et al., 2021) that are recognized to alter self-conception or confirm negative perceptions of oneself. In studies on traumatic experiences of childbirth, it has been proposed that women's sense of self was altered because of the trauma (e.g., Byrne et al., 2017; Kjelruff & Brubaker, 2018). For example, Byrne and colleagues found that traumatic childbirth included experiences of being ignored and discounted in childbirth, which resulted in altered perceptions of oneself, captured in the metaphor of "loss of self" (Byrne et al., 2017). In line with this, Schneider (2010; 2013; 2018) found that women often blamed themselves for difficult events during labor and felt like a failure when their experiences were negative. In contrast, good experiences have been described as transformative and empowering (Karlström et al., 2015), and even as hero journeys (Thomson & Downe, 2013).

1.2.2 What influences the quality of childbirth experiences?

Childbirth experiences are influenced by multiple factors related to the birthing person, events of the birth, the care received, caring systems, social support, and even the immediate postpartum time (Chabbert et al., 2021). As a result of a systematic review of childbirth experiences, Chabbert and colleagues (2021) concluded that most women experience their childbirths mainly positively, but up to one-third of women report negative experiences. The main risk factors for a negative childbirth experience are related to the labor and birth, such as emergency cesarean and highly perceived pain during the labor process and being dissatisfied with social support (Chabbert et al., 2021). Parity, experienced labor pain, and length of labor have showed conflicting results in different studies (Chabbert et al., 2021).

Obstetric risk factors include labor complications, such as an emergency cesarean or instrumental birth, prolonged labor, or the baby being transferred into a neonatal care unit after birth (Chabbert et al., 2021). In other studies, it has been noted that cumulative obstetric interventions beginning with labor induction and leading to an emergency caesarean are especially strong negative factors for childbirth experiences (Joensuu et al., 2022). This may be explained with other findings proposing that most women experience more medicalized births than expected, indicating a mismatch between expectations and reality, and contributing to feelings of a lack of control (Preis et al., 2019). Hospital organizational practices, such as differences in care related to the rush hours and quiet moments, also seem to shape birth experiences (Joensuu et al., 2021); this

may be explained with the quality of interaction with professionals, which has been shown to be important for women's birth experiences (Donate-Manzanares et al., 2021; Grekin & O'Hara, 2014; Henriksen et al., 2017; Koster et al., 2020). However, childbirth can be perceived as traumatic even in the absence of any obstetrical complications—even a birth that was perfectly good from the perspective of care providers may be experienced as traumatic (Beck, 2004). Similarly, experiencing strong labor pain does not necessarily imply a negative experience, as it can be perceived as a feature of a good birth as well (Karlsdottir et al., 2018). Indeed, McKelvin and colleagues (2021) conclude that significant contradictory evidence exists on what affects childbirth experiences. However, it should be noted that studies on positive childbirth experiences are extremely scarce, which may be related to our cultural understanding of childbirth as dangerous and female bodies as inferior to male bodies (McKelvin et al., 2021). In relation to negative experiences, fear-based emotions have been identified as central (Viirman et al., 2023).

The crucial role of social support for childbirth experiences has been recognized in many studies (Chabbert et al., 2021; Koster et al., 2020; Lundgren & Berg, 2007; McKelvin et al., 2021). In their study on intrapartum hotspots (i.e., the moments comprising the most troubling memories), Harris and Ayers (2011) found that interpersonal difficulties were the strongest predictors of posttraumatic stress disorder (PTSD), with most being concerned with lack of support. It seems that childbirth traumas are most often formed by poor interpersonal relationships, which include feeling abandoned and invisible. Similar findings have been reported in many other studies, indicating that poor relationships are strong predictors of poor experiences (Koster et al., 2020), and good relationships are central to positive experiences (Lundgren & Berg, 2007; McKelvin et al., 2021).

In general, home birth or natural birth is associated with positive experiences, while hospital birth is associated with more negative experiences (Chabbert et al., 2021). Protective factors from a negative experience include feeling of control and being satisfied with support (Chabbert et al., 2021) and continuity of a care model for birth, which means having the same or known midwife present at birth who cared for the mother in pregnancy (McLachlan et al., 2012; Sandall et al., 2016). Good childbirth experiences are promoted by good quality of care and a supportive relationship with the midwife (McKelvin et al., 2021), continuity of the care model (McLachlan et al., 2012; Perriman et al., 2018; Sandall et al., 2016), and perceptions of control (McKelvin et al., 2021). What matters to women in childbirth seems to be both safety and a positive experience, including support, participation, and a sense of control (Downe et al., 2018). Women with positive experiences have a sense of their own ability and strength, and they feel that they have trustful and respectful relationships with their midwives, as well as trust and support from their partners (Karlström et al., 2015). Physiological labor and birth are often experienced as very empowering, even transformational (Olza et al., 2018). This may be related to the altered state of consciousness that physiological birth creates (Olza et al., 2018).

The mother's psychological characteristics have also been studied in relation to childbirth experiences. For example, Asselmann and colleagues (2021) found that specific personality characteristics (e.g., emotional stability, conscientiousness, openness) were significant when specific birth incidents (i.e., preterm delivery, an emergency caesarean section, general anesthesia) happened. These findings enlarge the findings concerning the role of perfectionism in the perinatal period (e.g., Price et al., 2020). These findings imply that events of birth are perceived differently depending on the individual: for example, for women with high conscientiousness, ending up in an emergency caesarean section, especially under general anesthesia, may represent loss of control (Asselmann et al., 2021). Similarly, someone with perfectionist expectations for oneself and great concern of mistakes (i.e., self-oriented perfectionist) may feel like a failure if the labor and birth do not go as planned (see also Schneider, 2018). If the mother also has low tolerance for uncertainty, her appraisal of birth may be negative or even traumatic (Price et al., 2020).

Childbirth experience is also shaped by pre-labor expectations and how they are related to the actual experience. Preis and colleagues (2019b) adapted the transactional model of stress and coping to the context of birth experiences. According to this model, the nature of an experience is determined by the "fit between expectations and experience, congruence between the individual and the environment, and the crucial role of personal control" (Preis et al., 2019b, p. 106). The authors propose that birth satisfaction is predicted by (in)congruence between planned and actual birth, perceptions of control, emotions, and perceptions of care. They found out that most of the women (n = 330) had a more medicalized birth than expected. Birth satisfaction was lower with more medicalized births and when incongruence between expectations and experiences was greater. Perceived control mediated the association of actual birth with the different emotions and perceptions of care. However, the place and mode of delivery and incongruence with the plan also had independent associations with birth satisfaction. All in all, research findings on childbirth experiences suggest that personal dispositions, well-being, events of the birth, social support, maternity systems, and one's relationship with personnel affect how childbirth is experienced.

Surprisingly little attention has been paid to social class as a background factor for childbirth experiences. Earlier analyses of birth experiences tended to universalize women's experiences, but more recent texts, at least in the field of sociology, focus on individual and group-based differences. Zadoroznyj (1999) studied the childbirth narratives of 50 Australian women and their childbirth narratives. She found that social class is a significant organizing category for childbirth experiences. With respect to the first birth, working-class women tended to approach their childbirths in a fatalistic way, while middle-class women tended to be much more active, carefully choosing their preferred hospital, care provider, and birth plan. Middle-class women had relatively clear ideas about their preferences and hopes. In subsequent births, a significant shift had happened in many women's approaches. Working-class women had

changed their stance more than middle-class women: they were now active in choosing their care providers and hospitals and expressing their wishes, as they were not happy with how the first birth had been managed. However, many middle-class women also demonstrated a similar shift in their identities, even though perhaps not as pronounced as among working-class women. Similar findings concerning social class have been advanced by Martin (2003), who proposed that middle-class women try to exercise control over their birthing environments and themselves. In line with this, Nelson (1983) found that middle- and upper-middle-class women had more positive appraisals of their birth experiences than women in lower socioeconomic classes.

Alderdice and Gargan (2019) argue that, regardless of the quality of the experience, the event of birth creates an emotional high that often leaves women tired and stressed out in the postpartum period. According to their qualitative study on maternal well-being in the postpartum period, the experience of tiredness might be a defining attribute of new motherhood. Continuous caring for the newborn is intense and requires a lot of learning for new mothers, and often it is difficult to feel good about oneself in the postpartum period. Social isolation may also contribute to the well-being of new mothers, and changes in relationships were often perceived as negative and stressful (Alderdice & Gargan, 2019).

1.2.3 Childbirth ideologies—internal and external control in childbirth

What is expected of women in different phases of the transition to motherhood is dependent on the sociocultural context. The meaning of childbearing for societies is immense because reproduction is the very requirement for societies to continue. Women's reproductive bodies are surveilled and controlled for this exact purpose—societies and cultures are dependent on female reproductive work (Clarke, 1998; Morgan & Roberts, 2012; Yuval-Davis, 1997). Cultures are laden with values and beliefs related to childbearing and motherhood, and they are likely to hugely affect women's experiences. Both external practices such as monitoring, surveillance, and control (Martin, 2003) and internal technologies of gender (Chadwick & Foster, 2013; Das, 2019; Martin, 2003; Westergren et al., 2021) restrict women and nudge them toward certain behaviors in the perinatal period.

In pregnancy, notions of womanhood and motherhood become increasingly important. In societies and cultures, women are targeted with special demands concerning appropriate behavior in pregnancy and preparation for motherhood, which often translates into surveillance (Copelton, 2007) and public scrutiny (Longhurst, 1999). Indeed, in pregnancy, women are especially enculturated into motherhood in their society. Miller (2007) proposed that unrealistic expectations for motherhood are a defining feature of the pregnancy experiences of many mothers, and that these expectations are juxtaposed only when women are confronted with the reality of childbirth and early motherhood. Engaging with "appropriate" preparation for motherhood, including attending childbirth and parenting preparation classes, did not prepare women for childbirth and motherhood in effective ways (Miller, 2007).

An especially interesting event in the process of becoming a mother is childbirth. How childbirth happens in a particular society has been proposed to tell something about the values of that society and the place of women (Zadoroznyj, 1999). There are different orientations to childbirth (see, e.g., Davis-Floyd, 2001; Preis et al., 2019a), and they are manifested in different discourses that circulate in the culture (Baxter, 2011), as well as practices and structures in the care systems (Davis-Floyd, 2001; Kitzinger, 1986; Oakley, 1980). Care systems, the birthing people themselves, their families, and the media each produce their own discourses to create different versions of reality. Those different worldviews are not always compatible between women and care systems (Preis et al., 2019b). In general, childbirth discourses take place on a continuum between the medical and natural. On one end, the medical paradigm depicts childbirth as a risky process that needs to be monitored and controlled; on the other end, childbirth is presented as a natural event that should not be unnecessarily disturbed (see, for example, Beckett, 2005; Preis et al., 2019a). However, important parallels concerning the role of control have been proposed between these approaches; while medical control functions from the outside of women themselves, internalized control is required of women in the model of "natural" birth (Chadwick & Foster, 2013). Women's experiences of childbirth are influenced especially by beliefs about womanhood and the role of motherhood in women's life (Chadwick & Foster, 2013; Hall, 2016), and they partly define if women feel successful in accomplishing their tasks in reproduction and motherhood.

Davis-Floyd (2001) distinguished three different paradigms of birth that are evident in care systems and individual practitioners. In the technocratic model, the birthing body is seen as a machine, separate from mind, and in need of active management. In male-biased medicine, the female body is depicted as untypical and malfunctional. As Davis-Floyd describes, "the metaphor of the female body as a defective machine eventually formed the philosophical foundation of modern obstetrics" (2001, p. S6). As a result of male bias, care of childbirth aims at managing the process of birth with medical interventions. The body is seen as an object, which results in ignoring the birthing woman's subjective feelings and sensations as irrelevant (Davis-Floyd, 2001).

As alternatives for the technocratic paradigm, Davis-Floyd (2001) describes humanistic and holistic views of birth. The humanistic paradigm depicts the body as an organism and emphasizes the mind-body connection. In the case of childbirth, the laboring woman's emotional state may affect the course of labor, and emotional support is often seen as more effective for problems than technological interventions (p. S11). Kindness, touch, and caring are important aspects of good care (Davis-Floyd, 2001).

The holistic paradigm depicts mind, body, and spirit as one, describing the body as an energy field in interaction with other energy fields (Davis-Floyd, 2001). The essential aspect of care in labor and birth is addressing emotions of the laboring woman (p. S16). Both alternative therapies and conventional means of care are used, but they are individualized to each situation and each birthing

person. The goal of any intervention is to promote the free flow of energy (Davis-Floyd, 2001).

Many feminist scholars argue that the medical model, being based on the technocratic paradigm of birth, undermines women's bodies and their ability to give birth (e.g., Davis-Floyd, 2003; Martin, 1987; Oakley, 1980). Modern obstetrics is seen as controlling women through hospital policies and urging them to hand their control over to obstetricians (Maher, 2003; Simonds, 2002). Practices in modern hospitals are seen as controlling women's bodies with the excuse of safety, putting in place numerous technological devices for surveillance and restricting women's abilities to move (Martin, 2003). For example, many interventions, such as routine vaginal examinations, lack robust scientific evidence but are nevertheless used in hospitals (Downe et al., 2013). Women are sometimes urged to give birth in positions that are convenient for doctors but not necessarily for the women themselves, and their sensations are altered with medications (Martin, 2003). Moreover, in the technocratic model, institutional rules appear more important than women's subjective sensations and wishes (Davis-Floyd, 2001). For example, women's entry to the labor ward seems to be more determined by hospital policies than women's actual needs or preferences (Nyman et al., 2011). Martin (2003) sums up the feminist critique and describes that women's birth experiences are regulated and controlled by medical institutions and their technologies through interfering and disciplining women, their bodies, and the birthing process. Indeed, ritualistic aspects of birth tend to reinforce power structures in the society (Barbre, 2022).

The medical or safety discourse in childbirth has been criticized for using the standard curve based on population characteristics as indicative of pathology in individual cases, which causes unnecessary medicalization (Sandall et al., 2010; Stone et al., 2022). This also has consequences for women's confidence in labor. When the subjective, embodied knowledge of the woman is downplayed and information is gathered through technological devices and used as the standard for normality, this probably undermines women's and their caregivers' confidence in normal birth (Stone et al., 2022). The safety discourse ironically does not promote a feeling of safety in mothers but rather leads to an increased awareness of risks (Stone et al., 2022). The safety discourse may thus contribute to fear of childbirth both in women and in caregivers. There might be a similar logic here as that described by Cucchiara and Steinbugler (2021) in the context of motherhood: expert advice does not alleviate anxiety but exacerbates it, as mothers are more aware of all the different decisions and "choices" and their potential consequences.

Traditionally, most of those who critique medicalized childbirth have advocated for a natural model of birth. Natural childbirth advocates argue for the capacity of the female body to give birth without intervention or pain relief, and they depict women as capable and powerful (Beckett, 2005; Martin, 2003). Natural childbirth can indeed be experienced as extremely empowering, and it may help tackle other inequalities by promoting a sense of strength and daringness (Olza et al., 2018). However, it may also narrow the acceptable

birthing options for women by depicting a certain type of birth as favorable (Martin, 2003). Indeed, natural childbirth discourses also require women to actively manage themselves (Martin, 2003; Zadoroznyj, 1999). Internalized technologies of control over the self are encouraged by the natural birth discourses (Chadwick & Foster, 2013; Hall, 2016; Malacrida & Boulton, 2014; Zadorosnyj, 1999). The idealized birth may not be realized for many women, which often results in feelings of guilt and shame (Preis et al., 2019b; Schneider, 2013; 2018; Sonnenburg & Miller, 2021). For example, women with medical needs or risks that require special management in pregnancy and during labor may have quite restricted options regarding their "choices" (Malacrida & Boulton, 2014). Moreover, many women may not experience obstetric technologies as negative, but their experiences are probably much more nuanced and dependent on many different situational and personal factors (Beckett, 2005).

The natural childbirth discourse may thus represent a double-edged sword for gender equality by empowering the women who are well-prepared, healthy, and have lots of resources to help them achieve the empowering birth they wish to have; at the same time, it may alienate and disempower the women who must give birth in medicalized care systems for reasons related to their health, socioeconomic status, literacy, or lack of support. Moreover, women who truly find the medicalized model as suiting their own beliefs and choose, for example, to birth by elective caesarean section, may be perceived negatively by other women and professionals if natural childbirth discourse is dominant (see also Chadwick & Foster, 2013; MacDorman et al., 2008). Moreover, some researchers propose that regardless of their childbirth ideology, women are restricted by technologies of gender in childbirth (Chadwick & Foster, 2013), pressuring them to reproduce normative femininity (Westergren et al., 2021) and overlook their own needs for the sake of appearing nice and kind (Martin, 2003).

Feminist approaches to childbirth have in recent decades problematized dichotomous ways of approaching childbirth. Dualisms such as nature/culture and nature/technology have been presented as reproducing patriarchal notions (Beckett, 2005). Criticism has also been directed at deconstructing "natural," as the natural birth movement is accused of reflecting essentialist notions of womanhood (Annandale & Clark, 1996). Moreover, dividing childbirth ideologies as medical and natural may reflect professional divides and power struggles (midwives versus obstetricians) more than beliefs of childbearing women (see, e.g., Roome et al., 2016), and third-wave feminists have paid increasing attention to the diversity of women's preferences and experiences (see Beckett, 2005). Preis and colleagues (2019) suggest that belief in childbirth as a medical event and childbirth as a natural event may not cancel one another out, but it is possible to have a high level of belief in both notions. Some researchers (e.g., Carter, 2009) propose that women might be able to selectively act or renounce gender-conforming behaviors, prioritizing certain aspects of femininity. Indeed, women's experiences often do not fit these dichotomies, but seemingly contradictory childbirth choices can involve similar mechanics. Chadwick and Foster (2013) show that South African middle-class women opted for home birth

or an elective caesarean section to gain control over the birth. Based on their analysis, Chadwick and Foster (2013) proposed that childbirth is about "doing gender," that is, performing femininity in ways that reinforce or contradict dominant views. They draw interesting parallels between home births and elective cesarean births in the South African context of white femininity. Employing Foucauldian analysis, they identified three technologies of gender that are in play in both types of birth choices: a patriarchal optics of childbirth, the "natural childbirth" ideal, and the "good mother" imperative. Patriarchal optics refers to internalization of an outsider's gaze, which regards the birthing body as uncontrollable, disgusting, and to be practiced upon. Women who chose an elective cesarean section had internalized this view, and women who chose a homebirth constructed this horror as a feature of hospital birth and not childbirth per se. In a similar fashion, the natural childbirth ideal drew on essentialist assumptions of femininity and both elective cesarian birthers and home birthers produced and resisted these assumptions. Women's birth stories were also positioned toward the good mother imperative, which consisted of selfless, exclusive, and constant care (Chadwick & Foster, 2013).

Childbirth discourses are thus closely intertwined with assumptions of femininity, sexuality, and motherhood, and they cannot be understood in isolation. Chadwick and Foster (2013) also study point out that women's "choices" regarding childbirth should not be understood as real choices in all situations, but rather influenced by wider sociocultural factors, and especially by notions of selfless motherhood (see also Carter, 2008; Malacrida & Boulton, 2014). Therefore, motherhood discourses are already in play and affect women's experiences even before the baby is born. Pregnancy and childbirth are already perceived as acts of motherhood (see also Deutscher, 1970).

1.3 Maternal psychological well-being in the transition to motherhood

Psychological well-being in the transition to motherhood consists of many aspects, such as an absence of clinical symptoms (for example, depression or anxiety), a manageable stress level, and the presence of positive feelings, cognitions, and life conditions, such as a feeling of control, a good quality of life, good sleep, and high self-esteem (Jomeen et al., 2004). The components of perinatal mental well-being are sometimes divided into emotional and cognitive well-being (Alderdice & Gargan, 2019). However, well-being should not be considered an either/or construct, implying that all negative emotions are indicators of an illness; instead, the interaction among positive and negative psychological qualities should be more important (Jomeen et al., 2004). Some general well-being measures work well in the perinatal period, but some other measures may be somehow distorted, because there are symptoms (e.g., tiredness) that are normal in pregnancy and may not always be perceived as too

serious in comparison with other aspects of well-being (Alderdice & Gargan, 2019). However, women in low-risk groups (such as psychologically healthy, coupled, middle-class women) can experience significant stress in the transition to motherhood, and it seems that at least primiparity, young age and poor physical health increase the likelihood of experiencing psychological stress (Lynn et al., 2011). Some researchers (e.g., Jomeen et al., 2004) suggest that some distress is normal, and that the focus should be on a balance of stress and protective factors and overall well-being. This is in line with theories on general health psychology (see Antonovsky, 1996), which posit that well-being or health is determined by a complex set of enhancing and deteriorating factors (both in the individual and in the environment). According to Antonovsky (1996), the entire spectrum of well-being/ill-being should be considered. Similarly, Alderdice (2018) calls for research on the whole spectrum of perinatal well-being to better understand different aspects of psychological well-being in the transition to motherhood. In this dissertation, I will concentrate on self-esteem, fear of childbirth, and parental burnout as indicators of maternal psychological well-being or ill-being, and in this way cover some aspects of the full spectrum.

Traditionally, at least in the medical field, experiences of pregnancy and childbirth have been approached from the perspective of infant mental health. Most medical research and expert writings on pregnancy omit the subjectivity of the pregnant woman (Young, 2005). For example, research on maternal experiences has often been restricted to psychopathology, such as postpartum depression, and its consequences for child development (see, e.g., Szarpak et al., 2020). The perinatal period (i.e., pregnancy, childbirth, and the postpartum year), and especially the immediate postpartum time, has been recognized as a risky time for mother's mental health, both for mothers with pre-existing mental health disorders and for those with new-onset disorders (Howard & Khalifeh, 2020). Indeed, it includes many risks for the mother's psychological well-being, including depression, anxiety, and trauma (Ayers, 2004; Howard & Khalifeh, 2020; Jomeen, 2004), especially for marginalized women such as ethnic minorities or poor women (Stevens et al., 2018). These disorders are understood to be obstetric risk factors and hazards for later child development (Howard & Khalifeh, 2020). While this perspective is also important, the focus of the current dissertation is elsewhere. The basic assumption of the present thesis is that mothers' experiences are important in themselves.

Childbearing generates a possibility for psychological growth (Taubman-Ben-Ari, 2009), but sometimes the transition is overwhelming (Ayers et al., 2006; Brodén & Kivirauma, 2006; Dennis et al., 2017). During pregnancy, childbirth, and the postpartum period, control over the body may be diminished as physical changes take place. Many pregnant women experience their bodies as uncontrollable and difficult to manage (Neiterman & Fox, 2017). These experiences create stress and require coping strategies. Moreover, fear of childbirth (Saisto & Halmesmäki, 2003), low self-esteem (Jomeen, 2004; Lowe, 2000), negative or traumatic childbirth experiences (Ayers, 2004; Beck, 2003), and parental burnout (Mikolajczak & Roskam, 2018) are all conditions that complicate

the transition, and they may indicate difficulties in the psychological process. In the existing literature, however, they are often decontextualized from the psychological tasks and treated as separate disorders (e.g., on fear of childbirth, see Saisto & Halmesmäki, 2003). Jomeen (2004) suggests that the status of psychological health should be understood as a multidimensional construct that impacts the mother's well-being throughout the transition. Part of this dissertation research will concentrate on explaining such difficulties as poor childbirth experiences and parental burnout in terms of self-esteem, which seems to work in interaction with other variables (i.e., fear of childbirth and perfectionism).

1.3.1 The role of self-esteem in the transition to motherhood

Self-esteem refers to the subjective evaluation or belief of one's own worth or value (Jordan et al., 2015). It is manifested in feelings of self-worth, self-respect, and self-acceptance (Rosenberg, 1989). High self-esteem includes feelings of being good enough and accepted by others but does not reflect a belief that one is superior or better than others (Rosenberg, 1989). It does not reflect a person's real talents or abilities, nor does it tell how others see the person; rather, it shows their own beliefs about themselves (Orth & Robins, 2014). Self-esteem can thus be understood as part of psychological well-being but also as related to identity and social relationships; it comprises intrapsychic and interpersonal components (see, e.g., Crocker, 2011). There are differences in the average level of self-esteem according to gender (men typically show higher self-esteem than women) and ethnicity (Black people show a sharper increase in adolescence and a sharper decrease in old age than White people) (Orth & Robins, 2014). Self-esteem affects success in many life domains, such as school, studies and occupation, relationships, persistence in difficult situations, and recovering from failures or social rejection (Jordan et al., 2015). Self-esteem is strongly shaped in early childhood and good self-esteem represents security formed in early relationships; in adverse conditions, however, a child may internalize a belief about their own inferiority, which translates into low self-esteem (Cooper & Magagna, 2005).

High self-esteem is proposed to be an important resource in life; it has been shown to support adjustment in life transitions in general (Jordan et al., 2015), as well as in the transition to parenthood (Chen et al., 2016; Hutchinson & Cassidy, 2021) and pregnancy and childbirth (Jomeen, 2004); low self-esteem, in turn, may interfere with the ability to cope. In a review article on the well-being of childbearing women, Jomeen (2004) recommends that self-esteem should be studied both as a main effect and as an interaction effect with other psychological variables. It is possible that self-esteem also shapes the transition to motherhood, at least partly. High self-esteem may protect from anxiety and the uncertainty inherent in childbearing; it may also serve as a buffer in the face of disappointment and shame caused by unmet expectations that occur in many births (Preis et al., 2019b). Low self-esteem, in turn, may make childbirth more challenging for various reasons.

Theoretically, there are at least three mechanisms (Jordan et al., 2015) that may put individuals with low self-esteem at a disadvantage in the transition to motherhood: First, they are less likely to engage in behaviors that promote good physical health and may consequently be less prepared for the physical and emotional challenges of childbirth. Second, they experience elevated and prolonged cortisol responses to stressful situations, which may make childbirth and the immediate postpartum period more fearful experiences for them. Third, their interpersonal relationships are of poorer quality than those of others (Jordan et al., 2015), which means they probably need to cope with less support during pregnancy, birth, and the postpartum period. Moreover, when feeling insecure, people with low self-esteem are more likely to engage in self-protective but relationship-damaging (hostile or distancing) behavior (Stinson et al., 2008). This mechanism may be particularly detrimental to their childbirth experience, since it reduces the probability of receiving supportive and empathetic care, which has been shown to be an important factor for birth satisfaction (Dencker et al., 2020; Rubashkin et al., 2018). These mechanisms may contribute to a more complicated and prolonged labor, which increases the risk of having a negative birth experience (Chabbert et al., 2021). Self-esteem may thus operate on several levels in childbirth, affecting physical, psychological, and social processes contributing to the overall evaluation of the experience (see also Saxbe, 2017).

Transition to motherhood is an especially interesting topic regarding mother's identity development. Childbearing, by nature, represents liminality, and boundaries between persons, identities, and social roles are in flux (Barbre, 2022). For this reason, a need for reworking one's self-definitions arises (Mercer, 2004). In childbirth, a rapid change from being pregnant to being a mother happens, requiring change in self-understanding (Ulriko, 2019). However, little is known about which psychological characteristics affect how mothers experience the transition, especially childbirth. Most of the existing research is based on qualitative methods or clinical reports and self-esteem is rarely measured with validated tools. Moreover, the focus of research on maternal well-being has strongly been on psychopathology and the full spectrum of well-being has rarely been considered (see also Antonovsky, 1996). Only in recent years has the literature started to cover some aspects of individual dispositions, such as personality traits and their relation to childbirth experiences (Asselmann et al., 2021).

Following the developmental theory of Erikson (1950) and later psychoanalytical theories (e.g., Raphael-Leff, 2001), it is plausible to expect that major transitions are possibilities to rework previous developmental themes (see also Brodén & Kivirauma, 2006), and they may affect general self-esteem in the long run. For example, if a mother can resolve the developmental origins of her low self-esteem and rework it to a better solution, in Eriksonian terms, the whole ensemble of her psyche will be positively affected. And conversely, if the transition is experienced as confirming one's negative self-perceptions and low self-esteem, this may make it even harder to challenge the negative self-image later on. Moreover, the bodily nature of pregnancy, childbirth, and the

postpartum period is likely to invoke changes in self-conception, very much like in puberty. These changes may be even considered normal, as the transition to motherhood includes huge changes to mothers' bodies, minds, and social roles and responsibilities. Indeed, research findings propose that self-esteem or self-confidence affects how women experience childbirth (Lowe, 2000) and motherhood (Taubman-Ben-Ari, 2009), but this research is scarce and often restricted to context-specific variables.

Self-esteem is very little studied in terms of the transition to motherhood. We can assume, however, that if the expectant mother's experience of her own childhood has been that "no one understands, no one cares, no one can help" (Cooper & Magnana, 2005, p. 41), the core experiences that create low self-esteem, the transition to motherhood, must be very difficult. Specifically, if the laboring woman's beliefs are such, how can she survive labor in an emotionally healthy way? What if she also suffers from fear of childbirth? And what about parenting in a cultural environment that promotes the intensive mothering ideology and creates insufficiently high standards for mothers? What if the mother is a perfectionist and her goals for motherhood are unrealistically high? The present thesis sheds light on these questions.

1.3.2 Perfectionism in the transition to motherhood

Perfectionism can be broadly defined as an individual's general tendency toward excessive concern for maintaining very high standards and harsh criticism in the face of errors (Curran & Hill, 2019). It has been conceptualized in many ways, one of the most well-known being that of Hewitt and Flett (1991). The model of Hewitt and Flett differentiates between intrapsychic and interpersonal aspects of perfectionism (Curran & Hill, 2019). *Self-oriented perfectionism*, according to Hewitt and Flett (1991), is a combination of excessively high expectations of oneself, combined with harsh self-criticism. *Socially prescribed perfectionism* means that people perceive their social context as overly demanding and judging of errors, and perfectionism serves as a means to secure other people's approval. *Other-oriented perfectionism* involves high standards for other people, such as one's partner or children, and criticism toward them if they are perceived to not reach those standards (Hewitt & Flett, 1991).

Perfectionism seems to have increased at the population level in recent decades. Curran and Hill (2019) made a large meta-analysis on college students in the United States, Canada, and the United Kingdom and found that from the 1980s onward, the general level of multidimensional perfectionism has increased in the population. This finding applied to self-oriented perfectionism, socially prescribed perfectionism, and other-oriented perfectionism (Curran & Hill, 2019). The authors explain this increase with the neoliberal governance and competitive individualism in a culture that places increasing responsibility on individuals and supports competition between people. One explanation that they offer is that parents have become more demanding of children in this kind of environment. However, when receiving criticism from other researchers for assigning parental blame (Soenens & Vansteenkiste, 2019), the authors responded by clarifying their

aim to present multiple pathways to perfectionism and agreeing that parents are not to blame (Hill & Curran, 2019). More recently, however, based on two meta-analyses, Curran and Hill propose that "increases in parental expectations and parental criticism offer the most plausible explanation for rising perfectionism to date" (Curran & Hill, 2022, p. 107). This debate highlights how the current parenting culture is contested, with experts attributing various difficulties in children to parents' behavior and other experts defending parents against the blame.

Overall, parenting has become increasingly demanding and parenting standards have risen in recent decades (Hays, 1996; Ishizuka, 2019), often disproportionately targeting mothers (Hays, 1996; Henderson et al., 2016). This rise in standards has made it necessary for parents to be concerned about various topics that were previously perceived as trivial or simply not acknowledged at all. For example, children's safety is now increasingly monitored, as risk culture has been widely promoted by the media (Douglas & Michaels, 2004). This increase in parental standards is likely to be visible in the transition to motherhood; it is targeted especially at mothers in this period, since it is (biological) women who carry children, give birth to them, and breastfeed them.

A demanding culture may contribute to increasing perfectionism in parents and make the transition to motherhood more difficult. Perfectionism may indeed play an important role in the transition to motherhood. For example, the relationship between perfectionism and postpartum well-being has been discovered in many studies. Price and colleagues (2020) found in a sample of primiparous British women that higher perfectionism and intolerance of uncertainty were associated with more negative appraisals of the birth experience and a higher probability of experiencing postpartum traumatic symptoms. Perfectionism also independently predicted a more negative mood in the postpartum period, regardless of the quality of the birth experience. However, even though their study included a multidimensional perfectionism scale, they reported the results only for the whole scale and not according to each dimension. In line with this, the role of perfectionism for postpartum depression has been found in many studies (Gelabert et al., 2011; Hassert et al., 2018; Jackman et al., 2017; Oddo-Sommerfeld et al., 2015), and its socially prescribed components (Hassert et al., 2018) and great concern about mistakes (Gelabert et al., 2011) have proven to be crucial in the relationship. Moreover, several moderating factors have been proposed in the relationship between perfectionism and postpartum depression and anxiety; it seems that an external locus of control (i.e., belief that events are out of one's control; Jackman et al., 2017) and social support (Arnold & Kalibatseva, 2021) may protect from the negative effects of perfectionism.

All in all, it seems that perfectionism may increase ill-being throughout the transition to motherhood, increasing anxiety and depression in pregnancy (Oddo-Sommerfeld et al., 2015), lowering the appraisal of the quality of the childbirth experience (Price et al., 2020), and increasing anxiety (Arnold & Kalibatseva, 2021), depression (Arnold & Kalibatseva, 2021; Gelabert et al., 2011; Hassert et al., 2018), and posttraumatic symptoms (Price et al., 2020) in the

postpartum period; as well as jeopardizing the mother-infant relationship (Oddo-Sommerfeld et al., 2015). In later parenting, perfectionism is known to be a risk factor for parental well-being, increasing the probability for parental burnout (Lin et al., 2022; Sorkkila & Aunola, 2020).

1.3.3 Fear of childbirth jeopardizes well-being

Pregnancy is often depicted as a time full of joy and anticipation, but for some people it is a troublesome period because of fear of childbirth (FOC). There is no uniform definition for fear of childbirth, but most of the published research conceptualizes childbirth-related fear as a medical condition in the domain of anxiety (Huizink et al., 2004; Wijma et al., 1998). It is most often conceptualized as a continuum ranging from no fear to severe fear (or "tokophobia") (Nilsson et al., 2018; O'Connell et al., 2021). Most pregnant women (up to 80%) express at least some fear or concern toward upcoming labor and birth at some stage of pregnancy, and the fear tends to increase as pregnancy advances (O'Connell et al., 2021). This finding suggests that to some extent, fear is normal, especially in the third trimester of pregnancy. Contradicting findings have, however, been found in some studies (Hendrix et al., 2022), suggesting that fear tends to decrease as pregnancy advances. Hendrix and colleagues (2022) have also suggested that women with FOC actively seek help to manage their fear. While some fear is normal, "fear of childbirth" or "tokophobia" refers to the most intensely fearful end of the spectrum and it has debilitating effects on the well-being (Wigert et al., 2020), birth experiences (Handelzalts et al., 2015; Larsson et al., 2015), and healthcare costs (Nieminen et al., 2017) of the women it concerns.

Interest in fear of childbirth has significantly increased in the latest decades of empirical research and clinical practice, and today it is a vastly researched topic (O'Connell et al., 2017; Pazzagli et al., 2015). Across studies, there is considerable variation in definitions, measurement tools, cutoff scores, and measurement times (first, second, or third trimester in pregnancy); for these reasons, prevalence scores vary greatly (O'Connell et al., 2017). As a result of systematic review and meta-analysis, O'Connell and colleagues (2017) found a pooled estimate of 14% for worldwide prevalence, and they note significant heterogeneity in regard to screening tool, screening trimester, and parity. In addition, the prevalence varied in different countries and different historical time periods, suggesting that severe FOC prevalence is higher in Australia than in Scandinavia or the rest of Europe, and that it appears to be increasing after the turn of the millennium in all regions (O'Connell et al., 2017).

FOC can be conceptualized from different viewpoints. From a medical point of view, FOC is an anxiety disorder belonging to an individual woman (Huizink et al., 2004; Wijma et al., 1998). Predisposing factors include other mental health disorders (Rouhe et al., 2011; Zar et al., 2002) and vulnerabilities such as personality factors (Asselmann et al., 2021; Ryding et al., 2007). Treating fear effectively will reduce suffering and prevent subsequent problems, such as traumatic experiences of childbirth or postpartum depression (Rouhe et al., 2015). Treatment can include individual counseling focusing on information and

correcting of false beliefs about childbirth, psychoeducation (Striebich et al., 2018), group counseling (Rouhe et al., 2015; Striebich et al., 2018), or, in some cases, the promise of a caesarean section by maternal request (Gnanasambanthan & Datta, 2020).

From a developmental point of view, FOC can be understood as an indicator of difficulties in the psychological process in pregnancy (Brodén & Kivirauma, 2006; Raphael-Leff, 2001). Its origins lie in previous negative or traumatic experiences with early caregivers or intimate partners (Heimstad et al., 2006; Lukasse et al., 2010; Schroll et al., 2011), as unresolved mental issues prevent the pregnant person from resolving pregnancy-related inner conflicts. Treatment includes psychotherapy that specifically addresses the relationship between the mother and unborn baby and aims at helping with unresolved developmental tasks (Brodén & Kivirauma, 2006; Raphael-Leff, 2001).

Finally, from a sociocultural point of view, FOC is a manifestation of different cultural and structural factors, such as incompatibility of birth beliefs between the woman and hospital staff (Preis et al., 2018; Preis et al., 2019a; Preis et al., 2019b); hospital policies that may not be adapted to the individual mother's needs (Byrne et al., 2017) and may sometimes be abusive or neglectful (Bohren et al., 2015; Vihreäsalo, 2022); structural issues in the society, such as poverty, abuse, racism, and sexism, which disproportionately affect the perinatal mental health of the most vulnerable groups (Stevens et al., 2018; Ternström et al., 2015); and cultural images of good motherhood that cause worries and performance anxiety in many women (Hall, 2016; Martin, 2003). Moreover, a lack of social support (Dencker et al., 2020; Laursen et al., 2008; Lukasse et al., 2014) and dissatisfaction with one's partnership (Saisto et al., 2001) are also proposed to be contributory factors, indicating that women's needs are not being met in the perinatal period. This also represents mistreatment, as it can be interpersonal or represent systematic failures of health care institutions and systems (Bohren et al., 2015). Further, the assumption of fear of childbirth as situated in individual women has also been challenged; it has been proposed that fear actually resides in the culture and is induced in women by cultural stories of female incompetence and the discourse of childbirth as risky (Fisher et al., 2006). It has been asked "are women afraid or are we?", meaning that childbirth fear is misplaced on women when it more accurately reflects professionals' fear (Dahlen, 2010). Indeed, Striebich and colleagues (2018, p. 98) propose that increasing levels of FOC are at least partly caused by medicalization of childbirth, increasing use of technological interventions, and a lack of cultural competence in obstetricians.

Fear of childbirth can have a severe impact on the expecting woman, causing physiological symptoms (palpitations, dizziness); negative thoughts, beliefs, and expectations; catastrophizing; and avoidance behavior (Rondung et al., 2016). In a metasynthesis of qualitative studies, Wigert and colleagues (2020) concluded that women with fear of childbirth experience being at a point of no return and unable to turn back from their situation. The researchers conclude that women need support that can meet their existential issues of being in such a point.

Traditionally, FOC is defined as primary fear in nulliparous women and secondary fear in multiparous women, resulting from previous negative or traumatic childbirth experiences (Hofberg & Brockington, 2000; O'Connell et al., 2017). However, FOC seems to be a multifaceted phenomenon, with individual variation in causes, contents, and outcomes of fear (Rondung et al., 2018). Rondung and colleagues (2018) investigated 206 women in mid-pregnancy reporting fear of birth. As a result of cluster analysis, they classified the participants into five groups: overall low symptom load, general high symptom load, medium symptom load with high performance-based self-esteem, blood- and injection phobic anxiety, and specific anxiety symptoms. Both nulliparous and parous women were represented in all clusters. The authors concluded that fear of childbirth is not easy to understand through one explanation or model, but several explaining mechanisms are possible. They also recommend that interventions in health care should be diverse and individually suited for each woman rather than based on parity only (Rondung et al., 2018).

Most of the existing research treats women with FOC as a homogenous group, despite findings that propose it to be a multifaceted phenomenon (e.g., Dencker et al., 2020; Rondung et al., 2018). It would thus be important to know how women with fear of childbirth differ from one another and how care could be individualized to better meet the different needs of the women it concerns. The present dissertation research concentrates on differences among childbearing women and seeks to identify how self-esteem shapes birth experiences and maternal well-being before and after childbirth. This knowledge will be useful in understanding the psychological variations among women with FOC and contribute to theory formation and clinical practice.

1.3.4 Parental burnout—ending up in despair

Traditionally, developmental psychology has held children and their well-being as its core focus. In this kind of framework, maternal experiences and well-being are reduced to means of producing well-being in children, not considered interesting for their own sake. Mikolajczak and Roskam (2020) argue that parents have been seen as means to achieve certain developmental outcomes in children and, in this way, they have been "instrumentalized" in the service of their children's development and best interest (p. 2). However, things seem to be changing, and new avenues in research are developing. The rapidly growing literature on parental burnout explicitly states that parental experiences and mental health are important in their own right (Mikolajczak et al., in press).

Parenting can offer us a deep sense of meaningfulness and joy, but it can also be frustrating and tiring. Even though all parents sometimes feel stressed out, parental burnout is something else. As a stress-related syndrome manifested in the parenting domain (Mikolajczak et al., in press), parental burnout develops as a process, from overwhelming exhaustion to detachment and alienation from children to deep discontentment with the parental role and, finally, an experience that one has become such a bad parent that they do not recognize themselves anymore (Roskam et al., 2018). Parental burnout is conceptualized by four

dimensions: 1) an overwhelming exhaustion in regard to parenting; 2) contrast with previous and current forms of parental self-image (feeling that one is not as good a parent as before and the shame related to that); 3) feelings of being fed up with parenting and unable to stand it anymore; and 4) emotional distancing from children (minimum investment in parenting-related tasks and avoiding emotional contact with children) (Roskam et al., 2018). Parents experiencing burnout do not feel joy when interacting with their children: for those parents, parenting has become an endless and very demanding task where nothing is ever enough (Hubert & Ajoulat, 2018). They feel guilty about everything, nearly all the time, and do not believe themselves capable of fulfilling expectations, either their own or those of others (Mikolajczak et al., 2018).

Parental burnout occurs when stressors exceed resources, and this mismatch continues for a long time (Mikolajczak et al., in press). It is a syndrome resulting from overwhelming and continuous experiences of stress in the parenting domain (Mikolajczak & Roskam, 2018), and it can be tracked in various ways. In addition to parents' lived experiences (César et al., 2018; Hubert & Ajoulat, 2018) and affective symptoms (Mikolajczak & Roskam, 2018), there are changes in the biomarkers of the parents suffering from burnout; for instance, Brianda et al. (2020a) found out that the hair cortisol levels of burned-out parents were twice as high as in control parents. Following treatment for parental burnout, hair cortisol levels went back to normal (Brianda et al., 2020b).

Surprisingly little variation in parental burnout can be explained by demographic variables of the parents or the family (Mikolajczak & Roskam, 2018). Instead, it seems that individual characteristics of the parent, the child(ren), family functioning, support, and lack of leisure time explain more of the variance in parental burnout (Mikolajczak et al., in press). Parental burnout is associated with parenting styles, with an authoritarian parenting style increasing the risk and authoritative or permissive parenting styles reducing it (Mikkonen et al., in press). Moreover, the quality of coparenting affects the risk of parental burnout, with coparenting conflict increasing it and endorsement by the partner reducing it (Favez et al., 2022). Interestingly, individual predispositions and behaviors also affect the risk. For example, parents' perfectionism is associated with parental burnout (Mikolajczak et al., in press; Sorkkila & Aunola, 2020).

Some of the risk factors for parental burnout function at the cultural level; for example, high cultural individualism has been shown to increase the probability for parental burnout (Roskam et al., 2021). Gender equality as a cultural trait and gender equality beliefs at the individual level are especially interesting in the context of parental burnout. On average, parental burnout levels are higher in women than in men (Roskam & Mikolajczak, 2020), and part of this is explained by the fact that parenting remains a highly gendered activity even in the most egalitarian countries (Bianchi et al., 2012; Coltrane, 2000; Roskam et al., 2022). Indeed, Roskam et al. (2022) found that holding strong egalitarian values at the individual level and living in a country where gender equality is advanced at the societal level were associated with higher levels of parental burnout in mothers. This finding was not dependent on socioeconomic

differences at the individual or societal level. The authors conclude that "gender equality backfires on mothers" (Roskam et al., 2022, p. 159) when equality is advanced in many other areas in life but inequality still prevails in parenting. The authors explain the mechanisms behind their findings in three ways: unfulfilled expectations in mothers concerning shared parenthood and related frustration; different social comparison processes across countries (in egalitarian countries, mothers usually compare themselves to fathers, which increases their suffering caused by gender inequality, whereas in less egalitarian societies mothers compare themselves with other mothers, which protects them from the experience of inequality) (Roskam et al., 2022, p. 160); and, finally, the economic, psychological, and social value of having a child may be reduced for mothers in egalitarian countries, compared to less egalitarian countries, because of the norm of intensive motherhood (with more costs economically and psychologically) and more varied sources of identity and social status apart from motherhood.

Perfectionism is an especially interesting background factor for parental burnout, because although it is undeniably a feature of individual personality, it also includes social components (Hewitt & Flett, 1991; Hill & Curran, 2016). It seems that all three components of perfectionism as described by Hewitt and Flett (1991) contribute to the development of parental burnout: Sorkkila and Aunola (2020) found in a sample of Finnish parents that socially prescribed perfectionism is a more important risk factor for parental burnout than self-oriented perfectionism; however, self-oriented perfectionism was found to further increase the risk. Furthermore, Lin and colleagues (in press) found in a sample of Polish parents that child-oriented perfectionism and especially discrepancy (parents' perception that their children failed to meet their standards and expectations) was a risk factor for parents burning out. In their study, emotional intelligence in parents mitigated the effects of child-oriented perfectionism. The authors propose that current parenting norms (warm and supportive) are in contrast with how child-oriented perfectionism is often manifested (the need to express high standards to one's child(ren)), and this contradiction is a burden for perfectionist parents, increasing their probability for parental burnout. Another possible explanation could be that parents feel unduly blamed for their children's errors and shortcomings and this may make them feel that they are not good enough, no matter how hard they try. After all, children are not infinitely malleable, and even parents' best efforts do not always solve their children's problems.

It is possible that high societal demands explain why parental burnout levels are higher in women than in men (Mikolajczak & Roskam, 2018); perfectionist beliefs about motherhood may be hard to resist (Henderson et al., 2016), and they may predispose mothers to burnout. Rodriguez Castro and colleagues (2022, p. 462) even conclude that "burdensome feelings, such as stress, shame and guilt are prevalent in experiences of motherhood." Also, self-discrepancies, that is, the self-perceived gap between how one is and how one should be, increases the probability of parental burnout (Roskam et al., 2021). It is thus probable that how one perceives oneself as a parent is not only indicative

but also predictive of parental burnout. However, it remains unclear if longitudinal trajectories of ill-being beginning already in pregnancy help to explain parental burnout in the long run. Because multidimensional perfectionism is a risk factor for both perinatal ill-being and later parental burnout, theoretical models for mothering should ideally consider mothers' perinatal experiences as background factors for later development.

The rapidly evolving scientific literature on parental burnout has revealed the central components of burnout (Roskam et al., 2018), antecedents and risk factors (Gato et al., 2022; Mikkonen et al., in press; Mroskova et al., 2020), and consequences (Mikolajczak, Gross, & Roskam, 2019), as well as the explaining mechanisms of parental burnout (Mikolajczak & Roskam, 2018). In addition, protecting factors have been proposed (Lebert-Charron et al., 2022; Lin et al., 2021; Mikolajczak & Roskam, 2018). However, to gain a better understanding of the complex dynamics between individual and societal risk and protective factors, we should better understand the role of the perinatal period. Parenting is affected by psychological structures, such as self-esteem formed in childhood, that may serve as risk or protective factors. Moreover, parenting starts to develop in the imagination even before conception, evolves through pregnancy, is affected by childbirth experiences and postpartum, and continues to evolve later (see, e.g., Brodén & Kivirauma, 2006; Raphael-Leff, 2001). One of the aims of this dissertation is to discover how self-esteem, developed in early interaction with our own childhood caregivers, functions in relation to the risk of burning out. Moreover, this dissertation studies the perinatal period, which has its own risk and protective factors. This knowledge will help to build later research that considers the special characteristics of the perinatal period for the well-being of mothers.

1.4 Motherhood discourses and ideologies

Mothers' experiences and well-being are also affected by the society and the culture in which they live. New mothers are confronted in society with multiple messages of what it means to be a mother (Abetz & Moore, 2018; Christopher, 2012; Collins, 2019; Dow, 2016; Perälä-Littunen, 2018), and those cultural images shape their self-understandings and can affect their well-being and self-esteem. They must live with the overwhelming bodily changes that take place during the transition while also managing social expectations to look and behave in certain ways (Hutchinson & Cassidy, 2020; Kazmierzak & Goodwin, 2011; Martin, 2003). New mothers often struggle with the discrepancy between motherhood myths and reality (Choi et al., 2005), and greater discrepancy between the ideal mother and perceived self-as-mother has been found to be related to postpartum depression (Sonnenburg & Miller, 2021). New societal demands emerge for new mothers. For example, new mothers must negotiate their relationships with work and motherhood (Blair-Loy, 2003) and how to manage their responsibilities in the face of practical and cultural restrictions (Collins, 2019). Modern mothers do

not usually abandon their work but take some time off and then return to the workplace. However, requirements collide when women are urged to devote their full time and energy to at least two life areas at the same time. Blair-Loy (2003) found in her research on US women executives that they experienced conflict between two cultural expectations: devotion to the work schema and devotion to the family schema. Both schemas expected them to see either work or family as their main responsibilities in life and this created conflict and feelings of inadequacy, as they could not be fully present in both tasks at the same time.

Apart from work, motherhood is also often full of tensions. Mothers must negotiate their relationship with different motherhood ideologies, which have multiplied and solidified in the new millennium (Abetz & Moore, 2018). Modern and traditional values continue to exist aside one another, and this creates discursive tensions over the meaning of motherhood (Baxter, 2011). For example, gender equality as a value encourages women to build their own careers and seek equality in their relationships to men. However, ideologies that represent traditional values, such as familism (Cotter et al., 2011; Jallinoja, 2006) and intensive mothering (Hays, 1996; Liss, 2013; Perälä-Littunen, 2018), urge women to see parenting as a gendered task and put extensive time and effort into managing motherhood the best as possible.

Women perform motherhood already in pregnancy and childbirth, but when the baby is born, mothering becomes newly defined. In the postpartum period, women often experience a rapid change that is perceived as transformational (McMahon, 1995). While women receive a lot of attention and information during pregnancy, their experiences in postpartum often include feeling neglected, abandoned, and unprepared (Neiterman, 2013). The change from being needed to redundant is abrupt. However, women themselves may feel that they continue to share their bodies with their babies (Neiterman, 2013). In addition to these confusing experiences, caring for a newborn is emotionally and physically intense work. Parenting may not be highly appreciated in our society (Sánchez-Rodríguez et al., 2019), but at the same time, many parents experience high demands in terms of caring for and educating children (Meeussen & VanLaar, 2018). This kind of framework for parenting—a lack of respect combined with high demands—is challenging. Furthermore, our cultural beliefs make special demands of mothers, pressuring them to adhere to high standards (Hays, 1996; Henderson et al., 2016; Liss et al., 2013). These beliefs are manifested in different motherhood discourses.

Motherhood discourses are the meaning systems of motherhood that circulate in a culture (Baxter, 2011). Different discourses encompass different mothering ideologies and define what is good mothering and what role motherhood should take in women's lives (Gunderson & Barrett, 2015; Hays, 1996). Historical and cultural factors, such as gender-equality beliefs, shape motherhood discourses (Gilbert, 2008). Many researchers propose that despite earlier advances, the development of gender equality has stalled in Western countries since the mid-1990s (Cotter et al., 2011; England, 2010; Knight & Brinton, 2017). Traditional ideas have been quite popular in the new millennium in

Western countries; for example, the rise of familism (Cotter et al., 2011), which has also been recognized in Finland (Jallinoja, 2006), promotes traditional gender roles as beneficial for children. In its new egalitarian form, this type of ideology promotes traditional family roles while at the same time emphasizing gender equality and individual freedom of choice (Cotter et al., 2011).

Aside from familism, most Western cultures encompass an ideology of intensive motherhood (Hays, 1996; Henderson et al., 2016; Liss et al., 2013). In this ideology, individual mothers are responsible for managing every small detail of their motherhood to make their children as happy and healthy as possible. Mothers are expected to follow detailed expert advice to ensure the optimal development of their children. This emotional and intellectual labor (Cucchiara & Steinbugler, 2021) involves considerable effort to gather and synthesize knowledge and use it to guide one's behavior. At the same time, motherhood is understood as natural and inherently enjoyable to all women (Hays, 1996). Based on the work of Hays (1996), Loyal and colleagues (2022, p. 625) describe the central tenets of the intensive mothering ideology: "mothers are the best caregivers for children; parenting is a difficult, all-consuming, child-centered and expert-guided activity, as well as the most important and fulfilling job; and children must be cherished because of their innocence and preciousness." This ideology is built upon essentialism (females' superior ability to parent), fulfillment (parenting is rewarding), challenge (parenting is difficult), stimulation (children need cognitive stimulation) and child-centrism (the child's individual needs and rhythms should be respected) (see Liss et al., 2013).

This ideology has been identified as dominant since World War II in the US (Gunderson & Barrett, 2015) and elsewhere, including Finland (Perälä-Littunen, 2018). Standards for mothering seem to be escalating even, due to media influences (Douglas & Michaels, 2004) and social media (Abetz & Moore, 2018). Mothers may set high standards for themselves (self-oriented perfectionism; Hewitt & Flett, 1991) and their children (child-oriented perfectionism; Lin et al., 2022), or they may perceive that other people require very much of them as parents (socially prescribed perfectionism; Hewitt & Flett, 1991), and all of these may contribute to gendered pressure that they experience in the parenting domain.

Beside mothering, women are often pressured to adhere to high standards in other domains as well. Based on her research on middle-class, White women in the US, Blair-Loy (2003) proposes that women are affected by two competing schemas: devotion to family and devotion to work. Devotion to the family schema means that women should consider family life as the most precious arena in life and place their own interests as secondary to those of their husband and children. Devotion to the work schema means that women should commit their strivings and energy to the occupational world. These contradictory schemas may cause them to feel guilty and inadequate when they cannot adhere to both standards at the same time (Blair-Loy, 2003). Similar findings have been reported in other Western countries as well, including Australia (Rodriguez Castro et al., 2022) and Europe, for example, Italy and Germany (Collins, 2019), as well as

Finland (Helenius, 2020). However, women also try to reconcile contradicting ideals by making practical decisions about work and childcare and by reframing their mothering beliefs (Blair-Loy, 2003; Christopher, 2012; Dow, 2016). Part-time work, for example, may serve to achieve the most success in both areas (see Blair-Loy, 2003).

Intensive mothering beliefs seem to be more common among mothers than childless women (Liss et al., 2013; Loyal et al., 2022), and mothers' gender role attitudes seem to become more traditional after the birth of a child (Baxter et al., 2015). In a French study of intensive mothering beliefs and maternal mental health in the transition to motherhood (Loyal et al., 2022), it was found that intensive mothering ideology increases after childbirth in both nulliparous and parous women, and that this change happened mainly between pregnancy and two or four months postpartum, but not between two and four months postpartum. Moreover, multiparous women reported more challenge and sacrifice beliefs (i.e., beliefs that childrearing is difficult and beliefs that mothers should set aside their own needs for the well-being of their children). Changes in mothers' beliefs were studied in relation to maternal mental well-being, and it was found that growth in sacrificial beliefs was detrimental for mothers' well-being. (Loyal et al., 2022).

However, mothers themselves both contribute to and resist dominant mothering ideologies and discourses. Lankes (2022) found in her study on different dimensions of intensive mothering that mothers are selectively intensive: that is, they simultaneously "do" and "undo" intensive mothering, and their beliefs vary by socioeconomic group. The biggest group of mothers in her research was "relaxed mothers" (33 percent), which is somewhat surprising given that most of the previous research demonstrates the ubiquity of the intensive mothering ideology (e.g., Henderson et al., 2016; Loyal et al., 2022).

1.5 The Finnish childbearing and mothering context

The Finnish context is interesting and fruitful for studying childbearing and motherhood. In Finland, 49,726 children were born in 2021, which was a slightly higher number than the generally declining fertility trend in the last decade (Official Statistics of Finland, Perinatal Statistics, 2022). Maternal age has been increasing, and in 2021 the average maternal age at the birth of the child was 31.6 years (Official Statistics of Finland, Perinatal Statistics, 2022). Maternity health care, based on the Nordic welfare state model, is equally available at almost no cost (only some services, such as staying in the hospital, have a very low cost) for everyone (Viisainen, 2001). Antenatal health care is organized in maternity health centers at no cost, and almost all Finnish women utilize these services. Being pregnant and birthing are very safe in Finland, with one of the smallest maternity and infant mortality rates in Europe (Euro-Peristat Project, 2015). Almost all childbirths (99.3% in 2021) happen in hospitals (Official Statistics of Finland, Perinatal Statistics, 2022) in a medicalized system (Leppo & Itkonen,

forthcoming). Midwives are in charge of the majority of births in hospitals, but they work in collaboration with and under the supervision of obstetricians (Viisainen, 2001). After giving birth, women typically stay two to three days in a postpartum unit with the newborn before being discharged (Official Statistics of Finland, Perinatal Statistics, 2018). There are currently 23 maternity hospitals in Finland, and the number of births in those hospitals ranged from 281 to 9,223 births in 2021 (Official Statistics of Finland, Perinatal Statistics, 2022). A total of 35.4% of all births happened in the Helsinki capital and Uusimaa district hospitals. There were 119 planned home births in 2021, and 103 babies were born accidentally on the way to the hospital (Official Statistics of Finland, Perinatal Statistics, 2022).

It could be assumed that the Nordic welfare state is a place where fear of childbirth is not so common. However, Scandinavian countries in general have quite high rates of fear of childbirth, with recent estimates from 12% (O'Connell et al., 2017) to 14.3% (Nilsson et al., 2018). Fear of childbirth in the Finnish context is most often framed through the technocratic model (Davis-Floyd, 2001), which defines fear of birth as a medical problem in the domain of anxiety. In Finland, the medical view is predominant in care systems and "fear clinics" in Finnish hospitals work on this basis; they serve the double agenda of treating women's fear and exercising professional power and scrutiny to steer them toward vaginal birth, which is perceived as the safest option (Leppo & Itkonen, forthcoming). In Finnish culture and health care systems, the developmental view on fear of childbirth has also rapidly gained a foothold as psychotherapy for early interaction becomes increasingly popular. In psychotherapeutic journals, fear of childbirth is listed among the signs that indicate a disruption in the intrapsychic process of pregnancy. For example, Sarkkinen and Savonlahti (2014) proposed that fear of childbirth can indicate difficulties in the developing relationship between mother and child. In this way, some professionals are promoting the developmental interpretation of the nature of fear of childbirth, which partly challenges the technocratic explanation. From the point of view of pregnant and birthing individuals, the sociocultural interpretation is also sometimes supported: for example, Vihreäsalo (2022) proposed that traumatic experiences in interactions with health care staff create distrust and fear in women toward the hospital institution and staff. Sometimes women are fearful of the hospital system and not childbirth per se (Nilsson, 2014).

With respect to childbirth, the Finnish maternity system is very equivocal. Choices are quite restricted regarding birthing place; for example, the publicly funded system only supports hospital births and there has also been a tendency in recent years to centralize maternity wards, locating them only in the biggest hospitals (see Leppo & Itkonen, forthcoming). This has resulted in a reduction in maternity hospitals; in some places, distances to maternity wards have grown great and unplanned, out-of-hospital births have increased (Official Statistics of Finland, Perinatal Statistics, 2022). Moreover, the culture in Finnish maternity hospitals is quite medicalized (Leppo & Itkonen, forthcoming), with a foundation in science, extensive use of technology, and large-unit, hospital-based care. Even

though caesarean section rates remain relatively low (16–17% in recent years) with some increase since 2019 (18.4–19.6%; Official Statistics of Finland, Perinatal Statistics, 2022), the rates of some interventions such as ventouse extractions and the use of medical pain relief are increasing over a longer time period (Official Statistics of Finland, Perinatal Statistics, 2022). Moreover, ventouse extractions are more common in Finland than in other Nordic countries (Nordic Perinatal Statistics, 2020). This medicalization of care is sometimes in contradiction with birthing people's views, as the philosophy of natural birth exists separately from the medical understanding of childbirth in the culture (Viisainen, 2001). Women sometimes experience treatment in maternity hospitals as impersonal and, in some cases, even abusive or violent (Vihreäsalo, 2022). However, on average, Finnish birthing people are moderately happy with their births (Joensuu et al., 2022). It is likely that the universalization of care into big maternity wards and in the medicalized direction masks a large variety of different experiences. While some women may be happy and feel safe in those kinds of systems, other women may find them very difficult and psychologically unsafe. Moreover, simplistic methods for measuring childbirth experiences, such as the Visual Analogue Scale (VAS), may reduce contradictory or multifaceted experiences into a general appraisal.

While motherhood has been studied from many perspectives in Finland, childbirth studies mostly rely on medical understanding and omit sociocultural perspectives (see Leppo & Itkonen, forthcoming). The present study is one of the very few Finnish studies to consider the sociocultural aspects of childbirth, and part of the analysis in the present thesis specifically addresses these aspects. It is especially interesting to study different discourses on childbirth and motherhood in Finnish culture, because multiple ideologies may promote contradictions in Finnish mothers' accounts. When multiple ideologies collide, a discursive struggle emerges (Baxter, 2011). These struggles define and shape reality and people's experiences, and for that reason they are important to study.

Indeed, the context of Finnish mothering has many contradictions, with several different mothering discourses and ideologies in the society. Gender equality is considered advanced in Finnish society (The Global Gender Gap Report, World Economic Forum, 2018; Seierstad & Healy, 2012), and official politics aim at advancing it (Ministry of Social Affairs and Health, 2019). For example, a family reform in 2022 (Ministry of Economic Affairs and Employment, Ministry of Education and Culture, and Ministry of Social Affairs and Health, 2022) divided family leave in a novel way between parents, aiming at advancing gender equality in parenting. However, actual parenting practices (Lammi-Taskula, 2007) and ideologies (Perälä-Littunen, 2018; Sevón, 2012) remain gendered. This may be encouraged by traditionalist parenting ideologies such as familism. Jallinoja (2006) proposed that Finnish familism around the turn of the millennium was built on two basic ideas: that the care of children should be arranged to be as home-like as possible, and that parents should exert more control to guide children's growth and prevent mental ill-being and conduct problems in children.

In Finland, women are especially exposed to conflicting values of the gender equality promoted by the Finnish state (Ministry of Social Affairs and Health, 2019) and traditional family values such as intensive mothering and familism (Perälä-Littunen, 2018; Jallinoja, 2006). For example, Finnish parents often avoid clearly distinguishing the roles of father and mother, but parenting still appears to be primarily defined through mothering (Perälä-Littunen, 2007). Particularly in terms of the care of small children, it is often seen as natural that mothers take a higher responsibility (Perälä-Littunen, 2007; 2018). Indeed, the overwhelming majority of parental leave days (92.1%) is taken by mothers (Official Statistics of Finland, 2022).

Mothers' practical decisions are also shaped by laws and financial realities such as maternal leave and government subsidies, as well as availability of childcare (see Collins, 2019). The Nordic welfare state model informs the Finnish parenting policy (Määttä & Uusiautti, 2012). Moreover, development of increased gender equality in the parenting domain (e.g., on the parental leave reform in 2022, see Ministry of Economic Affairs and Employment, Ministry of Education and Culture, and Ministry of Social Affairs and Health, 2022) aims at increasing the participation of fathers in the care of children. This environment may cause more direct competition among discourses than before, which may result in new understandings of parenthood. The new law in Finland encourages parents to share parental leave (Ministry of Economic Affairs and Employment, Ministry of Education and Culture, and Ministry of Social Affairs and Health, 2022), but today it continues to be overwhelmingly taken by mothers (Official Statistics of Finland, 2022). Universal childcare is available at low cost for all children, and one would suspect that this might improve mothers' participation in the work force; however, Finnish women with small children are not employed as often as their counterparts in other Nordic countries (Ellingsaeter & Leira, 2006).

Families thus need to balance between contradictory discourses and ideologies. It seems that, in general, discourses may not greatly influence one another, but they can also remain unchanged and coexist. Indeed, empirical studies propose that a variety of discourses appear in Finnish culture. Helenius (2020) proposed that working women with families combined discourses of family life and motherhood in various ways. She identified several discourses and connected them with three publicly used discourses: the discourse of good parenthood, the discourse of motherhood, and the discourse of career and working life. While the discourse of good parenthood depicted parenting as an evenly shared activity where parents support one another and adapt according to each other's needs, the discourse of motherhood was gendered and placed the main responsibility of parenting on the shoulders of mothers (pp. 175–176). The career discourse, whichever form it took, was presented in conflict with the motherhood discourse. Prioritizing career and being a good mother were often presented as difficult to combine (p. 180; see also Blair-Loy, 2003). Similarly, Niemistö et al. (2021) suggested, on the basis of interviews with women working in the business sector in Finland, that mothers face contradictions vis-à-vis the

ideal worker and the ideal mother (see also Blair-Loy, 2003). These different discourses thus seem to remain quite separate, despite efforts to increase gender equality in the parenting domain. Some of the practices that families have in sharing care for children may limit direct conflict among discourses and in this way reduce the possibility for change.

Indeed, compartmentalizing in order to reconcile contradicting motherhood ideals may be likely for Finnish women, since they can take paid maternity leave after childbirth and remain at home, supported by a child home care allowance—a state-subsidized period for mothers to care for their child/children—up until the youngest child turns three. Even though most parental allowances can be used by either parent, home parenting remains extremely gendered in Finland (Official Statistics of Finland, 2022). These allowances may encourage women to see motherhood in traditional ways when they stay at home and then rely on different assumptions after they return to paid work. The present thesis studies mothers of infants (under 12 months old), which can shed light on the possible contradictory ideologies of mothers of small children.

1.6 Aims for the research

The aim of this dissertation is to study the transition to motherhood and specific risk and protective factors for the well-being of the mother. Because pregnancy, childbirth, and motherhood expose women to new situations and requirements and activates earlier developmental themes, I was interested in concentrating on the role of self-esteem in this process. Three broader themes—childbirth experiences, the role of self-esteem in the transition to motherhood, and mothering discourses—are examined in four studies. First, I wanted to study whether fear of childbirth and self-esteem form interconnected pathways that might predict the birth experience. Second, I sought to discover how women describe their childbirth experiences and whether birth experiences further shape self-esteem postnatally. I wanted to know which kinds of experiences predict positive or negative changes in self-esteem after birth. Third, I aimed to explore whether self-esteem affects mothers' psychological well-being in the first year of mothering. Specifically, I studied if self-esteem moderates the effect of socially prescribed perfectionism on parental burnout in mothers of infants. And finally, I wanted to explore mothering discourses in Finnish culture.

The dissertation consists of four articles (I–IV). The research questions of Study I were:

1) To what extent are self-esteem and FOC related to the childbirth experience?
2) Is the relationship between FOC and the childbirth experience different depending on self-esteem?

3) Is the relationship between self-esteem, FOC, and the birth experience different depending on age and parity?

The research questions of Study II were:

1) Does one's subjective birth experience predict changes in self-esteem during the first year after birth?
2) How do women describe their birth experiences?
3) How do women's descriptions of their birth experiences differ in different groups based on changes in self-esteem during the first year after birth?

The research questions of Study III were:

1) To what extent is mothers' self-esteem associated with parental burnout over and above SPP? Because self-esteem is related to psychological well-being (Orth & Robins, 2014), we hypothesized that the higher the self-esteem, the less mothers reported parental burnout (Hypothesis 1).
2) To what extent does self-esteem moderate the effect of SPP on parental burnout? Based on the demands-resources model of parental burnout (Mikolajczak & Roskam 2018), we hypothesized that high self-esteem could also reduce the adverse effects of SPP on parental burnout and that low self-esteem could further amplify the effect (Hypothesis 2).

The research questions of Study IV were:

1) What kinds of discourses of motherhood can be identified from Finnish mothers' open-ended responses to survey questions about their parenting resources, desired support, and other matters they wish to mention?
2) How do mothers construct the meaning of motherhood in their responses through the interplay among different motherhood discourses?

2 METHODS

The philosophical premises, samples, and measures used in the four studies are presented here, along with ethical considerations of the dissertation. More detailed descriptions of the employed methods can be found in the original publications.

2.1 Feminist childbirth and motherhood studies and positioning of the researcher

This dissertation is situated in the feminist research tradition on childbirth and mothering (see, for example, Chadwick, 2018; Collins, 2021; Hays, 1996; Martin, 2003; Rich, 1995; Young, 2005; Zadoroznyj, 1999). In general, feminism refers to an objective of creating a society where women and men are treated equally (Chamberlain, 2016). Historically, it has been proposed that the feminist movement developed in several waves, where new thoughts have emerged as central themes; however, some researchers also argue against defining feminism in distinct waves (Hewitt, 2010; Shiva & Nosrat Kharazmi, 2019). The wave narrative is critiqued for creating generational divides between feminists, for privileging western perspectives, and for excluding feminists of color, as well as for creating confusion with cross-wave themes (Evans & Chamberlain, 2015).

Despite the critique, the wave narrative can also be used for feminist timekeeping and is proposed as a useful tool for understanding continuity within the feminist movement (Chamberlain, 2016). Roughly defined, the first wave is generally situated in the 19th and early 20th centuries, and it is generally associated with suffragette activism and the objective of achieving the right to vote for women (Evans & Chamberlain, 2015). The second wave is situated from the 1960s to the 1990s, with increasing attention to social justice issues, equal pay, women’s right to their own bodies, and sexual liberation (Evans & Chamberlain, 2015). The third wave spanned from the 1990s to the early 2010s, with special focus on inclusivity and related discussions on the rights of queer people and

people of color (Evans & Chamberlain, 2015). The fourth wave is proposed as currently ongoing (Hewitt, 2010) and largely developed by the possibilities created by use of the internet, such as global interconnectedness (Munro, 2013). Social media has particularly facilitated the emergence of the fourth wave and enabled united efforts of feminists all over the world to challenge patriarchy and, among other things, call out incidents of sexual violence (Munro, 2013). The fourth wave has been especially devoted to combating sexual violence and targeting questions of intersectionality (multiple intersecting sources of oppression; Crenshaw, 1989; Gordon, 2016), raising issues surrounding the position of women in the labor market, such as maternity leave and the gender pay gap, and challenging the tenets of the neoliberal economy (Shiva & Nosrat Kharazmi, 2019).

In the context of childbirth, feminist debates have also evolved over time. Skowronski (2015) describes how discussions on pain relief in childbirth have developed historically and reflected childbirth discourses typical at different times. First-wave feminists fought for access to effective pain relief as women's right, second-wave feminists critiqued the medicalization of childbirth, advocating for female-controlled, "natural" childbirth, and third-wave feminists have again promoted women's right to choose a technological model of birth and resisted essentialist notions of womanhood promoted by the natural birth movement (Skowronski, 2015). Third-wave feminist notions can perhaps be most clearly seen in the debate over elective caesarean sections (Beckett, 2005). According to Beckett (2005), feminists have approached this choice from multiple perspectives, some supporting women's right to choose and some claiming that the desire to choose an elective caesarean represents passive socialization into dominant values. However, oversimplification of factors affecting this choice, failing to address the consequences for maternal and infant health, and ignoring the consequences for consumption of health care resources have been identified as critical for developing feminist thinking in debates over childbirth (Beckett, 2005).

Fourth-wave feminist childbirth scholars have increasingly discussed intersectionality. Intersectionality refers to a theoretical perspective that claims that oppression and power occur at the intersections of gender, race, class, ability, sexuality, economic position, et cetera (Crenshaw, 1989). Intersectionality allows study of interconnected forms of oppression and helps to avoid universalization of women's experiences (Broughton et al., 2022; Collins, 2019; Gordon, 2016). In the context of childbirth studies, intersectional perspectives have called attention to the uneven distribution of health care resources and to the different sources of oppression; for example, huge global inequalities exist in the availability and quality of maternity health care (Bongaarts, 2016). Inequalities also occur within societies; for example, maternal mortality rates in the UK and US are higher among mothers of color than among white mothers (Knight et al., 2020; MacDorman et al., 2021; Singh, 2021), and obstetric violence disproportionately affects women who are already in marginalized positions (Perera et al., 2022).

In motherhood studies, feminists have sought to distinguish motherhood as an institution and experience (Rich, 1995), describe and challenge culturally embedded discourses of motherhood and very high demands for mothers (Hays, 1996; Henderson et al., 2016; Liss et al., 2013), highlight tensions that many mothers experience between motherhood and work (Blair-Loy, 2003), and envision shared parenthood (Sevón, 2012; Perälä-Littunen, 2018). In motherhood studies, intersectionality has also been helpful in addressing multiplicity of experiences: for example, race, class, and economical position strongly shape what resources mothers have available and what kinds of restrictions they face (Dow, 2016).

Feminism has at times had trouble with theorizing motherhood and especially reproduction. Gender-neutral notions of parenthood easily dismiss important aspects of experience in pregnancy, childbirth, and early mothering (see Gribble et al., 2022); however, binary gender logic also seems problematic because it can easily lead to essentialist notions of biological determinism (Hollway, 2016). In the present research, special attention is paid to acknowledge diversity among mothers and to avoid essentialist notions of womanhood and motherhood.

This research centers around the subjectivity of women in childbirth and motherhood and attempts to describe both women's lived experiences and differences among women. This dissertation seeks to connect women's experiences to wider sociocultural influences and to recognize the impact of oppression on women through external control and restrictions (Martin, 2003) and internal technologies of gender (Chadwick & Foster, 2013; Martin, 2003; Hays, 1996). Feminist positioning in this dissertation can be seen most clearly in the interpretation of the results. The present dissertation takes a critical stance toward maternity health care systems and seeks to problematize what has generally been taken for granted. For example, Finnish maternity care is arranged around large hospital units, which has consequences for care and ideologies of childbirth. The choice to align with other voices than the dominant medical paradigm has been intentional (see, for example, Davis-Floyd, 2001). The coexistence and dialogue of different ideologies are seen as a value in themselves, because they allow different values and worldviews to be voiced, which is not possible in a totalitarian regime (see Baxter, 2011).

2.2 Participants and procedure

Data from two separate research projects were used to answer the research questions. The data for Studies I and II were obtained from a longitudinal research project "Fear of Childbirth, Birth Experiences, Self-Esteem and Parental Burnout" (Raudasoja & Aunola, 2019–2023). The data for Studies III and IV were obtained from the VoiKu (Vanhemmuuden voimavarat ja kuormitustekijät, Aunola & Sorkkila, 2018– present) research project concerning Finnish parents' demands and resources.

Studies I–II

The data consisted of a convenience sample of women (n = 125) recruited in their antenatal appointments in four medium-sized Finnish cities. Women had to be at least 30 weeks pregnant and able to fill in the survey in Finnish. The participants completed study surveys during 2020 and 2021. The study included three measurement points: late pregnancy (gestational weeks 30 +) (n = 125), 4–8 weeks postpartum (n = 113) and 1 year postpartum (n = 102). Women were given oral and written information about the purposes of the study, and they signed a voluntary participation form. They were also informed that participation could invoke feelings that might be experienced in a negative way, but it could also assist in psychological processing of the birth experience. They received the first-phase survey at their appointments, and they were asked to complete and return it to the researcher in a pre-paid envelope. The second- and third-phase surveys were sent directly to the women who participated in the previous phases of the study. Ethical approval for the study was obtained from the university's ethics committee prior to data collection (August 2019).

Women in the study were 22–44 years old (M = 31.1, SE = 4.46). Out of the 125 women, 67 were primiparous (59.3%) and 46 multiparous (40.7%). They lived in different family types: most of them (92.1%) lived in a nuclear family with the father of their child, 6.1% in a blended family, and 1.8% in another type of family. They reported their income level as average (68.8%), better than average (22.3%), poorer than average (8%), or poor (0.9%). Their average education level was high, as 73.5% had a degree in higher education. A total of 25.7% of participants had an occupational degree and 0.8% had no degree after compulsory schooling. Measured antenatally, 11.5% of the participants reported severe fear of childbirth (W-DEQ A sum score 85 or more), which is similar to the spectrum of 10–30% prevalence reported in developed countries (Rondung et al., 2018; Rouhe et al., 2013). Compared to the general population of Finnish childbearing women, the participants were more often primiparous (59.3% in the data vs. 42% in the population; Nordic Perinatal Statistics, 2020) and their educational level was higher (73.5% with higher education vs. 38% in the general population; Statistics Finland, 2022).

The participation rate in the first phase was only 25.6%, which should be considered a major limitation, as it could have introduced bias to the results. It is not known if the women who declined to participate were different from the women who participated. It seems that primiparous and highly educated women were more susceptible to participate in this study and this self-selection may have affected the survey responses, because multiparous women have previous experiences of childbirth, which may affect how they describe their birth experiences. It should also be noted when comparing the results with other studies that in many previous studies, the data is restricted to primiparous women. In addition, the over-representation of highly educated women in our sample may have affected how birth experiences were told. For example, feelings of control and agency may be expressed more often by highly educated women. Moreover, the small sample size limited possibilities for the interpretation of the

results. The characteristics of the sample are described in detail in the original publication.

Studies III–IV

The data for Studies III–IV consisted of survey responses of 1,725 parents (91% mothers), and mothers of infants (*n* = 479) were selected for the purposes of this study. The sample was ethnically and racially homogenous and, on average, highly educated. Details of the sample are presented in the original publication. The data were collected in 2018, either online (79.5%) or with pencil and paper, after appointments in Child Health Centers in three Finnish cities (20.5%) situated in the southern, middle, and northern parts of the country. Ethical approval for the study was obtained for the overarching research project prior to data collection.

2.3 Measures

For Studies I–II, the data consisted of surveys in three time points (see Table 1). The surveys included questions about fear of childbirth (all time points), the birth experience (T2 and T3), self-esteem (all time points), parental burnout (all time points; in pregnancy only for the participants who already had children), resources for parenting (all time points), satisfaction with partnership (all time points, only for the participants who were living in a relationship), and satisfaction with maternity health care (all time points). Most of the questions were quantitative and answered on a Likert scale, but there were also a few open-ended questions included in the questionnaires regarding the childbirth experience and satisfaction with maternity health care. For Studies III–IV, the data was collected in a cross-sectional survey study concerning Finnish parents' demands and resources (see Table 1). The survey included questions about parenting practices, values, the distribution of childcare and domestic work, parental burnout, and the life situation of the family. Most of the questions were quantitative, but a few qualitative open-ended questions were included (described under the subsection Maternal Experiences).

TABLE 1 Overview of the original studies

Study	Research project	Measurement points or design	Approach/ Orientation	Variables/ Open-ended questions	Data analysis methods
Study 1 The Role of Self-esteem on Fear of Childbirth and Birth Experience	Fear of Childbirth, Birth Experiences, Self-Esteem, and Parental Burnout	Time 1 (pregnancy; *n* = 125) Time 2 (postpartum; *n* = 113)	Quantitative	Fear of childbirth Childbirth experience Self-esteem Age Parity	Path analysis
Study 2 Passing the Test of Motherhood? Self-esteem Development and Childbirth Experience in the Transition to Motherhood: A Longitudinal Mixed Methods Study	Fear of Childbirth, Birth Experiences, Self-Esteem, and Parental Burnout	Time 1 (pregnancy; *n* = 125) Time 2 (postpartum; *n* = 113) Time 3 (one year after childbirth; *n* = 102)	Mixed methods	Childbirth experience (quantitative) Childbirth experience (qualitative) Self-esteem Age Parity	Path analysis with latent change factors Thematic analysis
Study 3 Self-Esteem Moderates the Effect of Socially Prescribed Perfectionism on Parental Burnout	International Investigation of Parental Burnout: Finnish Study	Cross-sectional study (*n* = 479)	Quantitative	Socially prescribed perfectionism Self-esteem Parental burnout Education Age Number of children Single parenthood status	Structural equation modeling
Study 4 "I Feel Many Contradictory Emotions" – Finnish Mothers' Discursive Struggles with Motherhood	International Investigation of Parental Burnout: Finnish Study	Cross-sectional study (n = 479)	Qualitative	Resources Support Other	Contrapuntal analysis

2.3.1 Childbirth experiences

In Studies I and II, childbirth experiences were assessed quantitatively with the Delivery Satisfaction Scale (DSS; Saisto et al., 2001). The scale consists of eight items that are answered on a five-point Likert scale, and negatively worded items are reverse-scored. The scale includes items such as *Was childbirth a positive experience for you? (1 = very; 5 = not at all)*. Cronbach's alpha for the scale was good (.78).

In Study II, childbirth experiences were also assessed qualitatively, as responses to the open-ended question *How was your experience of birth? Describe freely* were analyzed. Below the question, there was a blank space to write in. All mothers who returned the surveys at T2 (*n* = 113) responded to the open-ended question about childbirth experience.

2.3.2 Maternal well-being in the transition to motherhood

In Studies I and II, maternal well-being was measured with different sets of questionnaires. Fear of childbirth (FOC) was measured antenatally with the Wijma Delivery Expectancies Questionnaire (W-DEQ A; Wijma et al., 1998) with the permission of the copyright holder (Wijma, 2020). Cronbach's alpha for the scale was excellent (.92). Self-esteem was measured with the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1989). Cronbach's alpha for the scale was excellent (.91 at T1, .90 at T2, and .90 at T3).

For Study III, quantitative survey data about participants' self-esteem, socially prescribed perfectionism, and parental burnout were utilized. Self-esteem was measured with four items from the RSES described above. Cronbach's alpha for the four-item scale was good (.80). Socially prescribed perfectionism (SPP) was measured with three items from the Big Three Perfectionism Scale (Smith et al., 2016). Cronbach's alpha for the scale was good (.80). Parental burnout was measured with the Finnish version (Aunola et al., 2020) of the Parental Burnout Assessment (PBA; Roskam et al., 2018). The overall Cronbach's alpha for the scale was excellent (.97). Detailed descriptions of the scales can be found in the original articles.

2.3.3 Mothering discourses

For Study IV, responses to three open-ended questions were analyzed: 1) Resources (*Please write down things that give you joy in parenting and/or help you cope*); 2) Support (*Which kinds of things—for example, support and services—would best foster your well-being and happiness as a parent?*); and 3) Other (*Is there something else that you wish to mention regarding yourself, your family, or your parenting?*). The Resources question was only asked in the online version of the questionnaire, whereas the other two questions (Support and Other) were included in both versions of the questionnaire. Of the 479 mothers, 89% answered the Resources question, 78% answered the Support question, and 36% answered the Other question. A total of 91% of participants provided answers to at least one open-

ended question. All three open-ended survey questions were utilized to answer all the research questions.

2.4 Analyses

Study I

The data were analyzed with MPlus statistical software, version 7.3 (Muthén & Muthén, 1998–2012). Path analysis was used to predict the birth experience (dependent variable) with self-esteem and fear of childbirth (independent variables), and the method of estimation was a full-information, maximum-likelihood robust estimation (MLR estimator). The interaction term *Self-esteem* X *Fear of childbirth*, as well as parity and the age of the mother, were further included as independent variables in the model. Independent variables were allowed to correlate with each other.

Study II

In Study II, we utilized mixed methods (Creswell & Plano Clark, 2011; Plano Clark, 2008) to study different pathways of self-esteem development in the transition to motherhood. The analysis started with a quantitative part, and a path analysis with latent change factors was performed. Childbirth experience was regressed on self-esteem at T1, and change in self-esteem at T3 was regressed on childbirth experience. The model was estimated with the full-information, maximum-likelihood robust estimation (MLR estimator) with the Mplus 8.6 statistical program (Muthén & Muthén, 1998–2017). The second part of the analysis was qualitative, consisting of thematic analysis (Braun & Clarke, 2006) on the answers (n = 113) to the open-ended question considering the childbirth experience. The third part of the analysis selected individuals (n = 14) who showed a statistically significant change ($p < .05$) in their self-esteem between time points 2 and 3. They were divided into four groups based on their birth experience (mainly positive/mainly negative, based on both qualitative and quantitative assessments) and self-esteem development (increasing/decreasing between Time 2 and Time 3). Their written responses to the question considering the childbirth experience were then compared with each other.

Study III

In Study III, structural equation modeling (SEM) was used to study the relationships between parental burnout, self-esteem, and SPP variables. In the first model, the latent parental burnout variable (consisting of the four dimensions of parental burnout, as measured by PBA) was predicted by two latent variables, SPP and self-esteem. Then, in the second model, an interaction term *SPP x self-esteem* was introduced as predictor of parental burnout. The

Mplus 8.0 statistical software program (Muthén & Muthén, 2017) was used to perform the analyses.

Study IV

For Study IV, the open-ended responses to Resources, Support, and Other were analyzed with contrapuntal analysis (Baxter, 2011), which is a form of discourse analysis. It is an analysis method consistent with Relational Dialectics Theory (Baxter, 2011; Baxter et al., 2021). This framework presumes that discourses form a web of meanings competing over space and credibility on an unequal playing field (Baxter, 2011).

The analysis started with a thematic analysis (Braun & Clarke, 2006). Different subthemes were categorized under overarching themes or discourses. Discourses were tested against more data until they fitted the data and no more categories emerged. After that, participants' alignment or non-alignment with identified discourses was addressed, and practices of dealing with multiple discourses in the same answer were examined. In the answers, the discourse that was given the most legitimacy was identified. In this way it was possible to determine which discourses were dominant and which discourses were marginalized in Finnish mothers' answers.

2.5 Ethical considerations

This research followed the guidelines on ethical principles of research with human participants (TENK, 2021). Both the research projects that produced the data used in this dissertation were evaluated by the ethical review board in human sciences at the University of Jyväskylä.

This thesis utilized data gathered on sensitive topics such as fear of childbirth, birth experiences, and parental burnout. Ethical considerations thus needed to focus on the effect of answering on participants: namely, whether taking part in the research might cause them psychological harm. Someone with very difficult or traumatizing experiences of childbirth or parenting could suffer adverse effects from filling in the research form, because it might provoke difficult memories and emotions. However, participation was voluntary and based on informed consent that could be revoked at any time without consequences for the participant. Moreover, processing difficult memories can also be beneficial, even when it feels challenging. In the study concerning childbirth experiences ("Fear of Childbirth, Birth Experiences, Self-Esteem and Parental Burnout"), this possibility was considered in advance and participants were informed that they had a possibility to call the principal researcher and discuss any reactions that participating might have evoked. Three participants used this possibility and discussions were arranged. During the discussions, the researcher made recommendations for further contact in health care when it seemed beneficial for the participants. Participating in the research seemed to be

positive even for these participants and the difficulties they wished to discuss concerned their experiences and not participation in the research per se.

In the "Fear of Childbirth, Birth Experiences, Self-Esteem and Parental Burnout" research project, the data were managed by the researcher. Research data were stored in a locked cupboard during data collection, and all paper forms were destroyed after the data collection was done and the data was then stored in electric form. Participants' personal information and research data were stored in separate files. Personal identifiers needed to be collected to allow data gathered at different time points to be connected with the same person. The participants were given ID numbers that were used in all analyses. All data were stored in CollabRoom, the safe repository of the University of Jyväskylä, during data collection. Having completed the data collection, the code key allowing connection of the participants' personal identifiers with the research data was destroyed. The data were stored for further use in an anonymized form. In the "International Investigation of Parental Burnout: Finnish Parents' Resources and Demands" study, the data were ready and available and already anonymized.

A research diary, including notes and reflections on the researcher's own thoughts and feelings, was kept throughout the process. This allowed the researcher to recognize her own biases and reduce their potential effects on the research. This was particularly prominent when analyzing the participants' accounts of their childbirths (see Study II) and when analyzing the responses of mothers of infants in relation to the Resources, Support, and Other questions (Study IV). Moreover, the analysis and results were actively discussed among the researcher teams throughout the study periods.

3 OVERVIEW OF THE ORIGINAL STUDIES

3.1 Study I

The Role of Self-esteem on Fear of Childbirth and Birth Experience

The aim of Study I was to examine if self-esteem forms joint effects with fear of childbirth as predictive factors of mothers' childbirth experience. The aim was to discover whether the relationship between fear of childbirth and birth experience is different depending on antenatal self-esteem, and whether it is different depending on age and parity. Based on the theoretical background, it was expected that self-esteem would emerge as a significant predictor of the childbirth experience, and that it could have an interaction effect with fear of childbirth.

Participants (n = 125) filled in surveys in the third trimester of pregnancy, including questions about background characteristics (age, parity), fear of childbirth, and self-esteem. The birth experience was assessed 4–8 weeks postnatally, when participants filled in the second questionnaire. Most of the participants who responded to the first phase (90.4%, n = 113) also responded to the second phase. Missing data analyses revealed that the participants who dropped out between the two measurement points were not statistically significantly ($p < .05$) different from the participants who did not drop out in relation to variables of interest at T1 (self-esteem, fear of childbirth (FOC), age, and parity).

The results of the path analysis showed that participants' antenatal self-esteem predicted their birth experience. Furthermore, the results showed that the effect of antenatal fear of childbirth on the birth experience was dependent on self-esteem. That is, when a mother had a low level of self-esteem (-1 *SD* or lower), fear of childbirth had a particularly detrimental effect on the birth experience; conversely, high self-esteem (+1 *SD* or higher) protected from negative birth

experiences even when fear of childbirth co-occurred. Background variables were not associated with birth experience after considering the main effects of fear of childbirth and self-esteem.

Overall, the results of Study I support the previous finding that women with fear of childbirth are a heterogenous group (Rondung et al., 2018). Moreover, the results suggest that self-esteem is a significant factor for women's perinatal well-being (see Jomeen, 2004; Lowe, 2000), which may be theoretically related to the notion of childbirth as a developmental task for women (Hall, 2016). The results suggest that the level of self-esteem should be considered an important factor for well-being in the transition to motherhood. It should be noted, however, that the participation rate at T1 was low and could cause some bias in the results.

3.2 Study II

Passing the Test of Motherhood? Self-esteem Development and Childbirth Experience in the Transition to Motherhood: A Longitudinal Mixed-Methods Study

The aim of Study II was to examine women's childbirth experiences and their relation to self-esteem development in the postpartum year. Previous studies suggest that positive childbirth experiences may favorably affect women's sense of self (e.g., Olza et al., 2018; Simkin, 2006) and that negative experiences may challenge women's self-perceptions (Byrne et al., 2017; Schneider, 2010, 2013). However, the effect of birth experience on general self-esteem has not been studied before.

Study II had a mixed-methods approach and longitudinal design. The study utilized a triangulation design with three phases. At first, it was examined whether birth experiences statistically predict changes in the level of self-esteem during the postpartum year. Then, it was examined how women describe their birth experiences in responses to an open-ended question considering the experience of childbirth. Finally, study participants who demonstrated a statistically significant change in self-esteem in the postpartum year were identified and their open-ended responses were compared to one another.

The results of the path analysis with latent change factors demonstrated that antenatal self-esteem (at T1) was positively associated with postnatally (T2) measured childbirth experience. Childbirth experience, in turn, was associated with change in self-esteem between T2 and T3: the more positive the birth experience, the more the self-esteem increased. The results of the thematic analysis of open-ended responses considering participants' childbirth experience suggested three overarching themes to describe the meaning of childbirth for the participant: 1) childbirth as a lived experience; 2) childbirth as a relational event; and 3) childbirth as a medical event. More than one theme was often present in participants' answers. Of all participants, 14 demonstrated a change in self-esteem between T2 and T3 (n = 14). Four groups were proposed, based on the

quality of the birth experience and the direction of change in self-esteem: 1) positive experience and increasing self-esteem; 2) negative experience and increasing self-esteem; 3) negative experience and decreasing self-esteem; and 4) positive experience and decreasing self-esteem. Comparing these groups to each other suggested that the effect of the childbirth experience on self-esteem development might be straightforward only for women with extreme experiences, that is, either extremely positive or traumatic ones. The women with experiences closer to the average demonstrated changes in self-esteem after childbirth that were not necessarily consistent with the quality of the birth experience. This finding was interpreted to mean that other factors than childbirth experience probably contributed to the change in self-esteem for those participants. In future studies, factors affecting women's well-being in the postpartum year should be a priority, since our findings suggest significant changes for some participants that could not be explained by this study. It should be noted that while data saturation was achieved when analyzing the whole qualitative data, the number of participants in different groups based on self-esteem and birth experience was too small to draw definitive conclusions.

Overall, the results suggest that childbirth experiences are multifaceted (see, e.g., Dencker et al., 2020) and that they are described through different cultural scripts or discourses (Davis-Floyd, 2001). Furthermore, there seems to be considerable individual variation in women's self-esteem development in the transition to motherhood. Even though studies rarely concentrate on self-esteem in the transition to motherhood, our findings enlarge the previous literature (e.g., Byrne et al., 2017; Laney et al., 2014; Olza et al., 2018) by suggesting that childbirth may affect women's sense of self.

3.3 Study III

Self-Esteem Moderates the Effect of Socially Prescribed Perfectionism on Parental Burnout

The aim of Study III was to examine, first, whether mothers' self-esteem was associated with parental burnout over and above socially prescribed perfectionism (SPP) and, second, whether self-esteem moderated the effect of SPP on parental burnout. Based on previous literature, in line with the balance between risks and resources model (BR2; Mikolajczak & Roskam, 2018), it was expected that high self-esteem would protect mothers from parental burnout and SPP, and that low self-esteem could further amplify the adverse effects.

The results of structural equation modeling (SEM) showed that SPP predicted parental burnout at a statistically significant level; however, self-esteem moderated this relationship so that higher self-esteem protected from the detrimental effect of SPP on parental burnout and lower self-esteem further strengthened this effect. The results were not dependent on background factors, such as maternal education, age, number of children, or single parenthood status.

The findings of Study III are consistent with previous literature, suggesting that self-esteem is fundamental for well-being (Orth & Robins, 2014). The results provide supporting evidence for the demands-resources model of parental burnout (Mikolajczak & Roskam, 2018), which determines the risk for parental burnout consisting of a balance between risk and protective factors. However, the findings are also somewhat surprising, given that general—not parenting-related—self-esteem is so closely related to parental burnout.

3.4 Study IV

"I Feel Many Contradictory Emotions"—Finnish Mothers' Discursive Struggles with Motherhood

The aim of Study IV was to gain knowledge of mothering ideologies by identifying Finnish mothers' mothering discourses and their interplay. Finnish culture encompasses competing values of individualism (Hofstede, 2001), gender equality (Ministry of Social Affairs and Health, 2019), family values (Jallinoja, 2006), and intensive mothering (Perälä-Littunen, 2018). By identifying discourses and examining the struggles among them, it was possible to better understand how Finnish mothers deal with mothering-related demands and stress. The first year of motherhood was chosen as the focus for this study, because discursive struggles are, in general, likely to emerge in transitional phases in life (Baxter, 2011).

The results of contrapuntal analysis distinguished four different mothering discourses consisting of different inductively identified themes. Two overarching themes covering all data were identified: parenting is rewarding, and parenting is challenging. They could be identified in all four discourses:

1) The Equality Discourse constructed parenting as a shared responsibility between co-parents and advocated for an independent, modern, or career-focused mothering style and different family forms.
2) The Familistic Discourse advocated for separation of spousal roles between caring and earning, and constructed mothering around the stay-at-home motherhood ideal and unity of the family.
3) The Intensive Mothering Discourse presented motherhood as the most important task in life for women and quality of mothering as being constantly available and sensitive to children's needs.
4) The Balance Discourse advocated for respecting the limits and needs of each family member, as well as for flexibility of practical solutions and understanding for parents in society.

The findings of Study IV also suggested that discursive struggles are commonly found in Finnish motherhood discourses. Most often, traditional discourses (the Familistic and the Intensive Mothering discourses) were centered in the answers

and mothers positioned themselves in relation to these discourses. Most often, discourses were in counterpoint relation to one another; however, discursive hybrids occasionally emerged and the tension between discourses was temporarily dissolved.

The results of Study IV suggest that Finnish mothering discourses may be more varied than previously thought: the Identifying the Balance discourse is a new finding that represents change in motherhood ideologies. This implies that Finnish mothers have the flexibility to move between different discursive constructions of motherhood that encompass both motherhood and other areas in life. However, the co-existence of different ideologies may also produce stress for mothers to adhere to different and contradictory ideals at the same time. The results of Study IV can be applied to counseling and clinical work to alleviate mothers' parenting stress.

4 DISCUSSION

The aim of the present dissertation was to examine how individual and sociocultural influences affect experiences in the transition to motherhood. The first aim was to study the role of childbirth experiences in the transition to motherhood. The second aim was to examine the role of self-esteem for maternal well-being in the transition to motherhood, and the third aim to describe mothers' own childbirth and mothering discourses. The dissertation was situated within the feminist research tradition on childbirth (Chadwick, 2018; Davis-Floyd, 2001; Hall, 2016; Malacrida & Boulton, 2012; Martin, 2003) and mothering (Abetz & Moore, 2018; Chodorow, 1978; Dow, 2016; Hays, 1996; Liss et al., 2013; Oakley, 1980). The findings contribute to this research literature by providing important insights into the interplay of individual and cultural factors in producing well-being. Previous research has shown that the transition to motherhood is an important event that has the potential to shape identity, relationships, and social roles (Laney et al., 2014; Mercer, 2004; Taubman-Ben-Ari et al., 2009), and that gendered aspects of control appear pronounced in this period (Chadwick & Foster, 2013; Davis-Floyd, 2003; Martin, 2003). It is known that mothers often suffer from mental ill-being in the transition (Howard & Khalifeh, 2020; Jomeen, 2004), but risk and supporting factors have rarely been connected to the impact of previous developmental crises. Moreover, the psychological and social aspects of the transition are rarely studied together, which severely limits understanding of the complexity of the experiences. Humans are deeply social beings; therefore, failing to address social aspects of the transition reduces our possibilities for understanding. The present research adds to the existing literature by exploring the interaction of intrapsychic (self-esteem, perfectionism, childbirth experiences) and inter-psychic (childbirth and motherhood discourses) aspects and their effect on specific risks and resources in the transition to motherhood. The resulting knowledge can be used to build care systems and services that better acknowledge the complexity of human existence in the transition to motherhood. This will ultimately benefit women and families through better support.

4.1 The role of childbirth experiences in the transition to motherhood

The first aim of this dissertation research was to examine the role of childbirth experiences in the transition to motherhood. Childbirth experiences were studied from two different perspectives, qualitatively and quantitatively. First, mothers' qualitative descriptions of their childbirth experiences were analyzed with thematic analysis and three overarching themes were found: childbirth as a medical event, childbirth as a relational event, and childbirth as a lived experience. The first theme was overwhelmingly present in mothers' descriptions. Expert knowledge was represented in the medical understanding of childbirth as a risky process in need of monitoring and interventions (see Davis-Floyd, 2001). Indeed, this finding is in line with previous findings that propose that women often describe their childbirths through medical scripts (Martin, 2001). The finding is in line with international studies, suggesting that the technocratic model of birth (Davis-Floyd, 2001) is prevalent in Finnish culture as well. Moreover, it also suggests that women are restricted in their childbirth choices and behavior (see also Malacrida & Boulton, 2012). In line with Chadwick and Foster (2013), internalizing this view often meant women adopting the patriarchal optics to childbirth, which means internalizing distrust and even contempt for female bodies, and adopting an outsider's gaze to approach childbirth.

Moreover, the study participants described their births through medical norms such as the level of dilation of the cervix and the frequency of contractions. In the findings, therefore, the medical view was predominant, and this was probably affected by the Finnish context and services. While a couple of our participants mentioned that their childbirth involved an elective cesarean section, most women described vaginal births in hospitals. In Finland, there are no alternative, publicly funded options for a birthplace apart from hospitals; for example, there are no midwife-run birth homes like in some other countries, and home births are only possible with significant costs to the family to hire an independent midwife, as well as being strongly discouraged by health care professionals. This may be a context that especially reinforces the medical view of birth and discourages contradicting discourses. The cultural context and services may explain why the medical view was so dominant in the sample. This interpretation is supported by the findings of Vogels-Broeke and colleagues (2023), who suggested that in the Dutch context, the philosophy of Dutch perinatal care is translated into women's (natural) birth beliefs.

Another interesting feature in the birth stories in the data is that alternative themes of "childbirth as a lived experience" and "childbirth as a relational event" somehow challenged the dominant paradigm of "childbirth as a medical event" (see Study II). Both themes represent the humanistic paradigm of birth described by Davis-Floyd (2001). Childbirth as a lived experience might serve as an attempt to reframe childbirth in woman-centered terms and experiences, in opposition to

the medical view (see Downe et al., 2018; Nilsson, 2014). The frame "childbirth as a relational event" also challenged the assumptions of the medical view by proposing that relational bonds and relationships are important in childbirth and that women need to be supported by trusted persons throughout the process (see Lundgren & Berg, 2007; Rice, 2023). This finding is in line with the humanistic model of birth described by Davis-Floyd (2001), and it is in line with previous Finnish research on childbirth experiences related to the COVID-19 pandemic (Kuurne & Leppo, 2021).

However, performing femininity and good motherhood in culturally appropriate ways may also play a part in the "childbirth as a relational event" theme. Often "relational" included gendered aspects of power. For example, women in the study sometimes mentioned that the decision to leave for the hospital during early labor was initiated by their (male) partners. This may indicate that the decision-making power during birth is, at least partly, shared between partners or sometimes actually situated in the male partner. Other studies have also revealed that communication during labor and birth includes gendered dynamics. For example, Martin (2003) suggested that middle-class, white American women often worry about being nice and kind even during labor and birth. In her analysis, relationality often meant performing femininity in interaction with partners and with professionals. Interestingly, similar technologies of gender have been found with different samples in different places of the world (see, e.g., Chadwick & Foster, 2013; Malacrida & Boulton, 2014; Westergren et al., 2021). It can thus be asked whether relational aspects during labor and birth may also reinforce uneven power structures, gendered dynamics, and conforming to "good mother" ideals. However, it is important to bear in mind that in the Finnish context where parenting is increasingly framed as an equal activity shared by parents, emphasizing relational themes in childbirth may also represent the view of gender equality. Framing childbirth as a shared experience between partners may represent a gender-neutral view that seeks to minimize sex differences and emphasize similarities between parents. Indeed, during the COVID-19 restrictions in birthing hospitals in 2020, childbirth was increasingly constructed by parents as a family event where both parents should be present, and restrictions were criticized on this basis (see Kuurne & Leppo, 2021).

In the childbirth discourses in this dissertation, the theme of women's rights seems to be mainly lacking. This is quite surprising, given the strong egalitarian culture in Finland. For example, the official government program aims at increasing gender equality (Ministry of Social Affairs and Health, 2019). It is possible that Finnish discussions on parental equality in politics and the media during the latest decades have not reached childbirth discussions to a large extent; childbirth seems to remain an event overwhelmingly approached as a medical event, which may restrict other understandings from developing in the Finnish culture. This probably reflects the Finnish maternity system, which is very equivocal, with nearly all births happening in hospitals and nearly all women receiving antenatal care in communal maternity/child health centers. Another

explanation is that because our data consisted of short survey answers, the participants were somehow restricted in expressing contradictory views to the dominant narrative due to a lack of space. A limited space for answering may have restricted the possibilities for elaboration in answers. This interpretation is supported by previous Finnish research, such as that of Vihreäsalo (2022), suggesting that resistance and counter-narratives exist in the context of obstetric violence in Finland (see also Kuurne & Leppo, 2021). However, identifying some aspects of childbirth as obstetric violence may indicate a contradictory cultural stance, even a taboo, and be possible only for some women and unavailable for others. I would suggest that mainstream childbirth discourses rarely address women's rights or power imbalances in maternity care (see also Kuurne & Leppo, 2021), but also that this counternarrative probably exists in the culture and challenges the medical paradigm.

The second way to look at the role of childbirth experiences in the transition to motherhood in the present research was quantitative. The results of quantitative analyses connected childbirth experiences with later self-esteem development. The impact of the mother's childbirth experience on the development of her self-esteem in the subsequent year was studied. This question, however, could not be fully addressed, as the subgroups were too small and changes in self-esteem could not always be predicted with experiences of birth. It was found that self-esteem development was affected by the childbirth experience in cases when the childbirth experience was extremely good or traumatic: very good experiences were associated with increased self-esteem and traumatic experiences with decreased self-esteem in the postpartum year. On the contrary, average experiences did not explain changes in self-esteem. This may be explained with confounding factors; it is probable that apart from the childbirth experience, there were other factors that contributed to self-esteem development for women with average childbirth experiences. For example, the postpartum year includes significant stress (infant care, changes in social roles) and transitions (feeding, return to work) and these events may affect self-esteem more than the birth experience. In the case of very positive experiences, the new mother's evaluation of her childbirth performance might have worked as a source of pride and feelings of capacity in motherhood, facilitating postpartum adaptation. Moreover, very positive experiences may promote a feeling of daringness (Olza et al., 2018) that may help the woman cope with the new requirements apparent in motherhood. These women could later possibly revise their experiences and draw confidence from them, even when parenting felt challenging. The positive effect of the birth experience on self-esteem should be rigorously tested in future studies. For women with very negative childbirth experiences, the effect on self-esteem could be explained through traumatization that affects self-conception (Byrne et al., 2017). These women maybe thought that they had failed the "test of motherhood" that childbirth represents, resulting in feeling incapable and like a failure (see Schneider, 2010; 2013; 2018). Furthermore, traumatization is likely to impair motherhood in many ways, such as initial feelings of resentment and the development of insecure attachment patterns with

the child (Ayers et al., 2006), and these difficulties with the baby could result in a decline in the level of self-esteem.

Moreover, if the mother has previously given birth, her past birth experiences can create a "baseline" for successive births, affecting expectations, fears, and hopes. All births thereafter would be new possibilities to rework any aspects of the transition; for example, a negative or traumatic birth experience is often actively worked through in successive pregnancies, and women do their very best to have a better experience (Beck & Watson, 2010; Thomson & Downe, 2013). However, previous negative experiences may also signal a non-favorable resolution of the childbearing crisis and can also negatively affect adaptation in new pregnancies. For example, it is known that previous negative or traumatic birth experiences often translate into fear of childbirth in future pregnancies (Storksen et al., 2013), and not all women are able to overcome their fear.

Overall, it seems likely that childbirth experiences may affect the mother's developing identity in the transition to motherhood, sometimes contributing to developing and maintaining a compassionate attitude toward oneself and sometimes leading to an overly demanding and judging attitude toward oneself. This may be one of the important mechanisms behind developing maternal pride (Leonard & Kelly, 2022) or guilt (Rotkirch & Janhunen, 2010) already in the beginning of motherhood. Thus, childbirth may be important for mother to develop culturally pervasive beliefs, which has implications for feminist theorizing. Moreover, childbirth experiences are known to affect motherhood (Reisz et al., 2015). In future studies, it would be important to distinguish between different pathways of development: Does the childbirth experience affect self-esteem independently or through experience in motherhood? And what is the role of the partnership alliance in this development? More longitudinal research is needed to answer these questions.

4.2 The role of self-esteem in the transition to motherhood

The second aim of this dissertation research was to study the role of self-esteem in the transition to motherhood. More specifically, the interaction effects of self-esteem and fear of childbirth on the birth experience were studied first. It was found that self-esteem moderated the impact of fear of childbirth on the birth experience: good self-esteem protected from the detrimental effect of fear of childbirth on the birth experience, whereas low self-esteem further strengthened this effect. In previous studies, the context-specific self-efficacy for labor and birth has been studied (Lowe, 2000), but this construct is different from general self-esteem because it directly describes how women feel about their abilities in childbirth. Lowe (2000) also found that general self-esteem was lower in women with FOC than other women but did not distinguish between women with FOC and high self-esteem and women with FOC and low self-esteem. The findings of this dissertation augment these previous findings by suggesting that general self-

esteem may be important as an independent factor for maternal well-being in the transition to motherhood.

One way to explain the interaction of self-esteem and FOC could be that high self-esteem helps to buffer harmful expectations that may cause uncertainty and fear in pregnant and birthing women. For example, one contributing factor behind fear of childbirth may be birth beliefs (Preis et al., 2018) or ideologies (Davis-Floyd, 2001), such as the technocratic model of childbirth that was commonly found in the answers. This ideological stance approaches childbirth as a risky process that is unpredictable and out of control, and this may directly cause fear for mothers with low self-esteem. However, a natural childbirth ideology may also contribute to fear of childbirth for some participants by promoting unnecessarily high performance expectations and uncertainty of one's performance in advance. These two ideologies may coexist in the culture and contribute to feelings of uncertainty and fear in pregnant people. Moreover, dichotomized ways of approaching childbirth may undermine women's agency, since most women seem to appreciate both clinical safety and individualized, relational care (Downe et al., 2018). These two perspectives appear hard to integrate in the Finnish system, however, as it is moving in the direction of large, hospital-based maternity units. From this perspective, reducing fear of childbirth requires broader changes in society, childbirth care systems, cultures, and the belief systems of everyone involved. For example, the midwifery continuity of care model (Bradford et al., 2022) is one of the attempts to address some of these factors by promoting woman-centered, respectful care that is based on the mutual relationship between the woman and midwife, and promotes trust in women's ability to give birth. However, to the best of my knowledge, this model has not been implemented anywhere in Finland (see Bradford et al., 2022), and the only way to ensure continuity of care in Finland is to opt for home birth with an independent midwife.

Second, the impact of self-esteem and socially prescribed perfectionism (SPP) on parental burnout was studied. It was found that self-esteem moderated the effect of maternal socially prescribed perfectionism on maternal burnout in the postpartum year. That is, among those with high self-esteem, the detrimental effect of SPP on parental burnout was buffered; among those with low self-esteem, it was further strengthened. A similar logic as found in fear of childbirth may appear here regarding parenting. Maybe mothers with high self-esteem are able to buffer cultural expectations that may cause unnecessary high standards and performance expectations contributing to stress and burnout. Previous research has demonstrated that socially prescribed perfectionism (Sorkkila & Aunola, 2020) and individualism as a cultural value (Roskam et al., 2021) are associated with an increased risk of parental burnout. The present dissertation expands these findings by proposing that this is dependent on the parent's self-esteem.

Taken together, the findings of this dissertation study propose that self-esteem promotes well-being through supporting adaptation (better childbirth experiences) and indirectly by counterbalancing possible risk factors (fear of

childbirth, socially prescribed perfectionism) in the transition to motherhood. In line with theories of health psychology (e.g., Antonovsky, 1979; 1996) and the risks and resources model for parental burnout (Mikolajczak & Roskam, 2018), good self-esteem supported women's well-being in the transition even when risk factors (fear of childbirth, socially prescribed perfectionism) were present, and low self-esteem further strengthened the effect of those risk factors. The findings highlight how different psychological factors work together: the overall balance is more important than the existence of specific factors. This is encouraging, because it means that there are different pathways to support well-being in the transition to motherhood.

Self-esteem is known to be an important factor for well-being throughout the life course (Jordan et al., 2015; Orth & Robins, 2014), and this was supported by the results of the present study. The findings of this dissertation are important because they suggest that maternal psychological well-being in the transition is dependent on the mother's psychological structure of the self. It can be suspected that self-esteem is only one of the basic dispositions that thoroughly affect how the transition is experienced when some risk factors are present. However, the relative weight of self-esteem in relation to other factors, such as secure attachment models, cognitive factors, emotional factors, social support, or attachment to the baby, is currently unknown. Future research should further explore the development of the well-being of the mother—and the father— from a psychological perspective in the transition to parenthood. This research is urgently needed to better understand and help parents who have difficulties in the transition. This would also benefit children who often suffer the consequences of their parents' mental ill-being (Mikolajczak et al., 2018).

Nevertheless, it was somewhat surprising that general self-esteem had a clear role throughout the transition. This could be explained if one considers that childbearing is one of the developmental crises. Erikson (1950) proposed that solutions to previous life crises are revisited in new crises and that failure to achieve good outcomes in one crisis affects the whole ensemble. In line with Erikson's (1950) theory, it could be assumed that childbearing invokes solutions to the very early life crises, such as trust versus mistrust (i.e., whether the individual learns that the world is a safe place and other people can be trusted). Successful solutions to these early life crises could create healthy self-esteem and the ability to successfully navigate the transition to motherhood, especially the first time. However, if the solutions of the very first life crises are not successfully worked through, this can create significant pressure on the mother, as she must revisit previous crises simultaneously as navigating a significant transition that impacts her physiology, psyche, and social relations (see Saxbe, 2017). This double pressure can contribute to difficulties in the transition, creating self-doubt and mistrust in oneself and others. Moreover, achieving a good outcome (i.e., generativity; see Erikson, 1950) in this new life situation may even be dependent on the mother's self-esteem, because it requires a certain level of self-respect to feel that one is positively contributing to future generations.

Understanding the role of general self-esteem helps to integrate theories of childhood development and theories of perinatal development; for example, psychoanalytically oriented researchers propose that a woman's own childhood experiences affect how she adapts to the perinatal period (see, for example, Fraiberg et al., 1975; Raphael-Leff, 2001). The findings of the present dissertation help to explain the mechanisms between adverse childhood experiences and psychological difficulties in the transition to motherhood. For example, we may suspect that adverse childhood experiences may lead to lower self-esteem in the mother-to-be, which in turn reduces the resources necessary for motherhood and increases self-doubt and difficulties in trusting others. Low self-esteem may be detrimental to the ability to process the transition, prepare for motherhood, and receive help from others. This may in turn negatively affect adaptation to pregnancy, childbirth, and motherhood, and cause further difficulties in the family.

4.3 Mothering discourses

The third aim of this dissertation research was to describe mothers' own conceptions of motherhood. Previous research has shown that pregnancy (Sutherland et al., 2014), childbirth (Chadwick & Foster, 2013; Preis et al., 2019), and motherhood (Blair-Loy, 2006; Collins, 2019; Hays, 1996) are all embedded in cultural value systems (i.e., ideologies) and beliefs. These ideologies manifest in different discourses that circulate in the culture (Baxter, 2011) and determine good motherhood throughout the transition. Motherhood discourses also affect women's self-understanding and the ways to speak, write, and even think about motherhood. The closer that women perceive themselves to be with the ideal self-as-mother, the higher their motherhood-related self-esteem will be. However, cultural ideologies also affect women with good self-esteem, because they determine how it is even possible to speak about motherhood. They also define when mothers risk being labeled as bad mothers by behaving in ways that do not conform to these idealizations. For example, Henderson and colleagues (2016) found that the intensive mothering ideology even affects mothers who do not believe in it. For the abovementioned reasons, studying the contents of those cultural idealizations is important.

In the present dissertation research, there seemed to be a discursive continuum from childbirth to motherhood. The results suggest that both childbirth and motherhood are overwhelmingly approached through expert knowledge and that pregnancy and childbirth may serve as a period of enculturation to motherhood. Indeed, the meaning of childbirth is proposed as a "rite of passage" to motherhood in American society (Davis-Floyd, 2003), and the results of the present study are in line with this.

Motherhood discourses in this dissertation study were more varied than those of childbirth. In the findings concerning motherhood discourses, expert knowledge (as identified in childbirth) was manifested in the intensive

mothering discourse (see Study IV), which is also expert-driven and based on developmental psychology and medical understandings of good motherhood (see Collins, 2019; Hays, 1996; Henderson et al., 2016; Liss et al., 2013). Indeed, mothers in our data expressed worries of not knowing what is best for the baby or unintentionally choosing a way of parenting that is not optimal or the very best for their child(ren). These kinds of perfectionist concerns about one's parenting—self-criticism, concern over mistakes, and self-doubt—have been demonstrated to put parents at risk for parental burnout (Lin et al., 2021). The results are also in line with previous research suggesting that mothering in postmodern societies is intensive (Collins, 2019; Henderson et al., 2016), competitive (Abetz & Moore, 2018) and expert-driven (Cucchiara & Steinbugler, 2021; Hays, 1996). Many mothers expressed the desire to be constantly present, loving, and doing the very best for their children. Furthermore, they approached motherhood in an essentialist way as the most important arena in life for women. Mothering was proposed to be instinctual and natural, yet at the same time driven by expert knowledge that women struggled to gather and live the best they could. Feelings of inadequacy were often expressed in relation to this idealized mother, who can fulfill all expert recommendations naturally and without effort. Moreover, one feature of intensive motherhood may also be the perceived "success" of one's children and the pressure for them to achieve well—that is, child-oriented perfectionism (Lin et al., 2022).

This model of "expertized" motherhood seems to develop throughout the transition to motherhood, which is in line with previous research. For example, previous research (e.g., Sutherland et al., 2014) suggests that women are already socialized to treat their bodies as medical objects in pregnancy, while also preparing for culturally appropriate motherhood by adopting maternal responsibility and disciplining their bodies. This mental and practical work in pregnancy prepares women for culturally appropriate childbirth and motherhood, and a discursive continuum of the good mother is built throughout the transition. However, based on the findings of this dissertation, it seems that there is more flexibility in motherhood discourses than in childbirth discourses. This is important for feminist theorizing, and more research should be conducted on pregnancy and childbirth in the Finnish context. In this dissertation, mothers' accounts of motherhood also included elements that were contradictory to the dominant narrative and thus served to challenge it and offer alternative frameworks of understanding (see Baxter, 2011). Alternative views to the intensive mothering discourse were the Equality discourse, the Familistic discourse, and the Balance discourse (see Study IV).

The relative flexibility in motherhood discourses may be affected by the parenting discussions during the latest decades, which have increasingly advocated for equality of both parents (see Moring & Lammi-Taskula, 2019). However, different motherhood discourses coexist in a culture (Baxter, 2011) and their relative weight may change from one historical time to another. For example, Jallinoja (2006) proposed that the familistic discourse was increasingly produced around the turn of the millennium to advocate for traditional gender roles in

newspaper entries and opinion pieces. She proposed a "familistic turn" in Finnish culture, suggesting that traditional discourses had become popular again. More recently, Perälä-Littunen (2018) identified that Finnish parents perceived parenting in a gendered way and promoted the intensive mothering discourse, while at the same time suggesting that parenting should be ideally shared between parents. The findings of the present dissertation are in line with previous Finnish research on motherhood, proposing that traditional ways of understanding motherhood appear dominant but that alternative interpretations also exist.

The findings of this thesis reveal a lot of tension among different discourses, which probably reflects varying cultural values concerning motherhood. Tension emerged especially between traditional discourses (Intensive Mothering, Familistic) and modern (Equality, Balance) discourses of motherhood. This finding is partly in line with previous research. For example, Blair-Loy (2003) suggested that middle-class American women need to balance between different notions of womanhood that encompass both motherhood and work as essential duties in life. In her sample, women executives experienced guilt for not being able to fulfill both roles at the same time. Similarly, women in the present research expressed guilt at not being able to adhere to perfect motherhood ideals and requirements of "success" at the same time. However, the conflict was situated between the roles of the perfect mother and the independent woman, rather than the perfect mother and the perfect employee. This may reflect differences in the cultural environment and structural issues between Finland and the US, such as the availability of paid maternity leave in Finland. Both structural and cultural issues strongly shape how motherhood is experienced in different cultures (see Collins, 2019). In Finland, women may be more likely to compartmentalize discourses into different time periods, such as maternity leave and the time after it. Indeed, Helenius (2020, p. 185) argues that home mothering is framed as the "baby period" for highly educated women before they return to work outside home. This compartmentalizing may also have affected mothering discourses and their relationship to one another in our data, reducing conflict between discourses and thus making them more resistant to change. When different discourses do not interact, they are likely to stay unchanged.

Identifying the Balance discourse was probably the most surprising finding concerning motherhood discourses, as it has not been previously described in Finnish studies. This discourse, consisting of ideas of flexibility and the importance of supporting the needs of all family members, as well as a critique of non-understanding people and perfectionist parenting culture, has not been identified in previous research. This finding implies that Finnish motherhood discourses are diversifying. The Balance discourse was most often identified as negotiations for change and a critique of strict ways of understanding parenting, which indicates that it has a subordinate position to the dominant discourses—a marginalized discourse being mostly produced through a critique of the dominant discourse(s) (see Baxter, 2011). It was nevertheless a different voice that could be identified in many answers through several separate themes. This

finding is encouraging for Finnish mothers, because it means that motherhood discourses are diverse and that it is possible for mothers to choose different ideologies according to their own interests. However, we do not know if this ability to choose is dependent on some forms of privilege; for example, most women in our data were middle-class, Finnish-born, highly educated, and financially well off. We do not know if similar flexibility is possible for less advantaged women, such as foreign-born, racialized, or poor women. To address this question, future research is needed with more diverse samples and intersectional feminist perspectives.

4.4 Theoretical implications

The present thesis integrated developmental psychology, theories of early interaction and psychoanalysis, and sociology and gender studies to discover how certain aspects of identity are formed in the transition to motherhood. The results help to understand the development and possible difficulties in this very specific period of life. The crucial role of self-esteem throughout the transition is a major theoretical contribution of this thesis. It also contributes to the psychology of women in important ways. For example, childbirth is a major life event, but it has been understudied in the discipline of psychology, especially with longitudinal methods (Saxbe, 2017). This dissertation research contributes to answering these gaps in knowledge by studying birth experiences, self-esteem, and motherhood longitudinally. I argue that childbearing deserves attention in scientific research as an important identity-organizing period.

The results of the present thesis help to understand how self-esteem functions in interaction with variables specific to perinatal experiences. It mainly considers the psychological and cultural aspects of birth experiences and motherhood. Physical and embodied reality in the experiences of mothers was considered to the extent that it appeared in the open-ended answers. Furthermore, this dissertation research contributes to the rapidly growing body of literature on parental burnout (Mikolajczak et al., in press), a condition that severely compromises parents' well-being and family life (Mikolajczak & Roskam, 2018). The present research studied parental burnout in mothers of infants and how self-esteem adds to the risk of parental burnout. It also explored how mothers themselves produce mothering discourses—and in this way explains how mothers contribute to or resist the expectations that may expose them to feelings of inadequateness (Abetz & Moore, 2018).

I suggest that the transition to motherhood is a psychosocial developmental crisis that challenges mothers' means of coping and reorganizes their psychological structure. In the present thesis, self-esteem and cultural conceptions were understood as closely connected, because good self-esteem is manifested in the feeling of being "good enough" and accepted by others, which indicates a close enough match between actual self and ideal self, as described by Higgins (1987), as well as perceptions of others' regard (Crocker, 2011). This

theoretical stance is feasible in the transition to motherhood and previous studies have empirically tested it. For example, Sonnenburg and Miller (2021) found that a greater discrepancy between women's maternal self-concept and good mother ideals in the culture were associated with more severe postnatal depression symptoms. Of course, there can be different variations of the ideal self, but, in general, the contents for this idealization come from the surrounding culture and are dependent on the person's social role; in this sense, the self is dialogical (see Baxter, 2011; Frank, 2005). Women and especially mothers are restricted in their choices of what can be perceived as good womanhood and good motherhood (Abetz, 2016; Dow, 2016; Sonnenburg & Miller, 2021). Conversely, low self-esteem is often manifested in performance anxiety, feelings of inadequacy, and perceptions of being rejected by others. It has been proposed that self-esteem is a "sociometer" (Leary, 2005) that indicates a person's social value—the lower the status of the individual, the lower their self-esteem. The results of the present thesis help to understand the complex relationship of self-esteem and cultural ideologies.

4.5 Practical implications

The results of the present study can be used in several ways. First, knowledge concerning the crucial role of self-esteem in the transition to motherhood should be used in antenatal care to better identify women at risk for negative birth experiences. Interventions focusing on self-compassion should be developed and clinically evaluated for women with low self-esteem and/or high performance expectations for themselves. Second, knowledge of different ways of understanding childbirth should be distributed to maternity organizations, such as family health centers and birthing hospitals, as understanding different childbirth beliefs could improve communication among women, their partners, and professionals. The maternity care systems should better recognize the different beliefs and value systems that women and families may have, which would improve communication and shared decision-making. Third, different discourses of motherhood should be addressed in maternity care as possible sources of stress and internal conflict. Especially women with high performance-based self-esteem may be vulnerable to perfectionist beliefs and trapped between contradictory ideals. Mothers who are struggling with perfectionist beliefs should be offered psychosocial support that recognizes the impact of cultural ideals for motherhood and challenges them. Guided peer support, such as a support group with a professional facilitator, could be a good way to improve mothers' well-being (see Huang et al., 2020; McLeish & Redhaw, 2017; Rice et al., 2022).

4.6 Strengths and limitations

A special strength of the present dissertation is that it integrates different theoretical and practical orientations to study the transition to motherhood. The use of the multimethod longitudinal design allows studying of variations between individuals in interesting ways. For example, it helps to explain why some women's self-esteem is affected by their birth experience and other women's self-esteem is not; it was possible to study this using mixed-methods design. Furthermore, covering the transition from the third trimester of pregnancy to one year postpartum allows studying of specific risk and protective factors more reliably than a cross-sectional design. Two separate datasets were used to cover the topics of this dissertation, which increases the generalizability of the findings. Moreover, qualitative analyses were used in an innovative manner with short written answers; they proved to be a fruitful method for studying these kinds of datasets. Although the answers were short, a large number of answers increases the validity of findings. When answering a longer questionnaire, people may quickly answer open-ended questions and provide only the aspects they consider the most relevant. However, this can also be seen as a weakness, as it directs answering in a limited direction and may restrict the expression of contradictory views.

The present dissertation also has limitations. The participants in the two studies were mainly highly educated women in secure economical positions, and most of them were Finnish-born and living in heterosexual relationships. Thus, the results may not be generalizable to the general population of Finnish childbearing women and mothers (see Zadoroznyj, 1999, for social class and childbirth experience). Another limitation is that the changes that happen during the perinatal period would have been easier to understand if the first follow-up point had been in the time before conception (i.e., when the women were not yet pregnant). Follow-up from preconception would be especially suitable in studying changes in women's self-esteem and mothering ideologies over a longer time.

Finally, one of the datasets (Fear of childbirth, birth experiences, and parental burnout) was collected only in Central Finland, which limits the generalizability of the results in the general population of Finnish childbearing women. The participation rate was low and, thus, the results could be biased. In future studies, input from childbearing women could be used to design studies and make them more interesting, especially for immigrant women and those in less advantaged socioeconomic positions. Moreover, the data was collected during the COVID-19 pandemic, which could have affected the results; for example, birth experiences may have been more negative because of the uncertainty and restrictions in place in hospitals. In 2020, birthing hospitals commonly placed restrictions on the presence of supporting persons (and even fathers and other non-birthing parents) in labor and delivery, and these restrictions were also in place in some of the antenatal checkups. Pregnant

women had to attend appointments alone and even risk birthing without the support of their partners or other supporting persons. Moreover, visitors, including non-birthing parents, were excluded from postnatal wards, and new mothers thus needed to cope with their newborns without their social network. These restrictions created anxiety and fear in pregnant women (Boekhorst et al., 2021) and were associated with increases in ill-being in mothers (Iyengar et al., 2021). Women worried about not having their partner present at birth, childbirth itself, and something being wrong with the baby (Burgess et al., 2022). Research findings from many different countries have suggested that childbirth experiences during the pandemic were negatively affected by the lockdown measures (Aydin et al., 2022; Bertholdt et al., 2022), with an increase in traumatic experiences (Berthelot et al., 2020; Diamond & Colaianni, 2022; Mayopoulos et al., 2021). The postpartum well-being of mothers has been affected by the pandemic, at least in some countries, showing an increase in depressive symptoms, anxiety, and parenting stress (Fernandes et al., 2021; Gustafsson et al., 2021). Also, parenting became more challenging and isolated, and parental burnout levels increased all around the globe during the pandemic (Van Bakel et al., 2022). However, the restrictions concerning childbirth in Finnish hospitals were only in place for some months and most of the study participants did not give birth during the period when they were in place. This may explain why the prevalence of fear of childbirth in the data was lower than expected (only 11.5%). These findings probably reflect the position of Finnish society in relation to the pandemic in 2020: Finland had very low infection rates in 2020 (World Health Organization, 2022), and the measures in place to prevent the virus in the society were short-term and not very restrictive compared to those in many other countries.

4.7 Future directions

Perinatal psychology is an area of top priority in scientific research, not only because mental health difficulties are very common in the transitional period (Howard & Khalifeh, 2020) but also because of the extraordinary flexibility of the human mind during this time (Brodén & Kivirauma, 2006). Future research should explore normal psychological changes at that time (see also Alderdice, 2018), most importantly focusing on positive experiences (see also McKelvin et al., 2021) and their effects on psychological well-being. Individual variations in psychological characteristics and belief systems should be studied further. Self-esteem is only one of the individual dispositions that affect changes in the perinatal period, and research should cover them to a larger extent. For example, personality is one of the very little studied individual dispositions in the context of childbirth (see, however, Asselmann et al., 2021). Psychological characteristics should also be studied in their social context. Pregnancy, childbirth, and motherhood are such culturally laden constructs that we cannot understand women's experiences without understanding the culture they live in. It is

possible that some women may be able to challenge essentialist narratives of womanhood and motherhood because of certain personality factors, and this may contribute to good experiences for those women. Alternatively, this ability to form counter-narratives may be dependent on the social environment and status, such as social class, and this should also be studied. Furthermore, ideologies of pregnancy, childbirth, and motherhood should be studied in the future with in-depth methods to account for more complexity. Finally, fathers' experiences are important as well, and they should be studied in the context of the perinatal period.

I propose that childbirth discourses may be more restricted than motherhood discourses in the Finnish context. It is possible that in pregnancy, discourses are even more restricted, as the motherhood status is not yet established and women must conform to various expectations to be recognized as mothers. Indeed, the best interests of the child may be perceived more narrowly in the context of pregnancy, as compared to motherhood of a child that has already been born. Future research should compare discourses of pregnancy, childbirth, and motherhood to understand how good motherhood is discursively constructed in different phases of the transition and if and how counternarratives or discourses are manifested. The present research did not collect qualitative data on pregnancy discourses, and it should be studied in the future whether the intensive mothering discourse already emerges in relation to pregnancy in the Finnish context. An especially important future venue is a study of positive experiences with longitudinal methods throughout the perinatal period. This kind of research would allow a better understanding of how and why some women are able to flourish in this transition, and to build resources in society that would benefit more women. New knowledge and incentives are needed to foster good perinatal experiences in the care systems.

4.8 Conclusion

Mothers' self-esteem affects how they experience the expectations for childbirth and mothering and how they evaluate their own performances as compared to cultural images of good motherhood. Women with low self-esteem are vulnerable to high expectations and the negative impact of any difficulties they might face in the transition to motherhood. Perinatal service providers should recognize the negative impact of low self-esteem for mothers' psychological well-being throughout the transition to motherhood and help to reduce its adverse effects. This issue should be addressed at both individual and societal levels. At the individual level, assessing women's self-esteem in pregnancy, for example, through a single question (see Robins et al., 2001), and providing extra support for those who suffer from low self-esteem, might be beneficial. Such women would probably benefit from positive feedback on their mothering behaviors and preparation for motherhood in pregnancy, as well as from therapeutic discussions and social support. Moreover, teaching self-compassion in birth

preparation classes for all families would help them to prepare for the uncertainty and challenges of childbirth and parenting. At the societal level, increased knowledge of different ideologies and encouraging diverse views of childbirth and parenting would probably be beneficial, providing more flexibility to rely on ideologies that suit oneself. Moreover, perfectionist pressure could be reduced by means of information about different ways to think about childbirth and motherhood. We should be honest with parents about the impact of different ideologies; for example, recognizing the central features of intensive parenting and knowing that it can be harmful to mental health (see Henderson et al., 2016) might help to tackle the intensive and competitive pressure that especially mothers experience in parenting. This could in turn reduce the probability of parental burnout. In the future, it would be important to study the effectiveness of peer support programs for maternal well-being. Peer support could help to tackle perfectionist standards by reducing individualistic pressure in parenting. Parents could share their thoughts with other parents and jointly build more compassionate attitudes toward oneself and others. Findings concerning the interplay of different motherhood discourses support the benefits of discourses being challenged with other discourses: the more that different discourses interact in parents' speech, the more they influence one another, creating new ways of thinking (Baxter, 2011). This development could be promoted through peer support in the perinatal period. Evidence from previous studies suggests that peer support is effective in reducing perinatal depressive symptoms and promoting a sense of confidence in parenting in mothers (Huang et al., 2020; McLeish & Redhaw, 2017; Rice et al., 2022). Communities could initiate peer support programs for parents, especially during the transition to parenthood.

REFERENCES

Abetz, J., & Moore, J. (2018). "Welcome to the mommy wars, ladies": Making sense of the ideology of combative mothering in mommy blogs. *Communication, Culture & Critique, 11*(2), 265–281. https://doi-org.ezproxy/10.1093/ccc/tcy008

Alakärppä, O. (2022). *Nuorten naisten työn ja perheen yhteensovittamisen odotukset ja koetut toimintamahdollisuudet muotoutuvassa aikuisuudessa [Young women's expectations and their perceived capabilities for work-family reconciliation in emerging adulthood].* Jyväskylän yliopisto.

Alderdice, F. & Gargan, P. (2019). Exploring subjective well-being after birth: A qualitative deductive descriptive study. *European Journal of Midwifery, 3*(5). https://doi.org/10.18332/ejm/104679

Alderdice, F. (2018). Enduring questions in perinatal psychology. *Journal of Reproductive and Infant Psychology, 36*(5), 461-462. https://doi.org/10.1080/02646838.2018.1539440

Annandale, E., & Clark, J. (1996). What is gender? Feminist theory and the sociology of human reproduction. *Sociology of Health & Illness, 18*(1), 17–44. https://doi.org/10.1111/1467-9566.ep10934409

Antonovsky, A. (1979). *Health, stress, and coping.* San Francisco, CA: Jossey-Bass.

Antonovsky, A. (1996). The salutogenic model as a theory to guide health promotion. *Health Promotion International, 11,* 11–18. https://doi.org/10.1093/heapro/11.1.11

Arnold, M., & Kalibatseva, Z. (2021). Are "superwomen" without social support at risk for postpartum depression and anxiety? *Women & health, 61*(2), 148-159. https://doi.org/10.1080/03630242.2020.1844360

Asselmann, E., Garthus-Niegel, S. & Martini, J. (2021). Personality impacts fear of childbirth and subjective birth experiences: A prospective longitudinal study. *PLoS ONE 16*(11): e0258696. https://doi.org/10.1371/journal.pone.0258696

Aunola, K. & Sorkkila, M. (2018– present). International Investigation of Parental Burnout (IIPB): Finnish substudy. Research project. University of Jyväskylä.

Aunola, K., Sorkkila, M., & Tolvanen, A. (2020). Validity of the Finnish version of the Parental Burnout Assessment (PBA). *Scandinavian Journal of Psychology, 61*(5), 714–722. https://doi.org/10.1111/sjop.12654

Aydin, E., Glasgow, K. A., Weiss, S. M., Khan, Z., Austin, T., Johnson, M. H., Barlow, J., Lloyd-Fox, S. (2022). Giving birth in a pandemic: women's birth experiences in England during COVID-19. *BMC Pregnancy and Childbirth, 22*(1), 304. https://doi.org/10.1186/s12884-022-04637-8

Ayers, S. (2004). Delivery as a traumatic event: prevalence, risk factors, and treatment for postnatal posttraumatic stress disorder. *Clinical Obstetrics and Gynecology, 47*(3), 552–567. https://doi.org/10.1097/01.grf.0000129919.00756.9c

Ayers, S., Eagle, A. & Waring, H. (2006). The effects of childbirth-related post-traumatic stress disorder on women and their relationships: A qualitative study. *Psychology, Health & Medicine, 11*(4), 389-398. https://doi.org/10.1080/13548500600708409

Barbre, M. E. (2022). Motherhood enjambed: birth stories, ritual, and implicit religion. *Journal of Beliefs and Values, 43*(1), 40–50. https://doi.org/10.1080/13617672.2022.2005712

Baxter, L. A. (2011). *Voicing relationships.* Sage.

Baxter, J., Buchler, S., Perales, F., & Western, M. (2015). A life-changing event: first births and men's and women's attitudes to mothering and gender divisions of labor. *Social Forces, 93*(3), 989-1014. https://doi.org/10.1093/sf/sou103

Baxter, L. A., Scharp, K. M., & Thomas, L. J. (2021). Original voices. Relational dialectics theory. *Journal of Family Theory & Review, 13*(1), 7–20. https://doi.org/10.1111/jftr.12405

Beck, C. T. (2004). Birth trauma: In the eye of the beholder. *Nursing Research, 53*(1), 28–35. https://doi.org/10.1097/00006199-200401000-00005

Beck, C. T. & Watson, S. (2010). Subsequent childbirth after a previous traumatic birth. *Nursing Research, 59*(4), 241–249. https://doi.org/10.1097/NNR.0b013e3181e501fd

Beckett, K. (2005). Choosing cesarean: Feminism and the politics of childbirth in the United States. *Feminist Theory, 6*(3), 251–275. https://doi.org/10.1177/1464700105057363

Berthelot, N., Lemieux, R., Garon-Bissonnette, J., Drouin-Maziade, C., Martel, É. & Maziade, M. (2020). Uptrend in distress and psychiatric symptomatology in pregnant women during the coronavirus disease 2019 pandemic. *Acta Obstetricia et Gynecologica Scandinavica, 99*(7), 848–855. https://doi.org/10.1111/aogs.13925

Bertholdt, C., Epstein, J., Alleyrat, C., Ambroise Grandjean, G., Claudel, L., Olieric, M., . . . Morel, O. (2022). Comparative evaluation of the impact of the COVID-19 lockdown on perinatal experience: A prospective multicentre study. *BJOG: An International Journal of Obstetrics and Gynaecology, 129*(8), 1333-1341. https://doi.org/10.1111/1471-0528.17082

Betrán, A. P., Ye, J., Moller, A., Zhang, J., Gülmezoglu, A. M. & Torloni, M. R. (2016). The increasing trend in caesarean section rates: global, regional and national estimates: 1990–2014. *PLoS One, 11*(2), e0148343. https://doi.org/10.1371/journal.pone.0148343

Bianchi, S. M., Sayer, L. C., Milkie, M. A., & Robinson, J. P. (2012). Housework: who did, does or will do it, and how much does it matter? *Social Forces; A Scientific Medium of Social Study and Interpretation, 91*(1), 55-63. https://doi.org/10.1093/sf/sos120

Blair-Loy, M. (2003). *Competing devotions: Career and family among women executives.* Harvard University Press.

Boekhorst, M., Muskens, L., Hulsbosch, L. P., Van Deun, K., Bergink, V., Pop, V. J. M., et al. (2021). The COVID-19 outbreak increases maternal stress

during pregnancy, but not the risk for postpartum depression. *Archives of Women's Mental Health, 24*(6),1037–43. https://doi.org/10.1007/s00737-021-01104-9
Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Saraiva Coneglian, F., Diniz, A. L., Tunçalp, Ö., Javadi, D., Oladapo, O. T., Khosla, R., Hindin, M. J., & Gülmezoglu, A. M. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS medicine, 12*(6), e1001847. https://doi.org/10.1371/journal.pmed.1001847
Bongaarts, J. (2016). WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division trends in maternal mortality: 1990 to 2015 Geneva: World Health Organization, 2015. *Population and Development Review, 42*(4), 726. https://doi.org/10.1111/padr.12033
Bossano, C. M., Townsend, K. M., Walton, A. C., Blomquist, J. L. & Handa, V. L. (2017). The maternal childbirth experience more than a decade after delivery. *American Journal of Obstetrics & Gynecology, 217*(342). e1–8. http://dx.doi.org/10.1016/j.ajog.2017.04.027
Bradford, B. F., Wilson, A. N., Portela, A., McConville, F., Fernandez Turienzo, C., Homer, C. S. E. (2022). Midwifery continuity of care: A scoping review of where, how, by whom and for whom? *PLOS Global Public Health 2*(10), e0000935. https://doi.org/10.1371/journal.pgph.0000935
Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
Brianda, M. E., Roskam, I., & Mikolajczak, M. (2020a). Hair cortisol concentration as a biomarker of parental burnout. *Psychoneuroendocrinology, 117*, 104681. https://doi.org/10.1016/j.psyneuen.2020.104681
Brianda, M., Roskam, I., Gross, J., Franssen, A., Kapala , F., Gérard , F., & Mikolajczak, M. (2020b). Treating parental burnout: Impact of two treatment modalities on burnout symptoms, emotions, hair cortisol, and parental neglect and violence. *Psychotherapy and Psychosomatics, 89*(5), 330-332. https://doi.org/10.1159/000506354
Brodén, M. & Kivirauma, M. (2006). *Raskausajan mahdollisuudet: Kun suhteet syntyvät ja kehittyvät [The Possibilities of Pregnancy: When Relationships are Created and Evolving].* Therapeia-säätiö.
Broughton, S., Ford-Gilboe, M., & Varcoe, C. (2022). Mothering in the context of intimate partner violence: A feminist intersectional critique of the nursing literature. *Journal of Advanced Nursing, 78*(12), 3974–3986. https://doi.org/10.1111/jan.15450
Burgess, A., Breman, R. B., Roane, L. A., Dada, S., Bradley, D., & Burcher, P. (2022). Impact of COVID-19 on pregnancy worry in the United States. *Birth, 49*(3), 420-429. https://doi.org/10.1111/birt.12608
Byrne, V., Egan, J., Mac Neela, P. & Sarma, K. (2017). What about me? The loss of self through the experience of traumatic childbirth. *Midwifery, 51*, 1–11. http://dx.doi.org/10.1016/j.midw.2017.04.017

Carter, S. K. (2009). Gender performances during labor and birth in the midwives' model of care. *Gender Issues, 26*(3-4), 205–223. https://doi.org/10.1007/s12147-009-9084-x

César, F., Costa, P., Oliveira, A. & Fontaine, A. M. (2018). "To suffer in paradise": Feelings mothers share on Portuguese Facebook sites. *Frontiers in Psychology, 9,* 1797. https://doi.org/10.3389/fpsyg.2018.01797

Chabbert, M., Panagiotou, D. & Wendland, J. (2021). Predictive factors of women's subjective perception of childbirth experience: a systematic review of the literature. *Journal of Reproductive and Infant Psychology, 39*(1), 43–66. https://doi.org/10.1080/02646838.2020.1748582

Chadwick, R. (2018). *Bodies that birth. Vitalizing birth politics.* Routledge. https://doi.org/10.4324/9781315648910

Chadwick, R. J., & Foster, D. (2013). Technologies of gender and childbirth choices: Home birth, elective caesarean and white femininities in South Africa. *Feminism and Psychology, 23*(3), 317–338. https://doi.org/10.1177/0959353512443112

Chamberlain, P. (2016). Affective temporality: towards a fourth wave. *Gender and Education, 28*(3), 458–464. https://doi.org/10.1080/09540253.2016.1169249

Chen, E. Y., Enright, R. D., & Tung, E. Y. (2016). The influence of family unions and parenthood transitions on self-development. *Journal of Family Psychology, 30*(3), 341-352. https://doi.org/10.1037/fam0000154

Chodorow, N. J. (1978; second ed. 1999). *The reproduction of mothering: Psychoanalysis and the sociology of gender.* Berkeley: University of California Press.

Choi, P., Henshaw, C., Baker, S., & Tree, J. (2005). Supermum, superwife, supereverything: Performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology, 23*(2), 167–180. https://doi.org/10.1080/02646830500129487

Christopher, K. (2012). Extensive mothering: Employed mothers' constructions of the good mother. *Gender & Society, 26*(1), 73–96. https://doi.org/10.1177/0891243211427700

Clarke, A. E. (1998). *Disciplining reproduction: Modernity, American life sciences, and the problems of sex.* Berkeley: University of California Press.

Coleman, L., & A. Coleman. (1971). *Pregnancy: The psychological experience.* New York: Seabury Press.

Collins, C. (2019). *Making motherhood work: How women manage careers and caregiving.* Princeton University Press.

Collins, C., Landivar, L. C., Ruppanner, L., & Scarborough, W. J. (2020). COVID-19 and the gender gap in work hours. *Gender, Work & Organization, 28*(Suppl. 1), 101–112. https://doi.org/10.1111/gwao.12506

Coltrane, S. (2000). Research on household labor: Modeling and measuring the social embeddedness of routine family work. *Journal of Marriage and Family, 62*(4), 1208-1233. https://doi.org/https://doi.org/10.1111/j.1741-3737.2000.01208.x

Cooper, H., & Magagna, J. (2005). The origins of self-esteem in infancy. In: Magagna, J., Bakalar, N., Cooper, H., Levy, J., Norman, C. & Shank, C. *(Eds) Intimate Transformations: Babies with Their Families* (pp. 13–41). https://doi.org/10.4324/9780429476129-2

Copelton, D.A. (2007). "You are what you eat": nutritional norms, maternal deviance, and neutralization of women's prenatal diets. *Deviant Behavior, 28*(5), 467–94. https://doi.org/10.1080/01639620701252571

Cotter, D., Hermsen, J. M., & Vanneman, R. (2011). The end of the gender revolution? Gender role attitudes from 1977 to 2008. *American Journal of Sociology, 117*(1), 259–289. https://doi.org/10.1086/658853

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics (pp. 139–167). Routledge.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches (3rd ed.).* Thousand Oaks, CA: Sage.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research (2nd ed.).* Thousand Oaks, CA: Sage.

Crocker, J. (2011). Presidential address: Self-image and compassionate goals and construction of the social self: Implications for social and personality psychology. *Personality and Social Psychology Review, 15*(4), 394-407. https://doi.org/10.1177/1088868311418746

Cucchiara, M., & Steinbugler, A. C. (2021). "The books make you feel bad": Expert advice and maternal anxiety in the early 21st century. *Sociological Forum (Randolph, N.J.), 36*(4), 939–961. https://doi.org/10.1111/socf.12748

Curran, T., & Hill, A. P. (2022). Young people's perceptions of their parents' expectations and criticism are increasing over time: Implications for perfectionism. *Psychological Bulletin, 148*(1-2), 107-128. https://doi.org/10.1037/bul0000347

Curran, T., & Hill, A. P. (2019). Perfectionism is increasing over time: a meta-analysis of birth cohort differences from 1989 to 2016. *Psychological Bulletin, 145*(4), 410-429. https://doi.org/10.1037/bul0000138

Dahlen, H. G. (2010). Undone by fear? Deluded by trust? *Midwifery, 26*(2), 156–162. https://doi.org/10.1016/j.midw.2009.11.008

Das, R. (2019). The mediation of childbirth: 'Joyful' birthing and strategies of silencing on a Facebook discussion group. *European Journal of Cultural Studies, 22*(5–6) 495–510.

Davis-Floyd, R. E. (2003). *Birth as an American rite of passage: Second Edition, with a new preface (2nd ed.).* University of California Press. http://www.jstor.org/stable/10.1525/j.ctt1pndwn

Davis-Floyd, R. E. (2001). The technocratic, humanistic, and holistic paradigms of childbirth. *International Journal of Gynecology & Obstetrics, 75*, 5–23. https://doi-org/10.1016/S0020-7292(01)00510-0

Dencker, A., Bergqvist, L., Berg, M., Greenbrook, J. T. V., Nilsson, C., & Lundgren, I. (2020). Measuring women's experiences of decision-making and aspects of midwifery support: A confirmatory factor analysis of the

revised Childbirth Experience Questionnaire. *BMC Pregnancy Childbirth, 20*(1), 199. https://doi.org/10.1186/s12884-020-02869-0
Dennis, C., Brown, H. K., Falah-Hassani, K., Marini, F. C., & Vigod, S. N. (2017). Identifying women at risk for sustained postpartum anxiety. *Journal of Affective Disorders, 213*, 131–137. https://doi.org/10.1016/j.jad.2017.02.013
Deutscher, M. (1970). Brief family therapy in the course of first pregnancy: A clinical note. *Contemporary Psychoanalysis*, 21–35.
Diamond, R. M., & Colaianni, A. (2022). The impact of perinatal healthcare changes on birth trauma during COVID-19. *Women and Birth, 35*(5), 503–510. https://doi.org/10.1016/j.wombi.2021.12.003
Dikmen-Yildiz, P., Ayers, S., & Phillips, L. (2018). Longitudinal trajectories of post-traumatic stress disorder (PTSD) after birth and associated risk factors. *Journal of Affective Disorders, 229*, 377-385. https://doi.org/10.1016/j.jad.2017.12.074
Dixon, L., Skinner, J. & Foureur, M. (2014). The emotional journey of labour—Women's perspectives of the experience of labour moving towards birth. *Midwifery, 30*, 371–377. http://dx.doi.org/10.1016/j.midw.2013.03.009
Donate-Manzanares, M., Rodríguez-Cano, T., Rodríguez-Almagro, J., Hernández-Martínez, A., Santos-Hernández, G., & Beato-Fernández, L. (2021). Mixed-method study of women's assessment and experience of childbirth care. *Journal of Advanced Nursing, 77*(10), 4195-4210. https://doi.org/10.1111/jan.14984
Douglas, S. J., & Michaels, M. W. (2004). *The mommy myth: The idealization of motherhood and how it has undermined all women*. Free Press.
Dow, D. M. (2016). Integrated motherhood: Beyond hegemonic ideologies of motherhood. *Journal of Marriage and Family, 78*, 180–196. https://doi.org/10.1111/jomf.12264
Downe, S., Finlayson, K., Oladapo, O. T., Bonet, M., & Gülmezoglu, A. M. (2018). What matters to women during childbirth: A systematic qualitative review. *PloS One, 13*(4), e0194906. https://doi.org/10.1371/journal.pone.0194906
Downe, S., Gyte, G. M. L., Dahlen, H. G., & Singata, M. (2013). Routine vaginal examinations for assessing progress of labour to improve outcomes for women and babies at term. *Cochrane Database of Systematic Reviews, 7*, CD010088. https://doi.org/10.1002/14651858.CD010088.pub2
Ellingsæter, A. L., & Leira, A. (2006). *Politicising parenthood in Scandinavia: Gender relations in welfare states.* Policy Press.
England, P. (2010). The gender revolution: Uneven and stalled. *Gender & Society, 24*(2), 149–166. https://doi.org/10. 1177/0891243210361475
Erikson, E. H. (1950). *Childhood and society*. New York, NY: Norton.
Erikson, E. H., & Erikson, J. M. (1997). *The life cycle completed (extended version).* New York, NY: W. W. Norton.
Euro-Peristat Project (2015). *European Perinatal Health Report. Core indicators of the health and care of pregnant women and babies in Europe in 2015.* Available at

https://www.europeristat.com/index.php/reports/european-perinatal-health-report-2015.html.
Evans, E., & Chamberlain, P. (2015). Critical waves: Exploring feminist identity, discourse and praxis in Western feminism. *Social Movement Studies, 14*(4), 396–409. https://doi.org/10.1080/14742837.2014.964199
Favez, N., Max, A., Bader, M., & Tissot, H. (2022). When not teaming up puts parents at risk: Coparenting and parental burnout in dual-parent heterosexual families in Switzerland. *Family Process, 36*(1), 1–15. https://doi.org/10.1111/famp.12777
Fernandes, D. V., Canavarro, M. C., & Moreira, H. (2021). Postpartum during COVID-19 pandemic: Portuguese mothers' mental health, mindful parenting, and mother–infant bonding. *Journal of Clinical Psychology, 77*(9), 1997-2010. https://doi.org/10.1002/jclp.23130
Fisher, C., Hauck, Y., & Fenwick, J. (2006). How social context impacts on women's fears of childbirth: A Western Australian example. *Social Science & Medicine (1982), 63*(1), 64-75. https://doi.org/10.1016/j.socscimed.2005.11.065
Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry, 14,* 387–421.
Frank, A. W. (2005). What is dialogical research, and why should we do it? *Qualitative Health Research, 15*(7), 964-974. https://doi.org/10.1177/1049732305279078
Gato, J., Fontaine, A. M., César, F., Leal, D., Roskam, I., & Mikolajczak, M. (2022). Parental burnout and its antecedents among same-sex and different-sex families. *International Journal of Environmental Research and Public Health, 19*(13), 7601. https://doi.org/10.3390/ijerph19137601
Gelabert, E., Subirà, S., García-Esteve, L., Navarro, P., Plaza, A., Cuyàs, E., . . . Martín-Santos, R. (2011). Perfectionism dimensions in major postpartum depression. *Journal of Affective Disorders, 136*(1), 17-25. https://doi.org/10.1016/j.jad.2011.08.030
Gilbert, N. (2008). *A mother's work. How feminism, the market, and policy shape family life*. Yale University Press.
Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Harvard University Press.
Gnanasambanthan, S. & Datta, S. (2020). When is a maternal request caesarean section not a maternal request? *Obstetrics, Gynaecology & Reproductive Medicine, 30*(6), 190–193. https://doi.org/10.1016/j.ogrm.2020.03.003
Gordon, L. (2016). 'Intersectionality', socialist feminism and contemporary activism: Musings by a second-wave socialist feminist. *Gender & History, 28*(2), 340–357. https://doi.org/10.1111/1468-0424.12211
Goutaudier, N., Bertoli, C., Séjourné, N., & Chabrol, H. (2019). Childbirth as a forthcoming traumatic event: Pretraumatic stress disorder during pregnancy and its psychological correlates. *Journal of Reproductive and*

Infant Psychology, 37(1), 44–55. https://doi.org/10.1080/02646838.2018.1504284
Grekin, R., & O'Hara, M. W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: A meta-analysis. *Clinical Psychology Review, 34*(5), 389–401. https://doi.org/10.1016/j.cpr.2014.05.003
Gribble, K. D., Bewley, S., Bartick, M. C., Mathisen, R., Walker, S., Gamble, J., . . . Dahlen, H. G. (2022). Effective communication about pregnancy, birth, lactation, breastfeeding and newborn care: the importance of sexed language. *Frontiers in Global Women's Health, 3*, 818856. https://doi.org/10.3389/fgwh.2022.818856
Gunderson, J., & Barrett, A. (2015). Emotional costs of emotional support? The association between intensive mothering and psychological well-being in midlife. *Journal of Family Issues, 38*(7), 992–1009. https://doi.org/10.1177/0192513X15579502
Gustafsson, H. C., Young, A. S., Doyle, O., Nagel, B. J., Mackiewicz Seghete, K., Nigg, J. T., . . . Graham, A. M. (2021). Trajectories of perinatal depressive symptoms in the context of the COVID-19 pandemic. *Child Development, 92*(5), e749-e763. https://doi.org/10.1111/cdev.13656
Hall, C. (2016). Womanhood as experienced in childbirth: Psychoanalytic explorations of the body. *Psychoanalytic Social Work, 23*(1), 42–59. https://doi.org/10.1080/15228878.2015.1073161
Hamelin-Brabant, L., de Montigny, F., Roch, G., Deshaies, M., Mbourou-Azizah, G., Da Silva, R. B., . . . Fournier, C. (2015). Perinatal vulnerability and social-support during the postnatal period: A review of the literature. *Santé Publique (Vandoeuvre-lès-Nancy, France), 27*(1), 27-37.
Handelzalts, J. E., Becker, G., Ahren, M.-P., Lurie, S., Raz, N., Tamir, Z. & Sadan, O. (2015). Personality, fear of childbirth and birth outcomes in nulliparous women. *Archives of Gynecology and Obstetrics, 291*, 1055–1062. http://dx.doi.org/10.1007/s00404-014-3532-x
Harris, R., & Ayers, S. (2012). What makes labour and birth traumatic? A survey of intrapartum 'hotspots'. *Psychology & Health, 27*(10), 1166-1177. https://doi.org/10.1080/08870446.2011.649755
Hassert, S., Sharon, S. R., Payakkakom, A., & Kodyšová, E. (2018). Postpartum depressive symptoms: risks for Czech and Thai mothers. *The Journal of Perinatal Education, 27*(1), 38–49. https://doi.org/10.1891/1058-1243.27.1.38
Hays, S. (1996). *The cultural contradictions of motherhood.* Yale University Press.
Heimstad, R., Dahloe, R., Laache, I., Skogvoll, E., & Schei, B. (2006). Fear of childbirth and history of abuse: Implications for pregnancy and delivery. *Acta Obstetricia et Gynecologica Scandinavica, 85*(4), 435-440. https://doi.org/10.1080/00016340500432507
Helenius, P. (2020). *Ura, lapset ja tavoiteltava perhekulttuuri: Työn ja perheen jännitteitä koulutettujen naisten puheessa [Career, children and a desirable family culture – tensions between work and family in the discourses of educated women].* Doctoral dissertation. University of Tampere.

Henderson, A., Harmon, S., & Newman, H. (2016). The price mothers pay, even when they are not buying it: Mental health consequences of idealized motherhood. *Sex Roles, 74*(11–12), 512–526. https://doi.org/10.1007/s11199-015-0534-5

Hendrix, Y., Baas, M., Vanhommerig, J., de Jongh, A., Van Pampus, M. (2022). Fear of childbirth in nulliparous women. *Frontiers in Psychology, 13*, 923819. doi: 10.3389/fpsyg.2022.923819.

Henriksen, L., Grimsrud, E., Schei, B., & Lukasse, M. (2017). Factors related to a negative birth experience—A mixed methods study. *Midwifery, 51*, 33-39. https://doi.org/10.1016/j.midw.2017.05.004

Hewitt, N. (2010). Introduction. In: Hewitt, N. A., Châvez, M., Cobble, D., Fernandes, L., Garrison, E., Gilmore, S., . . . Nadasen, P. [Eds.] (2010). *No permanent waves: Recasting histories of U.S. feminism.* Rutgers University Press. https://doi.org/10.36019/9780813549170

Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: Conceptualization, assessment, and association with psychopathology. *Journal of Personality and Social Psychology, 60*, 456—470. http://dx.doi.org/10.1037/0022-3514.60.3.456

Higgins, E. T. (1987). Self-discrepancy: A theory relating to self and affect. *Psychological Review, 94*, 319-340.

Hill, A. P., & Curran, T. (2019). A case for multiple pathways to increasing perfectionism: Reply to Soenens and Vansteenkiste (2019). *Psychological Bulletin, 145*(4), 433-435. https://doi.org/10.1037/bul0000189

Hofberg, K. & Brockington, I. (2000). Tokophobia: An unreasoning dread of childbirth. A series of 26 cases. *The British Journal of Psychiatry, 176*, 83–85.

Hofstede, G. (2001). *Culture's consequences: Comparing values, behaviors, institutions and organizations across nations.* Sage.

Hollway, W. (2016). Feminism, psychology and becoming a mother. *Feminism & Psychology, 26*(2), 137-152. https://doi.org/10.1177/0959353515625662

Holmes, L. (2000). The object within: Childbirth as a developmental milestone. *Modern Psychoanalysis, 25*(1), 109–134.

Holopainen, A., Verhage, M., & Oosterman, M. (2020). Childbirth experience associated with maternal and paternal stress during the first year, but not child attachment. *Frontiers in psychiatry, 11*(September), 1-10. https://doi.org/10.3389/fpsyt.2020.562394

Howard, L. M. & Khalifeh, H. (2020). Perinatal mental health: a review of progress and challenges. *World Psychiatry, 19*(3), 313–327. https://doi.org/10.1002/wps.20769

Huang, R., Yan, C., Tian, Y., Lei, B., Yang, D., Liu, D., & Lei, J. (2020). Effectiveness of peer support intervention on perinatal depression: A systematic review and meta-analysis. *Journal of Affective Disorders, 276*, 788–796. https://doi.org/10.1016/j.jad.2020.06.048

Hubert, S., & Aujoulat, I. (2018). Parental burnout: when exhausted mothers open up. *Frontiers in Psychology, 9*, 1021. https://doi.org/10.3389/fpsyg.2018.01021

Huizink, A. C., Mulder, E. J. H., de Medina, P. G. R., Visser, G. H. A., & Buitelaar, J. K. (2004). Is pregnancy anxiety a distinctive syndrome? *Early Human Development, 79*(2), 81–91. http://dx.doi.org/10.1016/j.earlhumdev.2004.04. 014

Hutchinson, J. & Cassidy, T. (2021). Well-being, self-esteem and body satisfaction in new mothers. *Journal of Reproductive and Infant Psychology*, 40(5), 532-546. https://doi.org/10.1080/02646838.2021.1916452

Ishizuka, P. (2019). Social class, gender, and contemporary parenting standards in the United States: evidence from a national survey experiment. *Social Forces, 98*(1), 31-58. https://doi.org/10.1093/sf/soy107

Iyengar, U., Jaiprakash, B., Haitsuka, H. & Kim, S. (2021). One year into the pandemic: a systematic review of perinatal mental health outcomes during COVID-19. *Frontiers in Psychiatry, 12*, 674194. https://doi.org/10.3389/fpsyt.2021.674194

Jackman, L. C., Thorsteinsson, E. B., & McNeil, D. G. (2017). Perfect imperfections: locus of control, perfectionism, and postpartum depression. *SAGE open, 7*(2), 215824401771068. https://doi.org/10.1177/2158244017710689

Joensuu, J. M., Saarijärvi, H., Rouhe, H., Gissler, M., Ulander, V. M., Heinonen, S., Torkki, P., Mikkola, T. S. (2022). Maternal childbirth experience and induction of labour in each mode of delivery: a retrospective seven-year cohort study of 95,051 parturients in Finland. *BMC Pregnancy & Childbirth, 22*(1), 508. https://doi.org/10.1186/s12884-022-04830-9

Jomeen, J. (2004). The importance of assessing psychological status during pregnancy, childbirth and the postnatal period as a multidimensional construct: A literature review. *Clinical Effectiveness in Nursing, 8*(3), 143-155. https://doi.org/10.1016/j.cein.2005.02.001

Jordan, C. H., Zeigler-Hill, V. & Cameron, J. J. (2015). Self-Esteem. In: *Wright JD, editor. International Encyclopedia of the Social & Behavioral Sciences (2nd Ed.).* Elsevier, p. 522–528. ISBN 9780080970875.

Karlsdottir, S. I., Sveinsdottir, H., Kristjansdottir, H., Aspelund, T. & Olafsdottir, O. A. (2018). Predictors of women's positive childbirth pain experience: Findings from an Icelandic national study. *Women and Birth, 31*(3), e178-e184, https://doi.org/10.1016/j.wombi.2017.09.007.

Karlström, A., Nystedt, A., & Hildingsson, I. (2015). The meaning of a very positive birth experience: Focus groups discussions with women. *BMC pregnancy and childbirth, 15*(1), 251. https://doi.org/10.1186/s12884-015-0683-0

Katz Rothman, B. (1982). *In labor: Women and power in the birthplace.* New York: Norton.

Kennedy, H. P., Cheyney, M., Lawlor, M., Myers, S., Schuiling, K. & Tanner, T. (2015). The development of a consensus statement on normal physiologic birth: a modified Delphi study. *Journal of Midwifery and Womens' Health, 60*(2) (2015), 140-145. https://doi.org/10.1111/jmwh.12254

Kerr, M.L., Rasmussen, H. F., Fanning, K. A., & Braaten, S. M. (2021). Parenting during COVID-19: A study of parents' experiences across gender and

income levels. *Family Relations, 70*(5), 1327-1342. https://doi.org/10.1111/fare.12571
Kjerulff, K. H., & Brubaker, L. H. (2018). New mothers' feelings of disappointment and failure after cesarean delivery. *Birth, 45*(1), 19-27. https://doi.org/10.1111/birt.12315
Jallinoja, R. (2006). *Perheen vastaisku: Familistista käännettä jäljittämässä [The Family strikes back: In search of the familistic turn].* Gaudeamus.
Kazmierczak, M., & Goodwin, R. (2011). Pregnancy and body image in Poland: Gender roles and self-esteem during the third trimester. *Journal of Reproductive and Infant Psychology, 29*(4), 334-342. https://doi.org/10.1080/02646838.2011.631179
Kitzinger, S. (1986). *Pregnancy and Childbirth*. London: Penguin.
Knight, C. R., & Brinton, M. C. (2017). One egalitarianism or several? Two decades of gender-role attitude change in Europe. *American Journal of Sociology, 122*(5), 1485–1532. https://doi.org/10.1086/689814
Knight, M., Bunch, K., Kenyon, S., Tuffnell, D., & Kurinczuk, J. J. (2020). A national population-based cohort study to investigate inequalities in maternal mortality in the United Kingdom, 2009-17. *Paediatric and Perinatal Epidemiology, 34*(4), 392–398. https://doi.org/10.1111/ppe.12640
Koster, D., Romijn, C., Sakko, E., Stam, C., Steenhuis, N., Vries, D., . . . Fontein ‐ Kuipers, Y. (2020). Traumatic childbirth experiences: Practice-based implications for maternity care professionals from the woman's perspective. *Scandinavian Journal of Caring Sciences, 34*(3), 792-799. https://doi.org/10.1111/scs.12786
Kurz, E., Davis, D., & Browne, J. (2022). Parturescence: A theorisation of women's transformation through childbirth. *Women and Birth : Journal of the Australian College of Midwives, 35*(2), 135–143. https://doi.org/10.1016/j.wombi.2021.03.009
Kuurne (Ketokivi), K. & Leppo, A. (2021). A battle over birth: contestations, lived experiences and the restrictive policy of Finnish birth care in the Covid-19 pandemic. *Governing Human Lives and Health in Pandemic Times.* Routledge.
Lammi-Taskula, J. (2007). *Parental leave for fathers? Gendered conceptions and practices in families with young children in Finland.* Stakes. Available at: http://urn.fi/urn:isbn:978-951-44-7122-3
Laney, E. K., Carruthers, L., Hall, M. E. L., & Anderson, T. (2014). Expanding the self: Motherhood and identity development in faculty women. *Journal of Family Issues, 35*(9), 1227-1251. https://doi.org/10.1177/0192513X13479573
Lankes, J. (2022). Negotiating "impossible" ideals: Latent classes of intensive mothering in the United States. *Gender & Society, 36*(5), 677-703. https://doi.org/10.1177/08912432221114873
Larkin, P., Begley, C., & Devane, D. (2009). Women's experiences of labour and birth: An evolutionary concept analysis. *Midwifery, 25*(2), e49–e59. https://doi.org/10.1016/j.midw.2007.07.010.

Larsson, B., Karlström, A., Rubertsson, C. & Hildingsson, I. (2015). The effects of counseling on fear of childbirth. *Acta Obstetricia et Gynecologica Scandinavica, 94,* 629–636. https://doi-org.ezproxy.jyu.fi/10.1111/aogs.12634

Laursen, M., Hedegaard, M., & Johansen, C. (2008). Fear of childbirth: Predictors and temporal changes among nulliparous women in the Danish National Birth Cohort. *BJOG: An International Journal of Obstetrics and Gynaecology, 115*(3), 354-360. https://doi.org/10.1111/j.1471-0528.2007.01583.x

Leary, M. R. (2005). Sociometer theory and the pursuit of relational value: Getting to the root of self-esteem. *European Review of Social Psychology, 16*(1), 75-111. https://doi.org/10.1080/10463280540000007

Lebert-Charron, A., Wendland, J., Vivier-Prioul, S., Boujut, E., & Dorard, G. (2022). Does perceived partner support have an impact on mothers' mental health and parental burnout? *Marriage & Family Review, 58*(4), 362-382. https://doi.org/10.1080/01494929.2021.1986766

Leonard, M., & Kelly, G. (2022). Constructing the "good" mother: Pride and shame in lone mothers' narratives of motherhood. *International journal of sociology and social policy, 42*(9/10), 852–864. https://doi.org/10.1108/IJSSP-06-2021-0151

Leppo, A. & Itkonen, E. (forthcoming). Institutionalisation of emotion and desire—Encounters between maternity care professionals and pregnant women at "fear clinics". Manuscript submitted to *Culture Unbound* in 2022.

Levinson, D. J., & Darrow, C. N. (1978). *The seasons of a man's life.* Ballantine.

Levinson, D. J., & Levinson, J. D. (1996). *The seasons of a woman's life.* Ballantine Books.

Lin, G., Roskam, I., & Mikolajczak, M. (2021). Disentangling the effects of intrapersonal and interpersonal emotional competence on parental burnout. *Current Psychology* (New Brunswick, N.J.). https://doi.org/10.1007/s12144-021-02254-w

Lin, G., Szczygieł, D., & Piotrowski, K. (2022). Child-oriented perfectionism and parental burnout: The moderating role of parents' emotional intelligence. *Personality and Individual Differences, 198*, 111805. https://doi.org/10.1016/j.paid.2022.111805

Liss, M., Schiffrin, H. H., Mackintosh, V. H., Miles-McLean, H., & Erchull, M. J. (2013). Development and validation of a quantitative measure of intensive parenting attitudes. *Journal of Child and Family Studies, 22*(5), 621-636. https://doi.org/10.1007/s10826-012-9616-y

Longhurst, R. (1999). Pregnant bodies, public scrutiny: 'Giving' advice to pregnant women. In Teather, E. (ed). *Embodied Geographies: Spaces, Bodies and Rites of Passage*, pp. 78–90. London: Routledge.

Lowe, N. K. (2000). Self-efficacy for labor and childbirth fears in nulliparous pregnant women. *Journal of Psychosomatic Obstetrics & Gynecology, 21*(4), 219–224. https://doi.org/10.3109/01674820009085591

Loyal, D., Sutter, A.-L., & Rascle, N. (2022). Changes in mothering ideology after childbirth and maternal mental health in French women. *Sex Roles, 85,* 625–635. https://doi.org/10.1007/s11199-021-01242-5

Lukasse, M., Schrei, B. & Ryding, E. (2014). Prevalence and associated factors of fear of childbirth in six European countries. *Sexual & Reproductive Healthcare, 5*(3), 99–106. https://doi.org/10.1016/j.srhc.2014.06.007

Lukasse, M., Vangen, S., Øian, P., Kumle, M., Ryding, E. L., & Schei, B. (2010). Childhood abuse and fear of childbirth - A population-based study. *Birth, 37*(4), 267-274. https://doi.org/10.1111/j.1523-536X.2010.00420.x

Lundgren, I., & Berg, M. (2007). Central concepts in the midwife-woman relationship. *Scandinavian Journal of Caring Sciences, 21*(2), 220-228. https://doi.org/10.1111/j.1471-6712.2007.00460.x

Lynn, F. A. Alderdice, F. A., Crealey, G. E. & McElnay, J. C. (2011). Associations between maternal characteristics and pregnancy-related stress among low-risk mothers: An observational cross-sectional study. *International Journal of Nursing Studis, 48*(5), 620–627. https://doi.org/10.1016/j.ijnurstu.2010.10.002

MacDorman, M., Menacker, F., Declercq, E. (2008). Cesarean birth in the United States: Epidemiology, trends, and outcomes. *Clinics in Perinatology 35*(2): 293–307.

MacDorman, M. F., Thoma, M., Declcerq, E., & Howell, E. A. (2021). Racial and ethnic disparities in maternal mortality in the United States using enhanced vital records, 2016–2017. *American Journal of Public Health (1971), 111*(9), 1673–1681. https://doi.org/10.2105/AJPH.2021.306375

Maher, J. (2003). Rethinking women's birth experiences: Medical frameworks and personal narratives. *Hecate, 29*(2), 140–152.

Malacrida, C., & Boulton, T. (2014). The best laid plans? Women's choices, expectations and experiences in childbirth. *Health (London, England : 1997), 18*(1), 41-59. https://doi.org/10.1177/1363459313476964

Malacrida, C., & Boulton, T. (2012). Women's perceptions of childbirth "choices": Competing discourses of motherhood, sexuality, and selflessness. *Gender & Society, 26*(5), 748-772. https://doi.org/10.1177/0891243212452630

Martin, E. (1987). *The woman in the body. A cultural analysis of reproduction.* Open university press.

Martin, K. A. (2003). Giving birth like a girl. *Gender & Society, 17*(1), 54–72. https://doi.org/10.1177/0891243202238978

Mayopoulos, G. A., Ein-Dor, T., Dishy, G. A., Nandru, R., Chan, S. J., Hanley, L. E., . . . Dekel, S. (2021). COVID-19 is associated with traumatic childbirth and subsequent mother-infant bonding problems. *Journal of Affective Disorders, 282*, 122-125. https://doi.org/10.1016/j.jad.2020.12.101

McDonald, S., Slade, P., Spiby, H., & Iles, J. (2011). Post-traumatic stress symptoms, parenting stress and mother-child relationships following childbirth and at 2 years postpartum. *Journal of Psychosomatic Obstetrics and*

Gynaecology, 32(3), 141-146. https://doi.org/10.3109/0167482X.2011.596962
McKelvin, G., Thomson, G., & Downe, S. (2021). The childbirth experience: A systematic review of predictors and outcomes. *Women and Birth: Journal of the Australian College of Midwives, 34*(5), 407-416. https://doi.org/10.1016/j.wombi.2020.09.021
McLachlan, H., Forster, D., Davey, M., Farrell, T., Gold, L., Biro, M., . . . Waldenström, U. (2012). Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: The COSMOS randomised controlled trial. *BJOG: An International Journal of Obstetrics and Gynaecology, 119*(12), 1483-1492. https://doi.org/10.1111/j.1471-0528.2012.03446.x
McLeish, J., & Redshaw, M. (2017). Mothers' accounts of the impact on emotional well-being of organised peer support in pregnancy and early parenthood: A qualitative study. *BMC Pregnancy and Childbirth, 17*(1), 28. https://doi.org/10.1186/s12884-017-1220-0
McMahon, M. (1995). *Engendering Motherhood: Identity and Self-Transformation in Women's Lives.* New York: Guilford.
Meeussen, L., & Van Laar, C. (2018). Feeling pressure to be a perfect mother relates to parental burnout and career ambitions. *Frontiers in Psychology, 9*, 2113. https://doi.org/10.3389/fpsyg.2018.02113
Mercer, R. T. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship, 36*(3), 226–232. https://doi.org/10.1111/j.1547-5069.2004.04042.x
Mikkonen, K., Veikkola, H-R., Sorkkila, M., & Aunola, K. (in press). Parenting styles of Finnish parents and their associations with parental burnout. *Current Psychology*. https://doi.org/10.1007/s12144-022-03223-7
Mikolajczak, M., Aunola, K., Sorkkila, M., & Roskam, I. (in press): 15 years of parental burnout research: Systematic review and Agenda. *Current Directions in Psychological Science.*
Mikolajczak, M., Gross, J. J., & Roskam, I. (2021). Beyond job burnout: Parental burnout. *Trends in cognitive sciences, 25*(5), 333-336. https://doi.org/10.1016/j.tics.2021.01.012
Mikolajczak, M., & Roskam, I. (2020). Parental burnout: Moving the focus from children to parents. *New Directions for Child and Adolescent Development, 2020*(174), 7-13. https://doi.org/10.1002/cad.20376
Mikolajczak, M., & Roskam, I. (2018). A theoretical and clinical framework for parental burnout: The balance between risks and resources (BR 2). *Frontiers in Psychology, 9*, 886. https://doi.org/10.3389/fpsyg.2018.00886
Miller, T. (2005). *Making Sense of Motherhood: A Narrative Approach*. Cambridge: Cambridge University Press.
Miller, T. (2007). "Is this what motherhood is all about?" Weaving experiences and discourse through transition to first-time motherhood. *Gender & Society, 21*(3), 337–358. https://doi.org/10.1177/0891243207300561
Ministry of Economic Affairs and Employment, Ministry of Education and Culture, and Ministry of Social Affairs and Health (2022). *Family leave*

reform enters into force in August 2022. Press release 13.1.2022 in https://valtioneuvosto.fi/-/1271139/perhevapaauudistus-astuu-voimaan-elokuussa-2022?languageId=en_US
Ministry of Social Affairs and Health (2019). *Marin's Government. Government Program.* Retrieved 20.12.2022 from https://valtioneuvosto.fi/en/marin/government-programme/finland-built-on-trust-and-labour-market-equality
Morgan, L. M. & Roberts, E. F. (2012). Reproductive governance in Latin America. *Anthropological Medicine, 19*(2), 241–254. https://doi.org/10.1080/13648470.2012.675046
Moring, A., & Lammi-Taskula, J. (2021). Parental leave reforms in Finland 1977–2019 from a diversity perspective. *Social Inclusion, 9*(2), 338-349. https://doi.org/10.17645/si.v9i2.3796
Mrosková, S., Reľovská, M., & Schlosserová, A. (2020). Burnout in parents of sick children and its risk factors: A literature review. *Central European Journal of Nursing and Midwifery, 11*(4), 196-206. https://doi.org/10.15452/cejnm.2020.11.0015
Munro, E. (2013). Feminism: A fourth wave? *Political Insight (Political Studies Association of the United Kingdom), 4*(2), 22–25. https://doi.org/10.1111/2041-9066.12021
Muthén, L. K., & Muthén, B. O. (1998–2012). *Mplus user's guide (7th ed.).* Muthén & Muthén.
Muthén, L. K., & Muthén, B. O. (2017). *Mplus users' guide (8th ed.)* Los Angeles: Muthén and Muthén.
Määttä, K., & Uusiautti, S. (2012). How do the Finnish family policy and early education system support the well-being, happiness, and success of families and children? *Early Child Development and Care, 182*(3–4), 291–298.
Neiterman, E. & Fox, B. (2017). Controlling the unruly maternal body: Losing and gaining control over the body during pregnancy and the postpartum period. *Social Science & Medicine, 174*, 142–148. http://dx.doi.org/10.1016/j.socscimed.2016.12.029
Neiterman, E. (2013). Sharing bodies: The impact of the biomedical model of pregnancy on women's embodied experiences of the transition to motherhood. *Healthcare Policy, 9(SP),* 112-125. https://doi.org/10.12927/hcpol.2013.23595
Nelson, M. (1983). Working class women, middle class women and models of childbirth. *Social Problems, 30*(3), 785-796. https://doi.org/10.1525/sp.1983.30.3.03a00050
Nieminen, K., Wijma, K., Johansson, S., Kinberger, E. K., Ryding, E.-L., Andersson, G., … Wijma B. (2017). Severe fear of childbirth indicates high perinatal costs for Swedish women giving birth to their first child. *Acta Obstetricia et Gynecologica Scandinavica, 96*(4), 438–446. https://doi.org/10.1111/aogs.13091
Niemistö, C., Hearn, J., Kehn, C., & Tuori, A. (2021). Motherhood 2.0: Slow progress for career women and motherhood within the 'Finnish Dream'.

Work, Employment and Society, 35(4), 696-715. https://doi.org/10.1177/0950017020987392

Nilsson, C., Hessman, E., Sjöblom, H., Dencker, A., Jangsten, E., Mollberg, M., … Begley, C. (2018). Definitions, measurements and prevalence of fear of childbirth: A systematic review. *BMC Pregnancy and Childbirth, 18*(1), 28. https://doi.org/10.1186/s12884-018-1659-7

Nilsson, C. (2014). The delivery room: Is it a safe place? A hermeneutic analysis of women's negative birth experiences. *Sexual and Reproductive Healthcare, 5*(4), 199-204. https://doi.org/10.1016/j.srhc.2014.09.010

Nordic Perinatal Statistics (2020). Finnish Official Statistics, Tilastoraportti 9/2022, 12.04.2022. Retrieved 9.1.2023 from https://www.julkari.fi/bitstream/handle/10024/144263/Pohjoismainen_perinataalitilasto_2020.pdf?sequence=1&isAllowed=y

Nyman, V., Downe, S., & Berg, M. (2011). Waiting for permission to enter the labour ward world: First time parents' experiences of the first encounter on a labour ward. *Sexual & Reproductive Healthcare, 2*(3), 129-134. https://doi.org/10.1016/j.srhc.2011.05.004

Oakley, A. (1980). *Women confined: Towards a sociology of childbirth.* Oxford, UK: Martin Roberston.

Oddo-Sommerfeld, S., Hain, S., Louwen, F., & Schermelleh-Engel, K. (2015). Longitudinal effects of dysfunctional perfectionism and avoidant personality style on postpartum mental disorders: Pathways through antepartum depression and anxiety. *Journal of Affective Disorders, 191*, 280-288. https://doi.org/10.1016/j.jad.2015.11.040

O'Brien, A. P., McNeil, K. A., Fletcher, R., Conrad, A., Wilson, A. J., Jones, D., & Chan, S. W. (2017). New fathers' perinatal depression and anxiety—treatment options: an integrative review. *American Journal of Men's Health, 11*(4), 863–876. https://doi.org/10.1177/1557988316669047

O'Connell, M. A., Leahy-Warren, P., Khashan, A. S., Kenny, L. C., O'Neill, S. M. (2017). Worldwide prevalence of tocophobia in pregnant women: systematic review and meta-analysis. *Acta Obstetricia Gynecologica Scandinavica, 96*, 907–920. https://doi-org/10.1111/aogs.13138

O'Connell, M. A., Martin, C. R. & Jomeen, J. (2021). Reconsidering fear of birth: Language matters. *Midwifery*, *102*, 103079. https://doi.org/10.1016/j.midw.2021.103079.

Official Statistics of Finland (2022). Perinataalitilasto—synnyttäjät, synnytykset ja vastasyntyneet 2021 [Perinatal statistics]. Statistical Report 41/2022, 28.11.2022. Official Statistics of Finland, Perinatal statistics. Finnish Institute for Health and Welfare.

Official Statistics of Finland (2022). Kelan lapsiperhe-etuustilasto 2021 [Statistics of families with children]. Pösö, R. (ed.). ISSN 1796-0479. Retrieved 12.2.2022 from: https://helda.helsinki.fi/bitstream/handle/10138/343364/Kelan_lapsiperhe_etuustilasto_2021.pdf?sequence=1&isAllowed=y

Olza, I., Leahy-Warren, P., Benyamini, Y., Kazmierczak, M., Karlsdottir, S. I., Spyridou, A., Crespo-Mirasol, E., Takács, L., Hall, P. J., Murphy, M., Jonsdottir, S. S., Downe, S., & Nieuwenhuijze, M. J. (2018). Women's psychological experiences of physiological childbirth: A meta-synthesis. *BMJ Open, 8*(10), e020347. https://doi.org/10.1136/bmjopen-2017-020347

Orth, U., & Robins, R. W. (2014). The development of self-esteem. *Current Directions in Psychological Science: A Journal of the American Psychological Society, 23*(5), 381-387. https://doi.org/10.1177/0963721414547414

Pazzagli, C., Laghezza, L., Capurso, M., Sommella, C., Lelli, F. & Mazzeschi, C. (2015). Antecedents and consequences of fear of childbirth in nulliparous and parous women. *Infant Mental Health Journal, 36*(1), 62–74. https://doi-org/10.1002/imhj.21483

Perälä-Littunen, S. (2018). Childcare and work: Exploring the views of Finnish mothers and fathers. *Community, Work & Family, 21*(2), 209–225. https://doi.org/10.1080/13668803.2016.1274289

Perera, D., Munas, M., Swahnberg, K., Wijewardene, K., & Infanti, J. J. (2022). Obstetric violence is prevalent in routine maternity care: A cross-sectional study of obstetric violence and its associated factors among pregnant women in Sri Lanka's Colombo District. *International Journal of Environmental Research and Public Health, 19*(16), 9997. https://doi.org/10.3390/ijerph19169997

Perriman, N., Davis, D. L., & Ferguson, S. (2018). What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. *Midwifery, 62,* 220–229. https://doi.org/10.1016/j.midw.2018.04.011

Plano Clark, V. L., Huddleston-Casas, C. A., Churchill, S. L., O'Neil Green, D. & Garrett, A. L. (2008). Mixed methods approaches in family science research. *Journal of Family Issues, 29*, 1543–1566. https://doi.org/10.1177/0192513X08318251

Preis, H., Eisner, M., Chen, R. & Benyamini, Y. (2019a). First-time mothers' birth beliefs, preferences, and actual birth: A longitudinal observational study. *Women and Birth, 32*(1), e110–e117. https://doi.org/10.1016/j.wombi.2018.04.019

Preis, H., Lobel, M. & Benyamini, Y. (2019b). Between expectancy and experience: Testing a model of childbirth satisfaction. *Psychology of Women Quarterly, 43*(1) 105–117. https://doi-org/10.1177/0361684318779537

Preis, H., Pardo, J., Peled, Y., & Benyamini, Y. (2018). Changes in the basic birth beliefs following the first birth experience: Self-fulfilling prophecies? *PloS one, 13*(11), e0208090. https://doi.org/10.1371/journal.pone.0208090

Price, L., Centifanti, L., & Slade, P. (2020). Personality factors and vulnerability to post‐traumatic stress responses after childbirth. *British Journal of Clinical Psychology, 59*(4), 480-502. https://doi.org/10.1111/bjc.12262

Prinds, C., Hvidt, N. C., Mogensen, O. & Buus, N. (2014). Making existential meaning in transition to motherhood—A scoping review. *Midwifery, 30*, 733–741. http://dx.doi.org/10.1016/j.midw.2013.06.021

Raphael-Leff, J. (2001). *Pregnancy: The Inside Story.* Routledge.
Raudasoja, M. & Aunola, K. (2019–2023). Fear of childbirth, self-esteem, birth experiences, and parental burnout. Research project. University of Jyväskylä. Research data available at: https://doi.org/10.17011/jyx/dataset/81710
Reisz, S., Jacobvitz, D., & George, C. (2015). Birth and motherhood: Childbirth experience and mothers' perceptions of themselves and their babies. *Infant Mental Health Journal, 36*(2), 167-178. https://doi.org/10.1002/imhj.21500
Rice, C., Ingram, E., & O'Mahen, H. (2022). A qualitative study of the impact of peer support on women's mental health treatment experiences during the perinatal period. *BMC Pregnancy and Childbirth, 22*(1), 1–689. https://doi.org/10.1186/s12884-022-04959-7
Rice, K. (2023). Re-centering relationships: Obstetric violence, health care rationalities, and pandemic childbirth in Canada. *Medical Anthropology Quarterly, 37*(1), 59–75. https://doi.org/10.1111/maq.12739
Rich, A. (1995). *Of woman born: Motherhood as experience and institution* (Paperback ed., reissued.). Norton.
Robins, R. W., Hendin, H. M., & Trzesniewski, K. H. (2001). Measuring global self-esteem: Construct validation of a single-item measure and the Rosenberg Self-Esteem Scale. *Personality and Social Psychology Bulletin, 27*(2), 151–161. https://doi-org.ezproxy.jyu.fi/10.1177/0146167201272002
Rodriguez Castro, L., Brady, M. & Cook, K. (2022). Negotiating 'ideal worker' and intensive mothering ideologies: Australian mothers' emotional geographies during their commutes. *Social & Cultural Geography, 23*(3), 460–478. https://doi.org/10.1080/14649365.2020.1757140
Rondung, E., Ekdahl, J., Hildingsson, I., Rubertsson, C., Sundin, Ö. (2018). Heterogeneity in childbirth related fear or anxiety. *Scandinavian Journal of Psychology, 59*(6), 634–643. https://doi.org/10.1111/sjop.12481
Rondung, E., Thomtén, J., & Sundin, Ö. (2016). Psychological perspectives on fear of childbirth. *Journal of Anxiety Disorders, 44*(1), 80–91. https://doi.org/10.1016/j.janxdis.2016.10.007
Roome, S., Hartz, D., Tracy, S., & Welsh, A. (2016). Why such differing stances? A review of position statements on home birth from professional colleges. *BJOG : An International Journal of Obstetrics and Gynaecology, 123*(3), 376–382. https://doi.org/10.1111/1471-0528.13594
Rosenberg, M. (1989). *Society and the adolescent self-image (Rev. ed.).* Wesleyan University Press.
Roskam, I., Gallée, L., Aguiar, J., Akgun, E., Arena, A., Arikan, G., . . . Mikolajczak, M. (2022). Gender equality and maternal burnout: A 40-country study. *Journal of Cross-Cultural Psychology, 53*(2), 157-178. https://doi.org/10.1177/00220221211072813
Roskam, I., Aguiar, J., Akgun, E., Arikan, G., Artavia, M., Avalosse, H., . . . Mikolajczak, M. (2021). Parental burnout around the globe: A 42-country study. *Affective Science, 2*(1), 58-79. https://doi.org/10.1007/s42761-020-00028-4

Roskam, I., & Mikolajczak, M. (2020). Gender differences in the nature, antecedents and consequences of parental burnout. *Sex Roles, 83*(7-8), 485-498. https://doi.org/10.1007/s11199-020-01121-5

Roskam, I., Brianda, M., & Mikolajczak, M. (2018). A step forward in the conceptualization and measurement of parental burnout: The Parental Burnout Assessment (PBA). *Frontiers in Psychology, 9,* 758. https://doi.org/10.3389/fpsyg.2018.00758

Rotkirch, A., & Janhunen, K. (2010). Maternal guilt. *Evolutionary Psychology, 8*(1), 90–106. https://doi.org/10.1177/147470491000800108

Rouhe, H, Salmela-Aro, K., Toivanen, R., Tokola, M., Halmesmäki, E., Ryding, E-L., Saisto, T. (2015). Group psychoeducation with relaxation for severe fear of childbirth improves maternal adjustment and childbirth experience - a randomised controlled trial. *Journal of Psychosomatic Obstetrics and Gynaecology, 36*(1), 1–9. https://doi.org/10.3109/0167482X.2014.980722

Rouhe, H., Salmela-Aro, K., Toivanen, R., Tokola, M., Halmesmäki, E., & Saisto, T. (2013). Obstetric outcome after intervention for severe fear of childbirth in nulliparous women - randomised trial: Treatment of women with fear of childbirth. *BJOG: An International Journal of Obstetrics and Gynaecology, 120*(1), 75-84. https://doi.org/10.1111/1471-0528.12011

Rouhe, H., Salmela-Aro, K., Gissler, M., Halmesmaeki, E. & Saisto, T. (2011). Mental health problems common in women with fear of childbirth. *BJOG: An International Journal of Obstetrics and Gynaecology, 118*, 1104–1111. https://doi-org/10.1111/j.1471-0528.2011.02967.x

Rubashkin, N., Warnock, R., & Diamond-Smith, N. (2018). A systematic review of person-centered care interventions to improve quality of facility-based delivery. *Reproductive Health, 15*(1), 169. https://doi.org/10.1186/s12978-018-0588-2

Ryding, E. L., Wirfelt, E., Wängborg, I., Sjögren, B., & Edman, G. (2007). Personality and fear of childbirth. *Acta Obstetricia et Gynecologica Scandinavica, 86*(7), 814-820. https://doi.org/10.1080/00016340701415079

Saisto, T. & Halmesmäki, E. (2003). Fear of childbirth: a neglected dilemma. *Acta Obstetricia et Gynecologia Scandinavica, 82*(3), 201–208. https://doi.org/10.1034/j.1600-0412.2003.00114.x

Saisto, T., Salmela-Aro, K., Nurmi, J.E., Halmesmäki, E., (2001). Psychosocial characteristics of women and their partners fearing vaginal childbirth. *BJOG: An International Journal of Obstetrics and Gynaecology, 108*(5), 492–498. https://doi.org/10.1016/S0306-5456(00)00122-4

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews, 4*(4), CD004667. https://doi.org/10.1002/14651858.CD004667.pub5

Sandall, J., Devane, D., Soltani, H., Hatem, M. & Gates, S., (2010). Improving quality of safety in maternity care: the contribution of midwife-led care. *Journal of Midwifery and Women's Health, 55*(3), 255–261. https://doi.org/10.1016/j.jmwh.2010.02.002

Sarkkinen, M. & Savonlahti, E. (2014). Raskausajan vuorovaikutuspsykoterapia. *Psykoterapia, 33*(2), 93-110.

Saxbe, D. E. (2017). Birth of a new perspective? A call for biopsychosocial research on childbirth. *Current Directions in Psychological Science: A Journal of the American Psychological Society, 26*(1), 81–86. https://doi.org/10.1177/0963721416677096

Schachter, E. P. (2018). Intergenerational, unconscious and embodied: Three underdeveloped aspects of Erikson's theory of identity. *Identity: An International Journal of Theory and Research, 18*(4), 315–324. https://doi.org/10.1080/15283488.2018.1523731

Schneider D. A. (2018). Birthing failures: Childbirth as a female fault line. *The Journal of Perinatal Education, 27*(1), 20–31. https://doi.org/10.1891/1058-1243.27.1.20

Schneider, D. A. (2013). Helping women cope with feelings of failure in childbirth. *International Journal of Childbirth Education*, *28*(1), 46–50.

Schneider, D. A. (2010). *Beyond the baby: women's narratives of childbirth, change and power.* Doctoral dissertation. Smith Scholar Works: Smith College.

Schroll, A., Tabor, A., & Kjaergaard, H. (2011). Physical and sexual lifetime violence: Prevalence and influence on fear of childbirth before, during and after delivery. *Journal of Psychosomatic Obstetrics and Gynaecology, 32*(1), 19-26. https://doi.org/10.3109/0167482X.2010.547965

Seierstad, C., & Healy, G. (2012). Women's equality in the Scandinavian academy: A distant dream? *Work, Employment and Society, 26*(2), 296–313. https://doi.org/10.1177/0950017011432918

Sevón, E. (2012). 'My life has changed, but his life hasn't': Making sense of the gendering of parenthood during the transition to motherhood. *Feminism & Psychology, 22*(1), 60-80. https://doi-org.ezproxy.jyu.fi/10.1177/0959353511415076
Sherman, E. A. (1987). *Meaning in Mid-life Transitions.*
Sherman, E. A. (1987). *Meaning in Mid-life Transitions.*
Shiva, N., & Nosrat Kharazmi, Z. (2019). The fourth wave of feminism and the lack of social realism in cyberspace. *Journal of Cyberspace Studies*, *3*(2), 129–146. doi: 10.22059/jcss.2019.72456

Simkin P. (1991). Just another day in a woman's life? Women's long-term perceptions of their first birth experience. Part I. *Birth, 18*(4), 203–10. https://doi.org/10.1111/j.1523-536X.1991.tb00103.x

Simonds, W. (2002). Watching the clock: Keeping time during pregnancy, birth, and postpartum experiences. *Social Science & Medicine 55*(4), 559–570. https://doi.org/10.1016/S0277-9536(01)00196-4

Singh, G. K. (2021). Trends and social inequalities in maternal mortality in the United States, 1969–2018. *International Journal of MCH and AIDS, 10*(1), 29–42. https://doi.org/10.21106/ijma.444

Skowronski, G. A. (2015). Pain relief in childbirth: Changing historical and feminist perspectives. *Anaesthesia and Intensive Care, 43* Suppl(1_suppl), 25–28. https://doi.org/10.1177/0310057X150430S106

Smith, M. M., Saklofske, D. H., Stoeber, J., & Sherry, S. B. (2016). The Big Three Perfectionism Scale: A new measure of perfectionism. *Journal of Psychoeducational Assessment, 34*(7), 670-687. https://doi.org/10.1177/0734282916651539

Soenens, B., & Vansteenkiste, M. (2019). Are parents responsible for the rise of perfectionism? Comment on Curran and Hill (2019). *Psychological Bulletin, 145,* 430–432. http://dx.doi.org/10.1037/ bul0000167

Sonnenburg, C., & Miller, Y. D. (2021). Postnatal depression: The role of "good mother" ideals and maternal shame in a community sample of mothers in Australia. *Sex Roles, 85*(11-12), 661-676. https://doi.org/10.1007/s11199-021-01239-0

Sorell, G. T., & Montgomery, M. J. (2001). Feminist perspectives on Erikson 's theory: Their relevance for contemporary identity development research. *Identity (Mahwah, N.J.), 1*(2), 97-128. https://doi.org/10.1207/S1532706XID0102_01

Sorkkila, M., & Aunola, K. (2020). Risk factors for parental burnout among Finnish parents: The role of socially prescribed perfectionism. *Journal of Child and Family Studies, 29*(3), 648-659. https://doi.org/10.1007/s10826-019-01607-1

Statistics Finland (2022). Educational structure of population [online publication]. Reference period: 2021. ISSN=2242-2919. Helsinki: Statistics Finland [referenced: 9.1.2023]. Access method: https://stat.fi/en/publication/cktv672rs1i0m0b04xsnb57ob

Stevens, N.R., Heath, N.M., Lillis, T.A. et al. (2018). Examining the effectiveness of a coordinated perinatal mental health care model using an intersectional-feminist perspective. *Journal of Behavioral Medicine, 41,* 627–640. https://doi-org.ezproxy.jyu.fi/10.1007/s10865-018-9973-0

Stinson, D. A., Logel, C., Zanna, M. P., Holmes, J. G., Cameron, J. J., Wood, J. V., & Spencer, S. J. (2008). The cost of lower self-esteem: Testing a self- and social-bonds model of health. *Journal of Personality and Social Psychology, 94*(3), 412-428. https://doi.org/10.1037/0022-3514.94.3.412

Stone, N. I., Downe, S., Dykes, F., & Rothman, B. K. (2022). "Putting the baby back in the body": The re-embodiment of pregnancy to enhance safety in a free-standing birth center. *Midwifery, 104*, 103172. https://doi.org/10.1016/j.midw.2021.103172

Størksen, H. T., Garthus-Niegel, S., Vangen, S., & Eberhard-Gran, M. (2013). The impact of previous birth experiences on maternal fear of childbirth. *Acta Obstetricia et Gynecologica Scandinavica, 92*(3), 318-324. https://doi.org/10.1111/aogs.12072

Striebich, S., Mattern, E. & Ayerle, G. M. (2018). Support for pregnant women identified with fear of childbirth (FOC)/tokophobia—A systematic review of approaches and interventions. *Midwifery, 61*, 97–115. https://doi.org/10.1016/j.midw.2018.02.013

Sutherland, O., Forbes, L., Hodgson, B., & McLaren, K. (2014). Digital actualizations of gender and embodiment: Microanalysis of online

pregnancy discourse. *Women's Studies International Forum, 47,* 102-114. https://doi.org/10.1016/j.wsif.2014.05.005
Szarpak, J., Bator, D., Wójcik, M., Nieścior, H., Dąbrowska, J., & Milanowska, J. (2020). The influence of perinatal and postpartum depression on child development and its functioning in adult life. *Journal of Education, Health and Sport, 10*(9), 241–247. https://doi.org/10.12775/JEHS.2020.10.09.026
Taubman-Ben-Ari, O., Shlomo, S. B., Sivan, E., & Dolizki, M. (2009). The transition to motherhood—A time for growth. *Journal of Social and Clinical Psychology, 28*(8), 943–970. https://doi.org/10.1521/jscp.2009.28.8.943
TENK (2019). The ethical principles of research with human participants and ethical review in the human sciences in Finland. Finnish National Board on Research Integrity TENK guidelines 2019. Retrieved 30.1.2023 from https://tenk.fi/sites/default/files/2021-01/Ethical_review_in_human_sciences_2020.pdf
Ternström, E., Hildingsson, I., Haines, H., Rubertsson, C., (2015). Higher prevalence of childbirth related fear in foreign born pregnant women–findings from a community sample in Sweden. *Midwifery, 31,* 445–450. http://dx.doi.org/10.1016/j.midw.2014.11.011
Thomson, G. (2010). Psychology and labour experience: Birth as a peak experience. *Essential Midwifery Practice: Intrapartum Care*. Oxford: Wiley-Blackwell.
Thomson, G., & Downe, S. (2013). A hero's tale of childbirth. *Midwifery, 29*(7), 765-771. https://doi.org/10.1016/j.midw.2012.07.008
Upton, R. L., & Han, S. S. (2003). Maternity and its discontents: "Getting the body back" after pregnancy. *Journal of Contemporary Ethnography, 32*(6), 670-692. https://doi.org/10.1177/0891241603257596
Uriko, K. (2019). Dialogical self and the changing body during the transition to motherhood. *Journal of Constructivist Psychology, 32*(3), 221-235. https://doi.org/10.1080/10720537.2018.1472048
van Bakel, H., Bastiaansen, C., Hall, R., Schwabe, I., Verspeek, E., Gross, J. J., . . . Roskam, I. (2022). Parental burnout across the Globe during the COVID-19 pandemic. *International Perspectives in Psychology: Research, Practice, Consultation, 11*(3), 141-152. https://doi.org/10.1027/2157-3891/a000050
van Bussel, J., Spitz, B., & Demyttenaere, K. (2010). Childbirth expectations and experiences and associations with mothers' attitudes to pregnancy, the child and motherhood. *Journal of Reproductive and Infant Psychology, 28*(2), 143-160. https://doi.org/10.1080/02646830903295026
Vihreäsalo, K. (2022). Häpeä, objektivointi ja vastarinta synnytysväkivaltatarinoissa. *Sukupuolentutkimus, 35*(1), 4–20.
Viirman, F., Hess Engström, A., Sjömark, J., Hesselman, S., Sundström Poromaa, I., Ljungman, L., . . . Wikman, A. (2023). Negative childbirth experience in relation to mode of birth and events during labour: A mixed methods study. *European Journal of Obstetrics & Gynecology and Reproductive Biology (vol ahead-of-print).* https://doi.org/10.1016/j.ejogrb.2023.01.031

Viisainen K. (2001). Negotiating control and meaning: Home birth as a self-constructed choice in Finland. *Social Science and Medicine (1982), 52*(7), 1109–1121. https://doi.org/10.1016/s0277-9536(00)00206-9

Vogels-Broeke, M., Daemers, D., Budé, L., de Vries, R., & Nieuwenhuijze, M. (2023). Women's birth beliefs during pregnancy and postpartum in the Netherlands: A quantitative cross-sectional study. *Journal of Midwifery & Women's Health*.

Westergren, A., Edin, K. & Christianson, M. (2021). Reproducing normative femininity: Women's evaluations of their birth experiences analysed by means of word frequency and thematic analysis. *BMC Pregnancy and Childbirth, 21*(300). https://doi.org/10.1186/s12884-021-03758-w

Wigert, H., Nilsson, C., Dencker, A., Begley, C., Jangsten, E., Sparud-Lundin, C., Mollberg, M. & Patel, H. (2020). Women's experiences of fear of childbirth: a metasynthesis of qualitative studies, *International Journal of Qualitative Studies on Health and Well-being, 15*(1), 1704484. https://doi.org/10.1080/17482631.2019.1704484

Wijma, K., Wijma, B. & Zar, M. (1998). Psychometric aspects of the W-DEQ; a new questionnaire for the measurement of fear of childbirth. *Journal of Psychosomatic Obstetrics & Gynecology, 19*(2), 84–97.

World Economic Forum. (2010). *The global gender gap report 2010.* World Economic Forum. https://www.weforum.org/reports/global-gender-gap-report-2010

World Health Organization (2022). *Finland situation.* WHO health emergency dashboard. In: https://covid19.who.int/region/euro/country/fi. Referred 8.12.2022.

Young, I. M. (2005). Pregnant embodiment: Subjectivity and alienation. In: *On Female Body Experience: Throwing Like a Girl and Other Essays*. Oxford University Press USA - OSO, 2005.

Yuval-Davis, N. (1997). *Gender & nation.* SAGE.

Zadoroznyj, M. (1999). Social class, social selves and social control in childbirth. *Sociology of Health & Illness, 21*(3), 267–289. https://doi.org/10.1111/1467-9566.00156

Zar, M., Wijma, K., Wijma, B., (2002). Relations between anxiety disorders and fear of childbirth during late pregnancy. *Clinical Psychology and Psychotherapy, 9*, 122–130. http://dx.doi.org/10.1002/cpp.305.

ORIGINAL PAPERS

I

THE ROLE OF SELF-ESTEEM ON FEAR OF CHILDBIRTH AND BIRTH EXPERIENCE

by

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Journal of Reproductive and Infant Psychology (online first), 1-9

https://doi.org/10.1080/02646838.2022.2115989

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JOURNAL OF REPRODUCTIVE AND INFANT PSYCHOLOGY
https://doi.org/10.1080/02646838.2022.2115989

The role of self-esteem on fear of childbirth and birth experience

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ABSTRACT

Objective: Fear of childbirth (FOC), also referred to as tokophobia, can have detrimental consequences for a woman's well-being during pregnancy and for their subjective birth experience. However, it is unknown what role self-esteem plays in the relationship between FOC and the experience of childbirth. This study investigates the relation between FOC and the birth experience, and the role of self-esteem in that relation.

Methods: We studied 125 nulliparous and parous Finnish women from their third trimester of pregnancy to 4–8 weeks postpartum. Path analysis with MLR estimation was conducted using MPlus to predict the childbirth experience according to prior self-esteem and fear of childbirth as well as their interaction. Also, age and parity were included as predictors of the birth experience, as well as their interactions with self-esteem. FOC was measured with the Wijma Delivery Expectancy/Experience Questionnaire – version A (W-DEQ-A), self-esteem with the Rosenberg Self-Esteem Scale (RSES), and birthing experience with the Delivery Satisfaction Scale (DSS).

Results: We found that self-esteem moderated the association between fear of childbirth and the subjective birth experience: the lower the self-esteem, the stronger the negative connection between FOC and the birth experience; and, reversely, the higher the self-esteem, the weaker the connection between FOC and the birth experience.

Conclusions: The results highlight intra-group differences between fearful women and contribute to theory formation. They can be used in clinical practice and when planning interventions to reduce negative birth experiences.

ARTICLE HISTORY
Received 29 November 2021
Accepted 16 August 2022

KEYWORDS
Fear of childbirth; self-esteem; birth experience; childbirth; birthing; tokophobia

Introduction

Childbirth is a unique life event (Downe et al., 2018) that is often experienced as a transition stage of deep importance and vulnerability (Larkin et al., 2009). One third of women experience their childbirth as very positive (Hildingsson et al., 2013) and most women as at least somewhat positive (Chabbert et al., 2020). Negative experiences are rated by 10% to one-third of women (Chabbert et al., 2020). These experiences may be

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influenced by fear of childbirth (FOC; Saisto et al., 2006) that complicates 10–30% of pregnancies in developed countries (Rondung et al., 2016), affecting both nulliparous and parous women (Saisto & Halmesmäki, 2003). Previous studies have shown that the higher the FOC, the more negative the childbirth experience (Chabbert et al., 2020). However, most research to date fails to address the interaction effects of FOC with other variables, with a consequence of treating women with FOC as a homogenous group rather than addressing their differences (Rondung et al., 2018). In the present study, the role of general self-esteem – defined as person's evaluation of their value or self-worth (Jordan et al., 2015) ‾ on childbirth experience was investigated while considering the possible interaction effects with FOC. High self-esteem is proposed to serve as a resource to support adjustment in life transitions in general (Chen et al., 2016), as well as in relation to pregnancy and childbirth (Jomeen, 2004). Low self-esteem, in turn, may interfere with a woman's ability to cope. Theoretically, there are at least three mechanisms (Jordan et al., 2015) that may put individuals with low self-esteem at a disadvantage: First, they are less likely to engage in behaviours that promote good physical health and may consequently be less prepared for childbirth. Second, they experience elevated and prolonged cortisol response to stressful situations, which may make labour and the immediate postpartum period more fearful experiences for them. Third, their interpersonal relationships are of poorer quality than those of others (Jordan et al., 2015), which means they probably need to cope with less support during pregnancy, birth and postpartum.

Low self-esteem and FOC often co-occur (Lowe, 2000), affecting the course of the woman's labour negatively, in turn further reducing her self-esteem while increasing her fear (Jomeen, 2004). However, the possible interaction effects are not yet understood, and the effects of self-esteem on birth experience are seldom differentiated from the effects of fear. Furthermore, the effect of parity and age on birth experiences remains unclear (Chabbert et al., 2020). The present study sought to answer the following research questions:

(1) To what extent are self-esteem and FOC related to childbirth experience?
(2) Is the relationship between FOC and childbirth experience different depending on self-esteem?
(3) Is the relationship between self-esteem, FOC and birth experience different depending on age and parity?

Materials and methods

Participants

A total of 125 women were enrolled in the study. They were recruited from four medium-sized cities in Central Finland. In the area, a total of 2,754 women gave birth in the year 2020. Women were eligible to participate in the study if they were at least 30 weeks into gestation and were able to complete the survey in Finnish. They had expected dates of delivery between February and December 2020. Participants were 20 to 46 years old ($M = 31$, $SD = .49$), and 73 were nulliparous (58.4%) and 52 were parous (41.6%). The total number of children that they already had ranged from none to seven. The women either lived together with the father of their child or children (92%), in a mixed family (6.5%), or

in another type of family formation (1.5%). Their perceived income levels were above average (21.6%), average (68.8%), below average (8.0%), or poor (0.8%). A total of 72.0% of women had completed tertiary and 26.4% vocational education, whereas 0.8% of women had no further education after compulsory schooling.

Procedure

Ethical approval for the study was obtained from the University of Jyvaskyla Ethics Committee before data collection (August 2019). All family health centres in four medium-sized cities in Central Finland volunteered to participate in the data collection. Nearly all Finnish women receive antenatal care at their community health centre (Finnish Institute for Health and Welfare, 2013, p. 307), and that made it possible to reach the majority of the pregnant women there. Participants were recruited via public health nurses during their antenatal visits from February to October 2020. According to power analysis, sample size n = 100 is needed to detect .30 (or higher) correlation or standardised regression coefficient with a statistical power of .80 using nominal significance level at .05. Keeping this in mind and the expected drop out during the longitudinal study, the study survey was initially distributed to 489 women. They were given written information about the study, a voluntary participation form, and the study survey, which they were asked to fill in at home after the appointment and return to the researcher in a pre-paid envelope. A total of 125 women returned the survey. Consequently, the participation rate in the first phase was 25.6%. The second phase surveys were sent directly by mail to the women who had participated in the first phase. They were asked to complete the survey and to return it to the researcher in a pre-paid envelope. A total of 90.4% (n = 113) of women who participated in the first phase also returned the surveys in the second phase. The missing data analyses comparing the drop-out participants (n = 12) to those who did not drop out (n = 113) according to the independent variables under interest at T1 (i.e. self-esteem, fear of childbirth (FOC), age, and parity) revealed that the differences between the two groups were not statistically significant ($p < .05$) for any of the T1 independent variables.

Measures

Birth experience (T2, 4–8 weeks after childbirth)

Birth Experience was measured with the Delivery Satisfaction Scale (DSS), an eight-item scale developed and validated in Finland (Saisto et al., 2001). It is a 5-point Likert scale with items 4 and 8 reverse scored. Examples of items are as follows: *Was childbirth a positive experience for you?*; and, *Were you able to affect the course of your labour according to your wishes?* The maximum sum score of the scale is 40, and higher scores represent a more positive experience. Cronbach’s alpha for the scale was good, .78.

Fear of childbirth (T1, 30+ weeks into gestation)

FOC was measured with the Wijma Delivery Expectancy/Experience Questionnaire – version A (W-DEQ-A; Wijma et al., 1998) with the permission of the copyright holder. W-DEQ-A is a 33-item questionnaire that represents answers to each question on a visual scale (line) with numerical values from 0 to 5 and lingual expressions at each end. Examples of items are as follows: *How do you think your labour and delivery will turn out*

as a whole? (0 = *extremely fantastic*; 5 = *not at all fantastic*); and, *What do you think will happen when the labour is most intense?* (0 = *I will behave extremely badly*; 5 = *I will not behave badly at all*). The scale has been validated in English (Reisz et al., 2015) and was translated into Finnish by the researcher using a back-translation method. The accuracy of the translation was checked by a native speaker. The total score ranges from 0 to 165 and higher scores represent more fear. Cronbach's alpha for the scale was excellent, .92.

Self-esteem (T1; 30+ weeks into gestation)

Self-Esteem was assessed with the Rosenberg Self-Esteem Scale (Rosenberg, 1989). The scale includes 10 items that measure the general level of self-esteem, such as: *On the whole, I am satisfied with myself*; and, *I wish I could have more respect for myself*. The statements are answered on a 5-point Likert scale (1 = strongly agree; 5 = strongly disagree; items 2, 5, 6, 8 and 9 are reverse scored). Higher scores represent better self-esteem and the maximum sum score of the scale is 50. Cronbach's alpha for the scale was excellent, .91.

The descriptive data of the study variables revealed that information concerning birth experience was missing in the case of 12 participants, whereas information concerning self-esteem and parity was missing in the case of one participant. Information concerning fear of childbirth and age was available to all 125 participants. The data were slightly skewed concerning all these variables, skewness ranging from the value −.533 (age) to −1.01 (birth experience). In all cases, the skewness was statistically significant ($p < .05$).

Analysis

The data were analysed using MPlus statistical software, version 7.3 (Muthén & Muthén, 1998–2012). The method of analysis used was path analysis, and the method of estimation was full information maximum likelihood (FIML) robust estimation (MLR estimator). MLR takes missing data into account by using all available information when estimating the model. The few missing values (one missing value for parity and self-esteem, and 12 missing values for birth experience) were supposed to be missing at random (MAR), and the standard errors were corrected to be robust to address non-normality. FOC and self-esteem at Time 1 (third trimester of pregnancy) served as independent variables, and subjective birth experience at Time 2 (4–8 weeks after childbirth) served as the dependent variable in the analysis. Moreover, the interaction term *Self-esteem* X *Fear of childbirth*, as well as parity and age of the mother, was included as independent variables in the model. Independent variables were allowed to correlate with each other.

Results

The descriptive statistics and correlations of study variables are presented in Table 1. The cut-off score for severe FOC as measured with the W-DEQ-A is proposed to be 85 (Lukasse et al., 2014). In the present sample, the average score of the participants was 58.71 (SD = 19.88), suggesting that the participants reported, on average, moderate levels of FOC. A total of 11.5% of participants reported clinical levels of FOC (W-DEQ A ≥ 85). Self-esteem was positively and statistically significantly associated with birth experience, while

Table 1. Correlations between subjective birth experience, self-esteem, Fear of Childbirth (FOC), parity, and age.

	Birth Experience (T2) (n = 113)	Self-esteem (T1) (n = 124)	FOC (T1) (n = 125)	Parity (n = 124)	Age (n = 125)	*M*	*SD*
Birth Experience (T2)	1.000					31.96	5.03
A. Self-Esteem (T1)	.324***	1.000				40.45	7.17
B. FOC (T1)	−.220*	−.321***	1.000			89.55	19.88
Parity	.181*	−.042	−.096	1.000			
Age (measured by year of birth)	−.132	.023	−.088	−.333***	1.000		
A X B	.156	.001	−.097	−.052	.139		

T1 = pregnancy (30+ weeks gestation).
T2 = 4–8 weeks after childbirth.
*$p < .05$, *** $p < .001$.

FOC correlated negatively with birth experience. Further, self-esteem correlated negatively with FOC, whereas parity correlated positively with birth experience.

The aim of the present study was to find out if FOC and self-esteem have independent or interaction effects to be taken into consideration in predicting subjective childbirth experience. The results show that participants' self-esteem (standardised estimate = 0.300, $p = .001$; 95% confidence interval, .125–.481) predicted their birth experience with statistical significance: the higher the self-esteem, the more positive the reported birth experience. The results further show that the effect of FOC on birth experience was dependent on the level of self-esteem (standardised estimate for the interaction of *Self-esteem* X *Fear of childbirth* = 0.171, $p < .05$; 95% confidence interval, .011–.326). The interaction found is visualised in Figure 1. The results show that among mothers with a low level of self-esteem (–1 *SD*), FOC had a steeper negative effect on subsequent birth experience than among mothers with a high level of self-esteem (+1 *SD*). Consequently, good self-esteem seemed to protect from the detrimental effect of FOC on birth experience, whereas low self-esteem further strengthened this effect.

Another aim of our study was to find out if the relation between women's self-esteem and FOC during pregnancy until their reflection on the birth experience afterwards is different depending on age and parity. The results show that these background variables were not associated with the birth experience after taking into account the effects of self-esteem and FOC; neither did they show any interaction effect with FOC and self-esteem.

Discussion

In the present study, we investigated the role of women's self-esteem and FOC on their subjective birth experience. The results demonstrate that the role of FOC in women's postpartum assessment of their birth experience was dependent on their level of self-esteem: among mothers with a low level of self-esteem, FOC showed a stronger negative effect on their subsequent birth experience than among mothers with a high level of self-esteem. It was surprising that high self-esteem removed the effect of fear altogether, especially since previous studies have largely ignored the effect of self-esteem on the

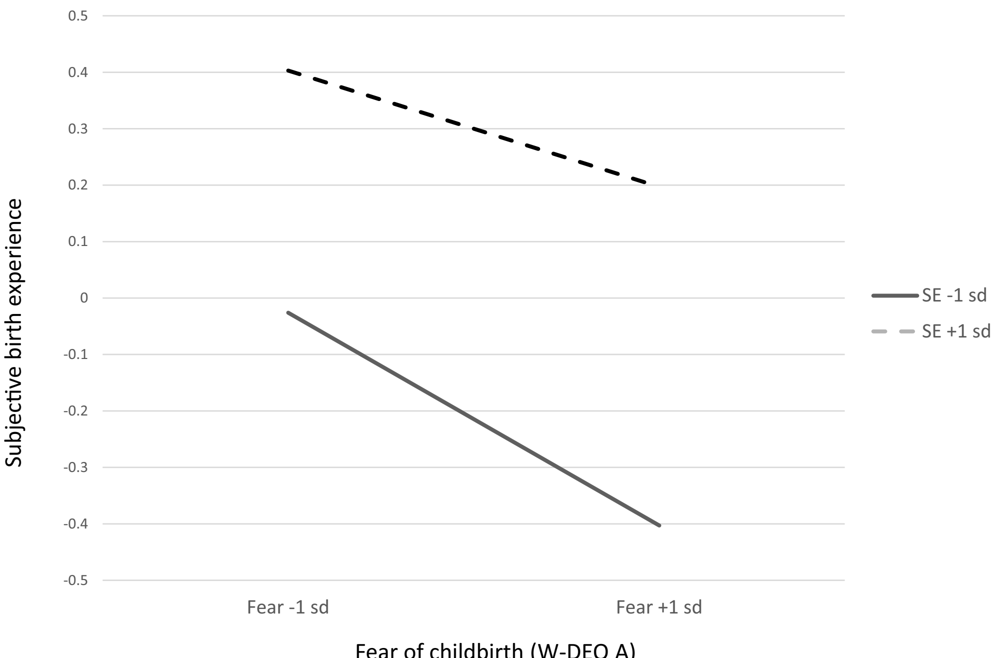

Figure 1. Fear of childbirth (Fear) and birth experience for participants with high (+1*sd*) and low (−1*sd*) self-esteem (SE).

birth experience and have described only the effect of FOC. However, we did not assess if obstetric characteristics of the labour and birth explain any negative evaluations of the birth experience associated with lower self-esteem. Future studies should assess whether the results are the same even after controlling for birth interventions and delivery mode.

While it has been proposed previously that women with FOC generally have lower levels of self-esteem than do women without FOC (Lowe, 2000), intra-group differences in self-esteem have not been studied before. In the present study, participants with high self-esteem and higher-than-average FOC scored higher with respect to the subjective birth experience than did mothers with average levels, whereas participants with low self-esteem and high levels of fear scored lowest. This result suggests that high self-esteem can protect against the detrimental effects commonly associated with FOC (Saisto & Halmesmäki, 2003), and that low self-esteem can further deepen those effects.

A further aim of our research was to investigate whether the relationship between self-esteem and FOC to birth experience is dependent on age and parity. No main or interaction effect between age or parity and birth experience was found. This means that the results apply to childbearing women with FOC regardless of age or parity. This result elaborates the previous finding by Lowe (2000) that low self-esteem is more common in nulliparous women who suffer from FOC than in those who have less fear: Our finding suggests that the level of self-esteem has clinical importance regardless of parity; and it suggests that for women with FOC, their level of self-esteem contributes more to their birth experience than does their prepartum level of FOC.

The present study has several strengths. First, it contributes to understanding the psychological premises of FOC and birth experiences, which is essential for theory formation and clinical practice. Second, studying women with severe fear in a longitudinal setting makes it possible to examine intra-group differences and different pathways to positive or negative birth experiences. The findings can be meaningful when planning relevant interventions, particularly for the most fearful women facing childbirth.

The present study also has limitations. The first limitation concerns the time of the data collection, year 2020: Because of the global COVID-19 pandemic causing uncertainty and limiting social connections worldwide, and in some cases restricting childbirth companions and visitors in hospitals, we do not know if the results would be the same during a less challenging time. The effect of self-esteem found in the present study may represent a resiliency factor that buffers the psychosocial effects caused by the pandemic and not so much of the FOC itself. Second, this study was conducted in only one cultural setting, Finland, that has a different maternity system from those in many other countries. Different findings might be obtained in different settings. Third, findings should be confirmed in clinical populations of women with fear of childbirth.

While a person's level of self-esteem has been proposed as an important factor in their general well-being (Jordan et al., 2015), it has rarely been discussed in relation to pregnancy and childbirth (Jomeen, 2004). Self-esteem has been found to predict postnatal depression (Beck, 2001) and has at times been indicated to be associated with FOC (Lowe, 2000), suggesting that it has clinical importance during the perinatal period. The present research suggests that FOC is a complicated phenomenon that cannot be adequately understood without understanding how it connects to the psychological structure of the self. It was found that including self-esteem in the model made the direct effect of FOC on the birth experience disappear altogether. One possible explanation would be that FOC is in close interplay with low self-esteem, and reciprocal interactions are likely. Women with FOC might feel their self-worth threatened by the upcoming birth that is perceived as frightening – doubting their performance (Reisz et al., 2015) and/or even their survival and that of the baby (Rondung et al., 2018) in advance. Prepartum feelings of inadequateness or incapability as a woman or a mother may make the upcoming birth seem like a mission impossible.

The moderating effect of self-esteem should be addressed when planning future research and support for women with FOC in order to improve birth experiences. While it is uncertain if self-esteem can be improved through interventions (Jordan et al., 2015), teaching self-compassion before and during pregnancy may be beneficial. However, special effort should be made to recognise those who are most in need of intervention. Women with low self-esteem may be less likely to seek support for their fear than women with higher self-esteem (Higgins et al., 1994), and more likely to engage in avoidant coping strategies (Kotzé et al., 2013) even though treating their fear is likely to be especially beneficial. Further, as Rondung and colleagues (Rondung et al., 2016) suggest, interventions should be individualised to suit all pregnant women suffering from fear.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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References

Beck, C. T. (2001). Predictors of postpartum depression: An update. *Nursing Research*, *50*(5), 275–285. https://doi.org/10.1097/00006199-200109000-00004

Chabbert, M., Panagiotou, D., & Wendland, J. (2020). Predictive factors of women's subjective perception of childbirth experience: A systematic review of the literature. *Journal of Reproductive and Infant Psychology*, *39*(1), 43–66. https://doi.org/10.1080/02646838.2020.1748582

Chen, E. Y.-J., Enright, R. D., & Tung, E. Y.-L. (2016). The influence of family unions and parenthood transitions on self-development. *Journal of Family Psychology*, *30*(3), 341–352. http://dx.doi.org/10.1037/fam0000154

Downe, S., Finlayson, K., Oladapo, O., Bonet, M., & Gülmezoglu, A. M. (2018). What matters to women during childbirth: A systematic qualitative review. *PLoS ONE*, *13*(4), e0194906. https://doi.org/10.1371/journal.pone.0194906

Finnish Institute for Health and Welfare; Klemetti R. & Hakulinen-Viitanen T., (Eds.) (2013). *Äitiysneuvolaopas*. Suosituksia äitiysneuvolatoimintaan. [Guide for maternity services. Recommendations for Maternal Health Care].

Higgins, P., Murray, M., & Williams, E. (1994). Self-esteem, social support, and satisfaction differences in women with adequate and inadequate perinatal-care. *Birth-Issues In Perinatal Care*, *21*(1), 26–33. https://doi.org/10.1111/j.1523-536X.1994.tb00912.x

Hildingsson, I., Johansson, M., Karlström, A., & Fenwick, J. (2013). Factors associated with a positive birth experience: An exploration of Swedish women's experiences. *International Journal of Childbirth*, *3*(3), 153–164. https://doi.org/10.1891/2156-5287.3.3.153

Jomeen, J. (2004). The importance of assessing psychological status during pregnancy, childbirth and the postnatal period as a multidimensional construct: A literature review. *Clinical Effectiveness in Nursing*, *8*(3–4), 143–155. https://doi.org/10.1016/j.cein.2005.02.001

Jordan, C. H., Zeigler-Hill, V., & Cameron, J. J. (2015). Self-esteem. In J. D. Wright (Ed.), *International encyclopedia of the social & behavioral sciences (2nd edition)* (pp. 522–528). Elsevier. https://doi.org/10.1016/B978-0-08-097086-8.25090-3

Kotzé, M., Visser, M., Makin, J., Sikkema, K., Forsyth, B., et al. (2013). Psychosocial variables associated with coping of HIV-positive women diagnosed during pregnancy. *AIDS and Behavior*, *17*(2), 498–507. http://dx.doi.org/10.1007/s10461-012-0379-7

Larkin, P., Begley, C. M., & Devane, D. (2009). Women's experiences of labour and birth: An evolutionary concept analysis. *Midwifery*, *25*(2), e49–e59. https://doi.org/10.1016/j.midw.2007.07.010

Lowe, N. K. (2000). Self-efficacy for labor and childbirth fears in nulliparous pregnant women. *Journal of Psychosomatic Obstetrics & Gynecology*, *21*(4), 219–224. https://doi.org/10.3109/01674820009085591

Lukasse, M., Schei, B., & Ryding, E. L. (2014). Prevalence and associated factors of fear of childbirth in six European countries. *Sexual & Reproductive Healthcare*, *5*(3), 99–106. https://doi.org/10.1016/j.srhc.2014.06.007

Muthén, L. K., & Muthén, B. O. (1998–2012). *Mplus user's guide* (7th ed.). Muthén & Muthén.

Reisz, S., Jacobvitz, D., & George, C. (2015). Birth and motherhood: Childbirth experiences and mothers' perceptions of themselves and their babies. *Infant Mental Health Journal*, *36*(2), 167–178. https://doi.org/10.1002/imhj.21500

Rondung, E., Ekdahl, J., Hildingsson, I., Rubertsson, C., & Sundin, O. (2018). Heterogeneity in childbirth related fear or anxiety. *Scandinavian Journal of Psychology*, *59*(6), 634–643. https://doi.org/10.1111/sjop.12481

Rondung, E., Thomtén, J., & Sundin, Ö. (2016). Psychological perspectives on fear of childbirth. *Journal of Anxiety Disorders*, *44*(1), 80–91. https://doi.org/10.1016/j.janxdis.2016.10.007

Rosenberg, M. (1989). *Society and the adolescent self-image* (Rev. ed.). Wesleyan University Press.

Saisto, T., & Halmesmäki, E. (2003). Fear of childbirth: A neglected dilemma. *Acta Obstetricia et Gynecologia Scandinavica*, *82*(3), 201–208. https://doi.org/10.1034/j.1600-0412.2003.00114.x

Saisto, T., Salmela-Aro, K., Nurmi, J. E., & Halmesmaki, E. (2001). Psychosocial predictors of disappointment with delivery and puerperal depression. A longitudinal study. *Acta Obstetricia et Gynecologia Scandinavica*, *80*(1), 39–45. https://doi.org/10.1034/j.1600-0412.2001.800108.x

Saisto, T., Toivanen, R., Salmela-Aro, K., & Halmesmäki, E. (2006). Therapeutic group psychoeducation and relaxation in treating fear of childbirth. *Acta obstetricia et gynecologica Scandinavica*, *85*(11), 1315–1319. https://doi.org/10.1080/00016340600756920

Wijma, K., Wijma, B., & Zar, M. (1998). Psychometric aspects of the W-DEQ; a new questionnaire for the measurement of fear of childbirth. *Journal of Psychosomatic Obstetrics & Gynecology*, *19*(2), 84–97. https://doi.org/10.3109/01674829809048501

II

PASSING THE TEST OF MOTHERHOOD? SELF-ESTEEM DEVELOPMENT AND BIRTH EXPERIENCE IN THE TRANSITION TO MOTHERHOOD: A LONGITUDINAL MIXED METHODS STUDY IN FINLAND

by

Mirjam Raudasoja, Katri Vehviläinen-Julkunen & Asko Tolvanen, 2022

Journal of Advanced Nursing, *78*(12), 1–15

https://doi.org/10.1111/jan.15468

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Received: 1 June 2022 | Revised: 8 September 2022 | Accepted: 4 October 2022
DOI: 10.1111/jan.15468

ORIGINAL RESEARCH: EMPIRICAL RESEARCH - MIXED METHODS

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Passing the test of motherhood? Self-esteem development and birth experience in the transition to motherhood: A longitudinal mixed methods study in Finland

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Abstract

Aims: To investigate women's childbirth experiences and their relation to self-esteem development in the postpartum year.

Design: A mixed methods study.

Methods: Women (N = 125) completed survey questionnaires regarding their self-esteem and childbirth experiences at three time points in 2020–2021: third trimester of pregnancy (T1), 4–8 weeks postpartum (T2) and 1 year postpartum (T3). The survey results were analysed using qualitative thematic and quantitative path analyses with latent change factors. The open-ended answers of the women who demonstrated a change in self-esteem between T2 and T3 were then compared. The STROBE checklist was used as the reporting guideline.

Results: The quantitatively measured childbirth experiences predicted statistically significantly and positively the changes in self-esteem in the following year. The women described their childbirth stories through three main themes: childbirth as a lived experience, childbirth as a relational event and childbirth as a medical event. On the basis of the thematic analysis, we propose that the relationship between childbirth experience and self-esteem development might only hold for women with extremely positive or negative childbirth experiences. There were mixed results for those women who had mixed experiences, indicating that other factors probably contributed to the changes in self-esteem.

Conclusion: Childbirth is a pivotal event that may have lasting effects on the mother's self-esteem after childbirth. Especially women with traumatic experiences deserve attention because they are at risk of the most negative consequences.

Impact: Perinatal services and policy makers must recognize the importance of childbirth experiences in women's well-being and improve their practices. Different cultural models of childbirth should be recognized and supported to facilitate good experiences and prevent traumatic ones.

Patient or Public Contribution: Service users recruited in Finnish Child Health Centers responded to surveys that were used as data for this study.

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KEYWORDS
childbirth experience, longitudinal study, midwife, mixed method, nursing, self-esteem

1 | INTRODUCTION

Childbirth experiences are multifaceted, an integral part of which are formed by feelings of capacity (Dencker et al., 2020). Women describe and evaluate their birthing performances against their own expectations (Preis, Lobel, et al., 2019) and cultural images of childbirth (Davis-Floyd, 2001; Hall, 2016). These evaluations sometimes produce feelings of accomplishment or failure, which may contribute to mothers' self-esteem later, supporting or hindering it. Feelings of inadequacy or failure related to childbirth (Schneider, 2013, 2018) or perceived discrepancy between expectations and reality (Preis, Lobel, et al., 2019) may negatively affect women's self-esteem in early motherhood. On the other hand, feelings of achievement and empowerment (Olza et al., 2018; Simkin, 2006) may promote increased self-esteem. The quality of the birthing experience has consequences to mothers' perceptions of themselves and their babies (Reisz et al., 2015). However, a gap exists in the current literature on the effect of childbirth experience on self-esteem. Most studies have concentrated on context-specific maternal self-esteem (Laney et al., 2014) or self-efficacy (Reisz et al., 2015) in the transition to motherhood. Furthermore, studies proposing that childbirth experience might affect maternal self-esteem later rarely combined quantitative and qualitative data. For this reason, the kinds of childbirth experiences that might affect women's self-esteem later are not exactly known. The present study examined the effects of childbirth experience on mothers' self-esteem, combining quantitative and qualitative methods to acquire knowledge on different developmental pathways.

1.1 | Background

The transition to motherhood involves bodily changes, psychological adaptation, and a changing social environment and can have both positive and negative implications for the mother (Taubman-Ben-Ari et al., 2009). A time for relational change, this transition invokes changes in women's self-concept (Laney et al., 2014). Childbirth is a possibility for psychological growth (Taubman-Ben-Ari et al., 2009) but sometimes leads to traumatization and consolidates negative perceptions of oneself (Byrne et al., 2017). Childbirth experiences refer to subjective experiences of labour and childbirth. Larkin et al. (2009) defined childbirth experience as individual life events with mutually related physiological and psychological processes influenced by contexts such as social, environmental and organizational factors. The central components of childbirth experiences include feelings of capacity, perceived safety and security, professional support and participation (Dencker et al., 2020).

Impact statement

- Patients will benefit from the results of this study if they are implemented in care systems. For example, mothers will receive better support after traumatic childbirth experiences.
- The results will be useful in clinical practice. They help to identify patients in need of support, because the risks of negative experiences of childbirth are better known.
- The results can be used in training of midwives, doctors, and nurses in perinatal care.
- The results can be used in communicating the importance of the perinatal period to the wider public, which may result in cultural change towards more supportive environment for mothers.

One important aspect affecting how women understand and narrate their childbirth experiences is the surrounding culture. Western cultures are often proposed to alternate between two extremes or narratives, natural and medical understandings of childbirth (Preis, Lobel, et al., 2019). Davis-Floyd (2001) proposed that American culture encompasses three paradigms of childbirth: The technocratic model is built on the separation of the mind and the body and depicts the body as a machine. The body is understood as prone to fail and in need of interventions, and healing is believed to occur outside in. The humanistic model, in turn, stresses a mind–body connection and values the connection and caring between labouring woman and healthcare practitioners. Healing is thought to occur both from the inside out and outside in, and practitioners must know how to listen to women. The holistic model stresses the oneness of body–mind-spirit and understands the body as an energy system interlinked with other energy systems. Thus, the purpose of healing is to care for the whole person in their whole life context, and healing is thought to occur inside out (Davis-Floyd, 2001). How women relate to cultural understandings of childbirth may affect how they assess their own labour performances. For example, when a mother has a strong conviction that natural childbirth is best for the child, birthing by caesarean section may cause feelings of failure or inadequacy.

Psychoanalytically oriented researchers have tried to explain how childbirth relates to female psychosexual development. Hall (2016) summarized the results of her analysis of interviews with 30 first-time mothers before and after their deliveries and proposed three central themes encompassing women's expectations and experiences of childbirth: fear of bodily damage, pride and awe about producing a baby and true womanhood.

These themes are often manifested as performance anxiety regarding childbirth choices and mothering (Hall, 2016). Women often experience pressure towards 'soft' and 'natural' childbirth choices, which may be perceived as indicators of true womanhood (Hall, 2016). However, in modern obstetric settings, childbirths are often more medicalized than expected (Preis, Eisner, et al., 2019). Unmet expectations expose women to feelings of failure that they most often blame themselves for (Schneider, 2010). In turn, at the core of a satisfying childbirth experience is the belief in one's ability to give birth (Olza et al., 2018). Confirming or disconfirming this belief in childbirth may have positive or negative consequences to self-esteem.

Self-esteem refers to a person's subjective evaluation of self-worth (Orth & Robins, 2014). Developed in childhood, self-esteem is thought to form a basis for psychological well-being and success in life (Orth & Robins, 2014). In the transition to motherhood, studies have attempted to identify a normative pattern of change in self-esteem. In a Norwegian study (van Scheppingen et al., 2018) in women who had had their first, second, third or fourth child, it was found that in all subgroups, self-esteem tended to decrease during pregnancy, increase until the child was 6 months old, and gradually decreased over the following years. In other studies (e.g. Bleidorn et al., 2016), a sharp decrease in self-esteem has been reported after the birth of the baby, followed by a gradual decrease in the following years. However, these studies have not predicted changes in self-esteem on the basis of childbirth-related variables.

Studies that explored the relationship between childbirth experience and self-esteem have often concentrated on context-specific maternal self-esteem (e.g. Laney et al., 2014; Reisz et al., 2015). For example, Reisz et al. (2015) found that subjective childbirth experience predicted context-specific maternal self-esteem in mothers who had given birth during the previous year. However, whether general self-esteem can also be affected by childbirth experience is currently unknown. Qualitative studies that examined the effect of childbirth experience on the mother suggest that good experiences promote a sense of accomplishment (Simkin, 2006) and empowerment (Olza et al., 2018), whereas traumatic experiences challenge and alter women's self-perceptions (Byrne et al., 2017). Altered self-perceptions may initiate changes in self-esteem resulting from a childbirth experience. According to Schneider (2010), an important central theme in childbirth experiences is that 'birth says something about me' (p. 104). Women in that study perceived childbirth as transformative and indicative of their inner qualities that they were not always aware of prior to childbirth (Schneider, 2010). Thus, studies suggest that the quality of the childbirth experience may affect women's self-esteem. However, which types of interpretations must be made about childbirth to induce changes in self-esteem remain unknown. Integrating quantitative and qualitative data into a mixed methods analysis will improve the existing knowledge about the processes of self-esteem development. The Finnish maternity system is especially suitable for this kind of study because public, low-cost maternity services are available to everyone and socioeconomic status does not affect availability of services. This knowledge will help to improve maternity services in Finland and internationally to recognize the impact of self-esteem for women's well-being in the perinatal period.

2 | THE STUDY

2.1 | Aims

The aim of the present study was to investigate variations in self-esteem development and their relations to childbirth experience. The research questions were as follows:

1. Does subjective childbirth experience predict changes in self-esteem during the first year after giving birth?
2. How do women describe their childbirth experiences?
3. How do women's descriptions of their childbirth experiences differ between different groups on the basis of changes in self-esteem during the first year after giving birth?

2.2 | Design

In this study, we used a mixed methods approach and longitudinal design. We conform to the STrengthening the Reporting of OBservational studies in Epidemiology (STROBE) standards (see Supplementary File 1). Quantitative and qualitative data were collected through surveys conducted from 2020 to 2021. The study included three measurement points: the third trimester of pregnancy (weeks 30+), 4–8 weeks postpartum and 1 year postpartum. Qualitative data about childbirth experiences were collected at time point 2, whereas quantitative data were collected at all time points. In the first phase of the study, the participation rate was 25.6%. A total of 90.4% (N = 113) of women who participated in the first phase also returned the questionnaire in the second phase. A total of 81.6% (N = 102) of the women who participated in the first phase completed all three phases of the study. The study design is presented in Figure 1.

This was a mixed methods study using a triangulation design with a three-phase approach (Creswell & Plano Clark, 2011, p. 62). In the first phase, the quantitative component provided knowledge of whether childbirth experiences predicted changes in self-esteem during the following year. The results of the first phase informed the second phase (Creswell & Plano Clark, 2011), which was a qualitative investigation needed to provide understanding about how women describe their childbirth experiences. The analysis methods were performed separately, using the quantitative analysis to first answer the subquestion about the predictive value of childbirth experience in self-esteem development and then using the qualitative analysis to address how the participants described their experiences. Through the integration of the results, we identified the types of experiences that predicted statistically significant changes in the participants' self-esteem.

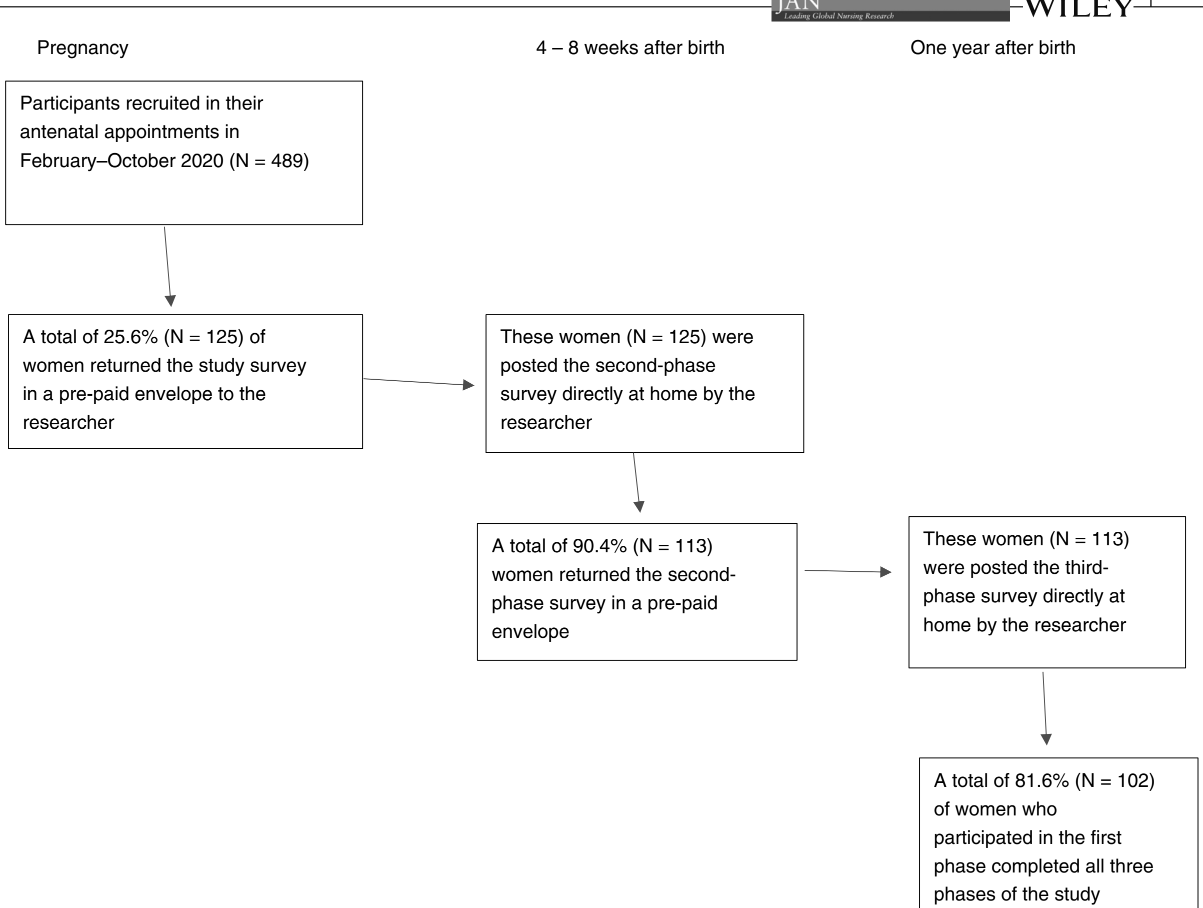

FIGURE 1 Study design.

2.3 | Assessment measures

2.3.1 | Self-esteem

Self-esteem was assessed using the Rosenberg Self-Esteem Scale (Rosenberg, 1989), which measures the general level of self-esteem in all three time points. The scale included 10 items such as '.' The statements were answered on a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree), and items that indicated low self-esteem were reverse-scored. The maximum total score on the scale was 50, and higher scores indicated better self-esteem. The value of Cronbach's alpha for the scale was excellent: 0.91 at T1, 0.90 at T2 and 0.90 at T3.

2.3.2 | Childbirth experience

The quality of childbirth experience was measured using the Delivery Satisfaction Scale (DSS) between 4 and 8 weeks postpartum. The DSS is an eight-item scale developed and validated in Finland (Saisto et al., 2001). The scale was answered on a 5-point Likert scale, and all but two items (questions 4 and 8) were reverse-scored. It consisted of items such as 'Was childbirth a positive experience for you'? (1 = very; 5 = not at all). The maximum total score was 40, and a higher score indicated a more positive experience. The value of Cronbach's alpha for the scale was good, 0.78.

The quality of childbirth experience was also measured with an open-ended question at the beginning of the questionnaire: 'How was your experience of birth? Describe freely'. Below the question was a blank space of nine lines to write on.

2.4 | Participants

The study participants were recruited in four medium-sized cities in Central Finland using convenience sampling. In the area, a total of 2754 women gave birth in the year 2020. Women were eligible to participate in the study if they were at least 30 weeks into gestation and could complete the survey in Finnish. Prior to the data collection, we expected to have at least 100 participants. A total of 489 women received the study survey questionnaire, and 125 women were enrolled in the study.

2.5 | Data collection

Participants were recruited via public health nurses in family health centres in their antenatal appointments between February and October 2020. They were provided with oral and written information about the study, a voluntary participation form, and the study survey questionnaire. They answered the survey questionnaire at home and returned it to the researcher in a prepaid envelope. In the second phase, the women who had participated in the first phase were approached directly by mail and asked to complete a second questionnaire and to return it to the researcher in a prepaid envelope. The third-phase survey questionnaire was sent to the women who participated in both the first and second phases, and they were asked to complete the questionnaire and send it to the researcher in a prepaid envelope. Participants were sent two text messages at 1-month intervals reminding them to participate if they had not completed the surveys on time. Reasons for not participating or dropping out were not asked for.

2.6 | Ethical considerations

Before data collection, ethical approval for the study was obtained from the ethics committee of the University of Jyväskylä (August 2019) and the study conforms to the Declaration of Helsinki standards. All participants received oral and written information about the study. Participation was voluntary and could be stopped at any time without consequences for the participant. As the study survey included questions about potentially sensitive experiences, all participants were provided with a chance to contact the responsible researcher to discuss any thoughts or feelings that participation might invoke. All data were anonymized and stored in a safe repository during data collection. All data samples are presented under pseudonyms.

2.7 | Data analysis

The first step of the analysis was quantitative, consisting of a path analysis with latent change factors (Voelkle & Oud, 2015). By modelling latent change factors both the mean changes, as well as individual variations, across these means are estimated. Three latent factors, namely F1, F2 and F3, for each self-esteem variables at time T1, T2 and T3 were specified, and factor loadings were set to one. The model was identified when residual variances were set as equal at the T1, T2 and T3 measurements. In this way, we could isolate the measurement error. Paths from F1 to F2 and from F2 to F3 were set at one, and the latent change factors CHF2 and CHF3 were set to capture all residual variances from F2 to F3. Therefore, the residual variances of F2 and F3 were set to zero. The paths from F1 to CHF2 and from F2 to CHF3 were freely estimated. Childbirth experience was regressed on self-esteem at T1, and change in self-esteem at T3 was regressed on childbirth experience. The saturated model was estimated using the full information maximum likelihood method with the Mplus 8.6 statistical program (Muthén & Muthén, 1998–2017). Standard errors were estimated with the 'maximum likelihood with robust standard errors' estimator, whose estimates are robust against non-normal distributions. Missing values (10% at T2 and 19% at T3) were supposed to be random, actually, the Little's MCAR test $\chi^2(7) = 13.22$, $p = .067$ showed that the assumption of 'missing completely at random (MCAR)' cannot be rejected.

The second step of the analysis was to investigate responses to the open-ended question at T2, considering childbirth experience. All responses (N = 113) were analysed by the first author using a thematic analysis (Braun & Clarke, 2006) to determine how childbirth experiences are constituted in women's open-ended responses. At first, the data were read through several times, and initial thoughts were written down. Then, the first half of the data were analysed for repetitive meanings, words, and sentences that were highlighted to obtain interesting and significant details from the data. Next, initial themes were formulated using the second half of the data, and these themes were then grouped under higher-order themes. The themes identified were tested against the first half of the data: a few lower-order themes were identified, and the higher-order themes remained the same. Finally, the responses were read as whole stories to determine what childbirth experiences mean to the participants.

After the statistical and thematic analyses, we selected individuals who showed a statistically significant change ($p < .05$) in their self-esteem mean score between T2 and T3 ($n = 14$). The individuals were divided into four groups: (1) those with a positive childbirth experience with increasing self-esteem; (2) those with a negative childbirth experience with an increasing self-esteem; (3) those with a negative childbirth experience with a decreasing self-esteem and (4) those with a positive childbirth experience with a decreasing self-esteem. This grouping was done based on the qualitative responses concerning the childbirth experience (the general tone and adjectives used to describe the birth experience). After that, the correspondence with DSS scores was checked. It seemed that all positive descriptions were for individuals whose DSS mean score was 4 or more; all negative descriptions were for individuals whose DSS score was less than 4. The responses of the four different groups to the open-ended question on childbirth experience were compared with each other.

2.8 | Validity and reliability

The statistical model was saturated, and all the instruments showed very good reliability. The statistical power to detect small effects at 0.05 level (0.27) with the planned sample size n = 100 was 0.80. This sample size is considered sufficient to find significant effects. In qualitative analysis, a second coder (KVJ) coded every tenth answer to ensure the validity of the thematic structure. Analytic decisions and disagreements were discussed between the researchers

until consensus was reached. The themes were further refined following the discussions. For example, the hierarchy of some of the themes changed after these reflections. An audit trail was kept during the analytical phase, including analytical decisions, the evolving thematic structure, discussions between the researchers, and the first analysts' thoughts and feelings about the subject. The findings of the statistical analyses and their relations to the qualitative data were actively discussed between the researchers.

3 | FINDINGS

3.1 | Sample

The study participants were 20 to 46 years old (mean [*SD*] age: 31 [4.49] years). Seventy-three participants (58.4%) were primiparous, and 52 (41.6%) were parous. The mean age was representative of all Finnish childbearing women, but the proportion of primiparous women was slightly greater. On average, the participants were highly educated. Details of the sample are presented in Table 1. Participants reported, on average, a mean DSS score of 4.02 (*SD* 0.62), indicating a positive experience of birth at T2 (see Table 1). The mean sum score of RSES was also high, indicating a high self-esteem, on average: 40.39 (*SD* 7.18) at T1, 40.49 (*SD* 7.25) at T2 and 41.27 (*SD* 6.96) at T3 respectively. However, big standard deviations indicated a large individual variation in both variables.

TABLE 1 Background characteristics of the sample ($n = 125$)

	M (*SD*)	*n* (%)
Age	31.1 (4.46)	
Number of children	0.62 (1.02)	
Primiparous		73 (58.4)
Parous		52 (41.6)
Level of education		
University or college degree		90 (72.0)
Technical college degree		33 (26.4)
No formal education after compulsory schooling		1 (0.8)
Missing data		1 (0.8)
Family form		
Nuclear family		115 (92.1)
Blended family		8 (6.8)
Other		2 (1.8)
Perceived financial situation		
Better than average		27 (21.6)
Average		86 (68.8)
Poorer than average		10 (8.0)
Poor		1 (0.8)
Missing data		1 (0.8)
Self-esteem (RSES sum score)		
T1	40.39 (7.18)	
T2	40.49 (7.25)	
T3	41.27 (6.96)	
Childbirth experience (DSS mean score)		
T2	4.02 (0.62)	
T3	3.98 (0.64)	

Note: Marital status and religious orientation of the participants were not asked about, nor were gender identities, sexual orientation or (dis) abilities.

3.2 | Childbirth experiences and self-esteem

The first research question was whether childbirth experience predicts changes in self-esteem during the first year after childbirth. Self-esteem at T1 was positively associated with childbirth experience at T2; that is, the higher the self-esteem at T1, the more positive the childbirth experience at T2. Childbirth experience at T2 was positively associated with change in self-esteem between T2 and T3, which means that the more positive the childbirth experience at T2, the higher the increase in self-esteem from T2 to T3 (see Figure 2). Maternal age, parity, income level and education level did not correlate statistically significantly with childbirth experience and self-esteem and were therefore left out of the model. Numbers for missing values were: self-esteem T1 $n = 0$, T2 $n = 12$, T3 $n = 23$ and childbirth experience T2 $n = 12$. At the 0.80 statistical power, we are able to detect 0.25, 0.26 and 0.27 standardized regression coefficient when the sample size is 125, 113 and 102 respectively. If the effects are smaller, it is difficult to find them with these sample sizes.

3.3 | Childbirth experiences

The second research question was how women describe their childbirth experiences. All women who returned the survey at T2 ($n = 113$) responded to the open-ended question. As a result of the thematic analysis of the open-ended responses on childbirth experience, nine themes were identified. These themes were grouped under three overarching themes that capture the meaning of childbirth as constructed by the participant: (1) childbirth as a lived experience; (2) childbirth as a relational event and (3) childbirth as a medical event. Often, more than one overarching theme was present in one answer. A thematic structure is presented in Table 2.

3.3.1 | Childbirth as a lived experience

Childbirth as a lived experience was described through three lower-level themes: (1) cognitive and emotional appraisal; (2) reactions and actions during childbirth and (3) situating birth in the life story. Cognitive and emotional appraisal consisted of several subthemes:

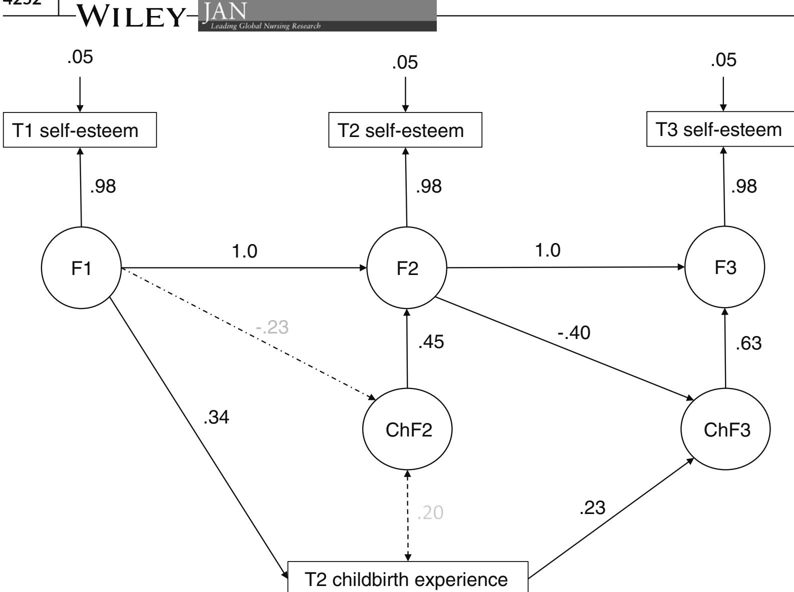

FIGURE 2 Relationship between self-esteem, childbirth experience and change in self-esteem.

describing the experience with various adjectives (e.g. great, good, hard, fearful and horrible), describing how one feels about childbirth afterward, comparing the experience with a previous childbirth or with expectations, appraising the decisions made during childbirth, and evaluating the experience on a scale (e.g. 'I rated the experience 10/10'). Emma (28 years old, first child) expressed her overall evaluation as follows:

> The birth was long and painful. [...] I received all the pain relief, but in the end, nothing helped anymore. It hurt terribly. [...] Now that I think of the birth, I wonder if it was a nightmare. It did leave me with fear of childbirth!

Emma's description indicated an overwhelming impression of pain. So difficult did Emma experience labour that she even wondered 'if it was a nightmare'. The impression in her story was that labour was something that happened to her, leaving her with intolerable pain and fear of childbirth to carry to the future.

The second theme in this category was one's reactions and actions during childbirth. The participants described them through several subthemes: feelings of control or diminished control, decision making, 'enduring' it, childbirth sensations, emotions and moments of disorientation. Raisa (39 years old, second child) wrote:

> This time, the birth was very empowering and great experience! I gave birth without pain relief, and for that purpose, I had learned to relax well. When I was bathing in the sauna in our sauna building on the yard and when I was dancing on the terrace of the sauna to good music, I felt downright euphoric! I could not have imagined that anybody could feel that good while having contractions every second minute or a little bit more than one minute. [...] In addition, right after the birth, I was totally in control: I told my husband to help me out of my bra so that I could take the baby to the breast. I instructed the midwives to let the cord pulse as long as it would, and I refused the oxytocin drip, because there was no immediate need for that (I asked that).

This very positive childbirth experience included many descriptions of Raisa's own reactions and actions during labour. Feelings of control were apparent: having learnt how to relax, bathing in the sauna, dancing, concentrating, being in control, and instructing husband and midwives. Childbirth sensations were mainly depicted as positive, and Raisa even felt 'euphoric', which she found somewhat interesting herself. Raisa also described herself as in charge of decision making, which strengthened the impression of being in control.

Some participants described their childbirths as part of a life story, describing their experiences over time. They described several aspects from before the childbirth: feelings, anxieties and fears, expectations, hopes, preparation for childbirth, expectations for partner and other life events. They also considered their experiences of previous childbirths and anticipated possible future childbirths (stating that they could give birth again, doubting it or expressing that they never want to give birth again). Jenni (27 years old, first child) wrote:

> I feel that I exceeded myself. The experience is now an extremely dear memory for me, and it gives me strength.

This positive experience captured how childbirth experience can be constructed as part of a life story. Jenni felt that she exceeded herself and the memory gave her strength. Her childbirth experience was empowering for her, and Jenni's answer implies that it affects her self-confidence positively. Some participants also wrote about their experience after childbirth.

TABLE 2 Presentation of the thematic analysis

Overarching theme	Lower-level themes and their contents	Data examples
Childbirth as a lived experience	1. Cognitive and emotional appraisal: describing the experience, comparing with a previous childbirth or with expectations, feelings considering birth, appraising the decisions afterwards, evaluating the experience on a scale, possible future births 2. Reactions and actions during birth: control/diminished control, decision making, enduring, childbirth sensations, emotions, moments of disorientation 3. Situating childbirth in the life story: Before the childbirth: feelings (anxiety/fear), expectations, hopes, preparing for birth, expectations for partner, other life events; birth experience as compared with previous births; changing perceptions over time; after the birth	*It wasn't like I expected. [...] I expected a calmer and more controllable experience in terms of pain, I did not experience it a very natural event because of medical induction and pain relief. At first, I was upset of my experience, now [I'm] mostly proud that I managed a difficult birth.* *During labor, I realized that I was bad at enduring pain. For that reason, opening phase was difficult, but I do not remember it in a bad way anymore. The pushing stage was OK for me because I felt that then I could best affect it [the labor] myself.* *Afterwards I am disappointed, on the other hand, because I did not have opportunity to experience a 'normal' birth, for I waited it for 9 months if not longer.* *I could birth again whenever.*
Childbirth as a relational event	4. Relationships with family and known people: relationship with baby (meeting the baby, describing the baby); relationship with partner (support from the partner, trusting the partner); relationship with another familiar person (someone familiar is present at birth, doula could be mentioned); becoming a family (cooperation with partner, first moments as a family) 5. Relationships with professionals: experiences of care or neglect, trust, 'chemistry' between mother and midwife, interaction, information	*I received a lot of support from my husband, and I experienced that our relationship was strengthened. Maybe a birth that went well also helped me to fall in love with the baby straight away. The first moments as a family were very meaningful.* *I had a strong sense of security, also a feeling that I and the father of the child (who was present at birth, in the birth room), gave birth to the child together.* *I had the water birth I hoped for, with me my partner, a doula (who is also a good friend) and a midwife. I trusted myself and everybody else seemed to trust my body and it indeed worked like automatically.*
Childbirth as a medical event	6. Obstetrical story: the duration of the childbirth stages and childbirth events, parity, gestational age, complications, interventions (induction, augmentation, episiotomy, ventose), pain relief, size of the baby, mode of birth, 'natural birth' 7. Condition of the baby (heartbeat during labour, condition after childbirth, Apgar score), 8. Condition of the mother (after the childbirth) 9. The care system: transitions (home to hospital, reception to delivery suite, delivery suite to maternal ward, hospital to home), aspects and quality of care (positive/negative evaluation), controlling power of the hospital system (corona restrictions, transitions 'allowed', obstetric violence)	*My labor lasted about 11 h, beginning from arrival at hospital at 1000 h noon for a scheduled induction and ending at the birth of my daughter at 2100 h in the evening. I did not have contractions before they ruptured the membranes. The labor was fairly quick even though contractions continued quite a while, so I got an epidural [anaesthesia] for pain relief. I suffered from slight dryness because nothing kept inside, and I was not allowed to drink for the risk of the bladder impeding the labor. The child was 3.9 kg, [and it] came head first with ventose [extraction]. [...] I would imagine that the labor went in a usual way. The heartbeat of the child became weaker a couple of times, and it took a long time before we got a midwife to come. We started to be afraid for the well-being of the child. The child did not descend [in the pelvis] and they did not intervene because of the hurry of midwives before 2 h. Finally, we ended up in fierce ventose extraction.* *The midwives did not tell that they were going to do an episiotomy, I realized myself when they spoke together about anaesthesia.*

3.3.2 | Childbirth as a relational event

Childbirth as a relational event was described through two lower-level themes: (1) relationships with family and known people and (2) relationships with professionals. The first theme consisted of subthemes of relationship with the baby, relationship with partner, relationship with another familiar person and becoming a family. Katriina (33 years old, first child) wrote:

> I was relieved that I gave birth before the hospitals placed stricter restrictions considering the presence of supporting persons during labor because of the coronavirus. I received a lot of support from my husband, and I experienced that our relationship was strengthened. Maybe a birth that went well also helped me to fall in love with the baby straight away. The first moments as a family were very meaningful.

Katriina suggested that childbirth is a family event, one which starts between partners and ends in meeting the baby. The partner has a 'supporting' role during labour, but when a baby is born, a family is also born. This answer centred around family members, but caregiving personnel were also mentioned in many answers. The second theme encompassed relationships with all care personnel during pregnancy, childbirth and postpartum. For example, in the following experience of

Hanna-Leena (38 years old, first child), negative aspects of childbirth were described through relational themes:

> The beginning and the opening phase of birth went very well, even though they took hours. [...] In the beginning of the pushing stage, though we were left totally alone with my husband, because the ward was full of birthing people and the midwives were with them. The heartbeat of the child became weaker a couple of times, and it took a long time before we got a midwife to come. We started to be afraid for the well-being of the child. The child did not descend [in the pelvis], and they did not intervene because of the hurry of midwives before 2 h. Finally, we ended up in fierce ventose extraction. I thus feel that we were well cared for until pushing stage, and I wasn't afraid, but then we were left alone in the room for a long time, and we both with my husband had to be afraid of weakening of the heartbeat and if somebody comes quickly to help if they weaken again. I was badly torn, which was one of my worst fears beforehand. The end of the birth was thus some kind of a disappointment, and I would have hoped for better support for it.

In Hanna-Leena's answer, feelings of loneliness and mistrust were apparent. She described that the parents were afraid for the condition of the baby and in need of support, care, and reassurance. However, Hanna-Leena and her partner were left alone because all the midwives were caring for others. A subtle hint of competition over midwives' care could also be inferred from her answer, which suggests that relationship with other mothers may also be a meaningful part of the childbirth experience.

3.3.3 | Childbirth as a medical event

Childbirth as a medical event consisted of four lower-level themes: (1) obstetric story; (2) condition of the baby; (3) condition of the mother and (4) the care system. An obstetric story consists of several subthemes: the duration of the childbirth stages and childbirth events, parity, gestational age, complications, interventions, pain relief, size of the baby, mode of delivery and 'natural birth'. Lilja (34 years old, first child) described:

> My labor lasted about 11 h, beginning from arrival at hospital at 1000 h noon for a scheduled induction and ending at the birth of my daughter at 2100 h in the evening. I did not have contractions before they ruptured the membranes. The labor was fairly quick even though contractions continued quite a while, so I got an epidural [anaesthesia] for pain relief. I suffered from slight dryness because nothing kept inside, and I was not allowed to drink for the risk of the bladder impeding the labor. The child was 3.9 kg, [and it] came head first with ventose [extraction]. [...] I would imagine that the labor went in a usual way.

In Lilja's childbirth story, the labour was described through institutional rhythms and hospital conventions. The details were obstetric, such as interventions, length of labour, mother's dryness and the size of the baby. Lilja described that the labour went 'in a usual way', indicating that the 'usual' is the same as the obstetric interpretation of the events.

The baby's condition was most often mentioned when there were worries, for example, when the heartbeat of the baby weakened. Moreover, many mothers mentioned how their babies were doing at birth, with a few also mentioning their babies' Apgar scores. The mother's condition was mentioned most often in relation to events after birth as a general appraisal of the physical and sometimes emotional condition of the mother.

The fourth theme, 'the care system', consisted of the following subthemes: transitions, positive and negative aspects of care and controlling power of the care system. Transitions were described, as leaving for the hospital, being admitted to the labour ward, moving to the postnatal ward, and leaving for home with the baby. For example, Sanna (36 years old, third child) described: 'At the arrival at the hospital, I was 7-cm open, and we were allowed straight to the labor room'. The choice of the words 'being allowed' indicated that Sanna positioned herself in a submissive role to the hospital, which had its own conventions and rules to determine labour progress and provide care.

Oftentimes, mothers described positive and negative aspects of care in their stories. They were distinct from relational aspects and consisted of evaluations of the quality of care and restrictive aspects of the care protocol. Furthermore, some mothers had descriptions of obstetric violence in their stories. Säde (23 years old, first child) wrote:

> The birth was a hard experience, especially the pushing stage, because I was not listened to but instructed, and I felt powerless and inferior. The experience was also hard because the contractions had continued for 4 days before our firstborn was born. Also, the midwives did not tell that they were going to do an episiotomy; I realized myself when they spoke together about anaesthesia.

Säde described that she experienced being instructed in a harsh way during the pushing stage, which made her feel powerless and inferior. Säde's description can be interpreted as indicative of the power imbalance between hospital staff and labouring women. In her case, this translated into harsh treatment. Furthermore, doing an episiotomy without consent represented obstetric violence. In our data, a few childbirth stories indicated incidents of obstetric violence. Even though the stories were short, some women wrote about mistreatment and control. Some descriptions of controlling power of the hospital were

concerning restrictions in place because of the coronavirus, whereas others were unrelated to the pandemic.

3.4 | Childbirth experiences and changes in self-esteem

The third research question was how women's descriptions of their childbirth experiences differed between different groups according to changes in self-esteem during the first year after birth. To answer this question, we investigated further the open-ended answers of the mothers who had a statistically significant change in self-esteem between T2 and T3. The individual change was compared with randomly varied change due to measurement error. Change should be at least two times the standard deviation of random measurement error. We aimed to investigate whether their childbirth stories could explain why their self-esteem changed for better or worse during the following year. Six participants demonstrated an increase in self-esteem, and eight demonstrated a decrease in self-esteem at that time (in total, $n = 14$). The mothers' qualitative descriptions of their childbirth experiences were markedly varied. Changes in self-esteem could not be directly related to positive and negative childbirth stories, but both types of experiences were reported in both groups. However, the mothers' descriptions did vary in their contents and the sense of accomplishment or failure that they encompassed.

3.5 | Positive experience and increasing self-esteem: 'Overall positive experience'

Four participants had a positive childbirth experience and a statistically significant increase in self-esteem between T2 and T3. They all described obstetrically uncomplicated births, even though two of them experienced labour induction or augmentation. One participant described her childbirth as 'natural', and three of the four participants mentioned that their childbirths were quick. All participants in this group described that their childbirths met their expectations. Anni (35 years old, first child) wrote:

> Overall, the birth was a positive experience for me. I was hoping that in labor, everything would advance as naturally as possible and at its own pace, if possible. This was mostly realized; only contractions needed to be restarted medically when they declined after having started.

In this group, all mothers described their childbirths mainly as lived experiences. One mother mentioned that events advanced mainly naturally and at their own pace, even though contractions were augmented medically. In these descriptions, the obstetric details were described as they were experienced, emphasizing the connection between events and experiences. One characteristic to these stories was also the participants' ability to flexibly define their births in favourable terms, even though some aspects were not realized according to the women's wishes (i.e. induction or augmentation of labour). The participants defined the unplanned aspects of their experience as minor distractions in an overall positive experience.

3.6 | Negative experience and increasing self-esteem: 'Harder and more painful than I expected'

Three participants demonstrated a negative childbirth experience and a statistically significant improvement in self-esteem between T2 and T3. All participants in this group described their childbirths as more difficult than expected or, otherwise, not meeting their expectations. However, they also described positive aspects of their childbirths. Maarit (29 years old, first child) wrote:

> The labor was long and harder and more painful than I expected. I got all the pain relief, but, nevertheless, the pain was bad. I did not really sleep for a couple of days or eat for 1 day. Fortunately, the midwives were lovely, and the labor was not only a negative experience thanks to them. I was disappointed, however, because the experience was mainly hard and painful and not the kind of empowering that I had wished. Remembering the labor only makes me weep. I stayed at hospital for 36 h, and the labor lasted for 13 h, pushing 50 min.

Maarit described her birth as more difficult and painful than expected. Many of her expectations were violated mainly because the labour was so long and painful. She described her experience mainly as a lived experience, with some obstetric details and praise for the midwives as lovely supporting persons, representing the main category of childbirth as a relational event.

The birth stories in this group were told either as a combination of the three main themes but centralizing on childbirth as a lived experience or as a medical event. None of the participants attributed the difficulties explicitly to anyone or anything, except for one participant who expressed that she was bad at enduring pain. However, the main difficulties in her description were elsewhere, and she described a complication that upset her. Overall, these descriptions paint a picture of somehow complicated or hard childbirths; however, all three mothers also described something positive in their experiences. The readers got the impression that these births were difficult but not extremely traumatic to women due to positive factors.

3.7 | Negative experience and decreasing self-esteem: 'Terrible'

Two of our participants demonstrated a negative experience of childbirth and a statistically significant reduction in self-esteem

between T2 and T3. Both described an extremely difficult childbirth experience, and both gave birth through a caesarean section. Paula (34 years old, first child) wrote:

> Terrible. My only wish was that I would not need to go to C-section, I was prepared for pain, and I think that my expectations for birth were realistic. However, the labor did not advance after the beginning, the heartbeat of the child dropped once greatly, and I developed a fever (infection of the membranes). Pain relief was insufficient (the epidural block worked only on one side). After about 24 h, the child was born by C-section, where pain relief was inadequate (the spinal block was inserted in the epidural space). After the exertion of the child, they attempted to strongly medicate the pain for 30 minutes while the operation continued, but the operating pain was severe, and, finally, I was anaesthetised unconscious. The only positive thing was that I did not experience the C-section as preposterous, but there were indications to proceed into it, and there was no sense of hurry. The event itself and prolonging and fear for the child's well-being and operating without adequate anaesthesia were not nice.

Paula wrote that her childbirth expectations were realistic and that her 'only wish' was to avoid a caesarean section. However, she defined her childbirth experience as 'horrible' and described a violation of numerous implicit expectations: the labour did not advance, worry concerning the baby's condition and development of an infection. Anaesthetic pain relief did not sufficiently block her pain, and the childbirth ended in a caesarean section after a long time in labour. Finally, she had to undergo operation under general anaesthesia because of the continuing pain during the caesarean section. Paula did not attribute the difficulties clearly, and the reader is left wondering whether she blames someone or something for the labour that did not advance as expected.

Both birth stories in this group described births that can be understood as potentially traumatic events. Both participants expressed concern for the well-being of the baby, and both experienced a threat to their own integrity. In the example above, Paula experienced severe pain over a prolonged time. In the other story in this group, Vilja (28 years old, first child) described having a deep sense of failure: 'I felt that I had let down all people who were present because I was not able to push the baby out. Even now feelings of guilt pass my mind sometimes'. It is possible that these childbirth experiences might have altered the participants' self-perceptions or perceptions of the world through traumatization. These birth stories were told through all three main themes, suggesting that the participants had an overall negative experience at all possible interpretations or frameworks.

3.8 | Positive experience and decreasing self-esteem: 'All went fairly quickly and well'

Six participants experienced positive childbirths and had a statistically significant decrease in self-esteem between T2 and T3. Though rated as mainly positive, all but one participant in this group described experiences that included both positive and negative elements. Three of six participants in this group described interventions: induction of labour, caesarean section and instrumental birth (vacuum extraction). Marika (27 years old, second child) wrote:

> Daughter was born at gestational age 40 + 6. The labor started naturally and lasted for about 8 h. At the beginning, I went without medical pain relief. At 7 cm, the pain started to be so severe that we tried a spinal block. The first time did not work, so 1 h after, at 9 cm, it was inserted again, and then it worked. Until that moment, the contractions came every couple of minutes, and they were really fierce (my whole body trembled because of the force of the contractions). The end went quickly. Pushing took 15 min and felt controlled. I liked this birth because it did not last too long, and I did thus not get too tired, but I could well follow the course of labor and concentrate on the experience.

Marika shared her experience as both a medical event and lived experience. The main positive factors were related to her experiences, such as feelings of control, conserving her energy, and being able to concentrate. However, this was described as enabled by an obstetrically uncomplicated birth that advanced well. Marika's story is about something happening to her, not about her doing something.

In this subgroup, mothers most often told their birth stories through a combination of lived experience and obstetric event or a combination of all three themes. Even though their experiences were positive, most mothers in this group did not merit themselves. Instead, they described that giving birth 'did not last too long', 'advanced fairly quickly', 'all went fairly quickly and well', 'avoided complications' and 'this time, I was met and heard'. Positive aspects were interpreted as obstetric and sometimes relational, not intrinsic to the mothers themselves. The only exception in this group for this type of birth story is the description of Ellen (27 years old, first child). She described active agency and pride of her own capacities: 'I am proud of my own actions, because they kept the labor advancing' and 'I knew how to push and gave my best. I am very happy that I concentrated fully on every moment and gave my best without panicking'. Ellen had a very high self-esteem at all time points, even though it decreased between T2 and T3. In her case, it was difficult to interpret that her childbirth experience was associated with decreased self-esteem. Rather, it was probably due to other factors.

4 | DISCUSSION

The aim of the present research was, first, to determine whether childbirth experience predicts changes in self-esteem during the first year after childbirth. As a result of the statistical analyses, we found that childbirth experience as measured by the Delivery Satisfaction Scale statistically predicted changes in self-esteem during the first year after childbirth. The more positive the childbirth experience, the greater the increase in self-esteem; conversely, the more negative the childbirth experience, the greater the decrease in self-esteem. The results were not dependent on parity or other background variables. This finding is in line with previous research (e.g. Laney et al., 2014; Reisz et al., 2015). For example, Parratt (2002) concluded in a literature review on the effects of childbirth on women's sense of self that childbirth can have either positive or negative effects. Though not specifically concentrating on self-esteem, Parratt's 'sense of self' encompasses many aspects contributing to healthy self-esteem, such as feelings of control and empowerment, an ability to listen to oneself empathically, effective communication and forming trusting relationships. Studies that concentrated on positive experiences (e.g. Olza et al., 2018) have suggested that childbirth can be empowering for women. On the other hand, the traumatic experiences of childbirth have been identified to alter women's self-perceptions negatively (e.g. Byrne et al., 2017).

The second aim of this research was to investigate how mothers describe their childbirth experiences when answering an open-ended question. The findings of our qualitative analysis demonstrated that women understand their childbirth experiences through three main themes: childbirth as a lived experience, childbirth as a relational event and childbirth as a medical event. Even though responses were generally quite short, many of them included several subthemes and often two or three main themes. This finding confirms most of the extant research suggesting that childbirth experiences are multifaceted (see, e.g. Dencker et al., 2020). However, it also contributes to the current understanding by showing that most women consider their childbirth experiences from multiple perspectives or ideological standpoints. The contents of the overarching themes resemble partly those of Davis-Floyd (2001), most notably in case of childbirth as a medical event, which resembles Davis-Floyd's technocratic model. Many women in our data wrote their birth stories as medical events, including surprisingly many obstetric details. Women appear to have internalized the normative biomedical model of birth (Preis, Eisner, et al., 2019) to such extent that they tell their stories through that lens. However, our findings suggest that for Finnish women, their lived experiences and the relational aspects of childbirth were the other main aspects of birth, which both represent the humanistic paradigm of birth in Davis-Floyd's (2001) analysis. Representing other frameworks apart from the medical model, these overarching themes challenge the normative technocratic model of birth. Holistic interpretations appear to be absent in our findings, possibly because of our research methodology (short survey answers) or the cultural differences between Finland and the United States.

The third aim of the present research was to determine how women's descriptions of their childbirth experiences differed between different groups on the basis of changes in self-esteem during the first year after birth. Our findings suggest that the effect of childbirth experience on self-esteem might be straightforward only for extreme cases, that is, women who had an exceptionally positive childbirth experience and women who experienced their childbirths as traumatic. One explanation for the negative impact is that traumatization affects self-concept (Byrne et al., 2017). However, the effects of both positive and negative experiences may be explained by cognitive factors. Schneider (2010) suggested that women evaluate themselves on the basis of their labor performances, much like birth were a test of their values. In her interpretation, one's sense of self can be altered when the actual childbirth experience does not match expectations. Our findings are in line with the effect of feelings of failure (Schneider, 2018) but also suggest that positive experiences may contribute to better self-esteem.

Women with mixed experiences were among those who had a trajectory of increasing self-esteem and those whose self-esteem decreased. In case of mixed experiences of childbirth, it is probably factors other than childbirth experience per se that could explain changes in self-esteem during the following year. This is encouraging because it means that childbirth experiences do not always determine self-esteem development. This is also somewhat surprising compared with the findings of Schneider (2010): in her data, 60% of women experienced feelings of failure in relation to childbirth, whereas in our data, 12% of women experienced a change in self-esteem in the postpartum year. This discrepancy may imply that in most cases, feelings of failure do not affect self-esteem in the long run. One possible interpretation is that it depends on the women as to what aspects of the childbirth experience are most important for their self-esteem. Contrasting positive and negative aspects of childbirth may also sometimes cancel out each other, that is, partially diminishing and partially supporting one's self-esteem.

The results of our study are somewhat confusing for the participants, whose childbirth experiences were positive and who, nevertheless, showed a decrease in self-esteem in the postpartum year. All but one participant in this group had a trajectory of (statistically non-significantly) increasing self-esteem from T1 to T2 and decreasing self-esteem from T2 to T3. Although different trajectories in self-esteem development could not be identified in the statistical analyses owing to the small sample size, one explanation for these unexpected findings could be that a positive childbirth experience might already have affected self-esteem at T2: that is, compared with that at baseline, self-esteem had increased but decreased back to baseline during the following year. This might also be explained by the way that the participants described their childbirths. The positive aspects they described most often were obstetric factors such as short delivery duration, and they did not merit themselves for it. It is probable that obstetric factors were perceived as uncontrollable and, in this case, represent good luck rather than one's own capacities.

Another interesting group with unexpected findings was those of women who had a negative experience of birth and whose self-esteem increased in the following year. Those women had DSS scores situated in the middle of the scale, that is, clearly more negative than the scores of most women in our data. The main difficulties described in the birth stories were obstetric and not interpreted through one's own capacities (or lack thereof). Instead, the participants described either unexpected complications or unexpectedly long delivery duration perceived as difficult and painful. These kinds of stories can be interpreted as hero stories: these women were faced with enormous challenges that they successfully went through. This kind of interpretation is likely to support one's self-esteem even in cases where some weaknesses are attributed to oneself.

Overall, our study contributes to existing knowledge by suggesting that self-esteem development in the perinatal period is a complex issue, with considerable individual variation. Childbirth experience seems to contribute to the development of self-esteem for some women but appears to be unrelated or not so significant for others. However, the findings of the present research are unique because of the longitudinal study design and focus on basic, not domain-specific, self-esteem in the perinatal period. Furthermore, a mixed methods approach is useful for complex issues such as psychological development in the transition to motherhood. In our research, this method allowed the examination of individual variation in self-esteem development and childbirth experiences. Despite its strengths, the present study also has limitations. First, the sample size was small, which made it unreasonable to statistically divide the sample into subgroups. For that reason, opportunities for triangulation were limited. Second, the sample was homogenous, which limits the generalizability of the results. For example, less advantaged women might generally have lower self-esteem than the highly educated women in our sample, and this difference might have produced even more inter-personal variability in the results. Third, despite the longitudinal study design, self-esteem was measured only three times during data collection, and possible daily fluctuations were not accounted for. Thus, we could not evaluate the role that the stability or reactivity of self-esteem plays in our results. Finally, due to the global pandemic, our results may be specific to this stressful situation and need to be confirmed in other studies. In future research, larger and more heterogenous samples are needed, and daily fluctuations in self-esteem should be accounted for.

5 | CONCLUSION

In line with previous research (Byrne et al., 2017; Laney et al., 2014; Olza et al., 2018), our findings support the hypothesis that childbirth experience may affect self-esteem development for better or worse in the year after birth. For women who find their childbirths especially satisfying, the experience may serve as an important personal resource. Therefore, care systems should be adapted to support positive experiences for all women, for example, by developing continuity-of-care models within the care systems (Donate-Manzanares et al., 2021) and respectful, women-centred care. Women's own interpretations of their childbirth experiences should be encouraged, which may facilitate the recognition of birth as a multifaceted experience and build self-compassion. More attention should be directed at women who experienced traumatic childbirths because they are at risk of negative changes in self-esteem. Women should be screened for traumatic childbirth experiences in postpartum care and offered adequate support. More research is needed to confirm the results in bigger and more heterogenous samples and to better understand variations in self-esteem development in postpartum women.

AUTHORS' CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE*):

1. substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
2. drafting the article or revising it critically for important intellectual content.

FUNDING INFORMATION

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

CONFLICT OF INTEREST

No conflict of interest has been declared by the author(s).

PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.15468.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in JYX data archive at https://doi.org/10.17011/jyx/dataset/81710.

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REFERENCES

Bleidorn, W., Buyukcan-Tetik, A., Schwaba, T., van Scheppingen, M. A., Denissen, J. J. A., & Finkenauer, C. (2016). Stability and change in self-esteem during the transition to parenthood. *Social Psychological and Personality Science*, *7*(6), 560–569. https://doi.org/10.1177/1948550616646428

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Byrne, V., Egan, J., Mac Neela, P., & Sarma, K. (2017). What about me? The loss of self through the experience of traumatic childbirth. *Midwifery*, *51*, 1–11. https://doi.org/10.1016/j.midw.2017.04.017

Creswell, J., & Plano Clark, V. (2011). *Designing and conducting mixed methods research* (2nd ed.). SAGE.

Davis-Floyd, R. E. (2001). The technocratic, humanistic, and holistic paradigms of childbirth. *International Journal of Gynecology & Obstetrics*, *75*(1), 5–23.

Dencker, A., Bergqvist, L., Berg, M., Greenbrook, J. T. V., Nilsson, C., & Lundgren, I. (2020). Measuring women's experiences of decision-making and aspects of midwifery support: A confirmatory factor analysis of the revised childbirth experience questionnaire. *BMC Pregnancy and Childbirth*, *20*(1), 199. https://doi.org/10.1186/s12884-020-02869-0

Donate-Manzanares, M., Rodríguez-Cano, T., Rodríguez-Almagro, J., Hernández-Martínez, A., Santos-Hernández, G., & Beato-Fernández, L. (2021). Mixed-method study of women's assessment and experience of childbirth care. *Journal of Advanced Nursing*, *77*(10), 4195–4210. https://doi.org/10.1111/jan.14984

Hall, C. (2016). Womanhood as experienced in childbirth: Psychoanalytic explorations of the body. *Psychoanalytic Social Work*, *23*(1), 42–59. https://doi.org/10.1080/15228878.2015.1073161

Laney, E. K., Carruthers, L., Lewis Hall, M. E., & Anderson, T. (2014). Expanding the self: Motherhood and identity development in faculty women. *Journal of Family Issues*, *35*(9), 1227–1251. https://doi.org/10.1177/0192513X13479573

Larkin, P., Begley, C., & Devane, D. (2009). Women's experiences of labour and birth: An evolutionary concept analysis. *Midwifery*, *25*(2), e49–e59. https://doi.org/10.1016/j.midw.2007.07.010

Muthén, L. K., & Muthén, B. O. (1998–2017). *Mplus user's guide* (8th ed.). Muthén & Muthén.

Olza, I., Leahy-Warren, P., Benyamini, Y., Kazmierczak, M., Karlsdottir, S. I., Spyridou, A., Crespo-Mirasol, E., Takács, L., Hall, P. J., Murphy, M., Jonsdottir, S. S., Downe, S., & Nieuwenhuijze, M. J. (2018). Women's psychological experiences of physiological childbirth: A meta-synthesis. *BMJ Open*, *8*(10), e020347. https://doi.org/10.1136/bmjopen-2017-020347

Orth, U., & Robins, R. W. (2014). The development of self-esteem. *Current Directions in Psychological Science*, *23*(5), 381–387. https://doi.org/10.1177/0963721414547414

Parratt, J. (2002). The impact of childbirth experiences on women's sense of self: A review of the literature. *The Australian Journal of Midwifery*, *15*(4), 10–16. https://doi.org/10.1016/S1031-170X(02)80007-1

Preis, H., Eisner, M., Chen, R., & Benyamini, Y. (2019). First-time mothers' birth beliefs, preferences, and actual birth: A longitudinal observational study. *Women and Birth*, *32*(1), e110–e117. https://doi.org/10.1016/j.wombi.2018.04.019

Preis, H., Lobel, M., & Benyamini, Y. (2019). Between expectancy and experience: Testing a model of childbirth satisfaction. *Psychology of Women Quarterly*, *43*(1), 105–117. https://doi.org/10.1177/0361684318779537

Reisz, S., Jacobvitz, D., & George, C. (2015). Birth and motherhood: Childbirth experience and mothers' perceptions of themselves and their babies. *Infant Mental Health Journal*, *36*(2), 167–178. https://doi.org/10.1002/imhj.21500

Rosenberg, M. (1989). *Society and the adolescent self-image* (Rev. ed.). Wesleyan University Press.

Saisto, T., Salmela-Aro, K., Nurmi, J. E., & Halmesmaki, E. (2001). Psychosocial predictors of disappointment with delivery and puerperal depression. A longitudinal study. *Acta Obstetricia et Gynecologia Scandinavica*, *80*(1), 39–45. https://doi.org/10.1034/j.1600-0412.2001.800108.x

Schneider, D. (2010). *Beyond the baby: Women's narratives childbirth, change and power [doctoral dissertation, Smith College]*. Smith ScholarWorks. https://scholarworks.smith.edu/theses/385

Schneider, D. A. (2013). Helping women cope with feelings of failure in childbirth. *International Journal of Childbirth Education*, *28*(1), 46–50.

Schneider, D. A. (2018). Birthing failures: Childbirth as a female fault line. *The Journal of Perinatal Education*, *27*(1), 20–31. https://doi.org/10.1891/1058-1243.27.1.20

Simkin, P. (2006). What makes a good birth and why does it matter? *International Journal of Childbirth Education*, *21*(3), 4–6.

Taubman-Ben-Ari, O., Shlomo, S. B., Sivan, E., & Dolizki, M. (2009). The transition to motherhood—A time for growth. *Journal of Social and Clinical Psychology*, *28*(8), 943–970. https://doi.org/10.1521/jscp.2009.28.8.943

van Scheppingen, M. A., Denissen, J. J. A., Chung, J. M., Tambs, K., & Bleidorn, W. (2018). Self-esteem and relationship satisfaction during the transition to motherhood. *Journal of Personality and Social Psychology*, *114*(6), 973–991. https://doi.org/10.1037/pspp0000156

Voelkle, M. C., & Oud, J. H. L. (2015). Relating latent change score and continuous time models. *Structural Equation Modeling: A Multidisciplinary Journal*, *22*(3), 366–381. https://doi.org/10.1080/10705511.2014.935918

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How to cite this article: Raudasoja, M., Vehviläinen-Julkunen, K., & Tolvanen, A. (2022). Passing the test of motherhood? Self-esteem development and birth experience in the transition to motherhood: A longitudinal mixed methods study in Finland. *Journal of Advanced Nursing*, *78*, 4246–4260. https://doi.org/10.1111/jan.15468

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III

SELF-ESTEEM, SOCIALLY PRESCRIBED PERFECTIONISM, AND PARENTAL BURNOUT

by

Mirjam Raudasoja, Matilda Sorkkila & Kaisa Aunola, 2022

Journal of Child and Family Studies, 6(1)

https://doi.org/10.1007/s10826-022-02324-y

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Journal of Child and Family Studies
https://doi.org/10.1007/s10826-022-02324-y

ORIGINAL PAPER

Self-Esteem, Socially Prescribed Perfectionism, and Parental Burnout

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Received: 6 August 2020 / Accepted: 20 April 2022
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Abstract
Socially prescribed perfectionism (SPP) has been shown to be a risk factor for parental burnout (Sorkkila & Aunola, 2020). In the present study, we investigated the moderating role of self-esteem in this association. A total of 479 Finnish mothers of infants filled in questionnaires measuring their self-esteem, SPP, and symptoms of parental burnout. The results of structural equation modelling (SEM) showed that mothers' self-esteem moderated the effect of SPP on parental burnout: Mothers with high self-esteem were at lower risk of showing burnout symptoms even when SPP co-occurred, whereas for mothers with low self-esteem, the effect of SPP on burnout symptoms was further strengthened. The results can be applied when aiming to improve maternal well-being by recognizing the risk factors of parental burnout and by offering counseling for parents at high risk.

Keywords Parental burnout · Self-esteem · Socially prescribed perfectionism

Highlights
- Mothers' self-esteem moderated the relationship between parental burnout and socially prescribed perfectionism (SPP).
- Mothers with high self-esteem were at lower risk of burnout than mothers with low self-esteem even when SPP co-occurred.
- For mothers with low self-esteem, the effect of SPP on burnout symptoms was further strengthened.

Most new parents experience high levels of distress during the early parenting period (Emmanuel & St John, 2010; Law et al., 2018). This distress arises from the demanding nature of practical caregiving for the baby, as well as from the need to reflect one's new role and related demands in a changing social environment. Parents sometimes report being ill-prepared for the demands of parenting and finding it unexpectedly hard (Barclay & Lupton, 1999; Read et al., 2012). Elevated stress levels for a prolonged time can result in parental burnout (Mikolajczak & Roskam, 2018), a relatively common phenomenon with a prevalence between 2 and 12% in general populations of parents (Roskam et al., 2017; Roskam & Mikolajczak, 2020). Psychologically and physically exhausted, burned-out parents no longer feel joy when interacting with their children (Hubert and Aujoulat 2018). They feel overwhelmingly guilty and incapable of fulfilling the expectations of themselves or others (Mikolajczak et al., 2018). Parental burnout has detrimental effects on parental well-being and the marital relationship; it also increases the likelihood of abuse and neglect toward children (Mikolajczak et al., 2018).

Parental burnout has been conceptualized by four dimensions: (1) an overwhelming exhaustion in relation to the parental role; (2) contrast with previous self-as-parent (feelings that one is not as good a parent as before and shame related to it); (3) feelings of having had enough of parenting and not being able to stand it anymore; and (4) emotional distancing from children (which means that one is investing the minimum effort to get crucial tasks done, and nothing more; one is also avoiding emotional contact with children) (Roskam et al., 2018). Following the demands-resources model of job burnout (Demerouti et al., 2001; Schaufeli & Bakker, 2004), it has been proposed that parental burnout is also caused by overwhelming demands that exceed parental resources (Mikolajczak & Roskam, 2018). Parenting-related demands, which are risk factors for burning out, consist of parental personality factors, poor

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Published online: 05 May 2022

childrearing practices, practical parenting duties, and lack of support (Mikolajczak & Roskam, 2018). Resources, in turn, are protective factors for parental burnout, and they consist of parental self-compassion, childrearing skills, time for leisure, positive co-parenting, and external support. In this model, the balance between demands and resources is crucial; even if one suffers from many demands, if the resources outweigh them, one may still avoid burning out (Mikolajczak & Roskam, 2018). In the present study, we focus on maternal burnout during the postpartum period. Postpartum period itself poses challenges that might be risk factors for parental burnout in the long run – especially for mothers who experience the physical changes of pregnancy, childbirth and postpartum, and who generally spend more time caring for babies and managing housework than fathers do (Ascigil et al., 2021). Even though parental burnout can occur at any stage in parenting (Mikolajczak et al., 2018), we wanted to explore the first year postpartum, since its effects could accumulate and pose a risk for later coping with parenting demands. The demanding nature of the postpartum period may, furthermore, provide understanding on the reasons why parental burnout is more common in women than in men (Mikolajczak et al., 2018).

In previous research, background variables such as female gender, parental inconsistent discipline, lack of support from spouse, and reduced marital satisfaction have been related to parental burnout (Mikolajczak et al., 2018). However, personality factors seem to be stronger predictors of parental burnout than background factors (Mikolajczak et al., 2018; Sorkkila & Aunola, 2020). One specific risk factor is multidimensional perfectionism (Hewitt & Flett, 1991; Hill & Curran, 2016), which includes self-oriented perfectionism (SOP) and socially prescribed perfectionism (SPP). SOP means that a person has high standards for oneself and uses harsh self-criticism in face of errors; SPP, in contrast, means that a person expects high standards from others. It has been found that SPP is a stronger predictor of parental burnout than various background variables or SOP (Sorkkila & Aunola, 2020), suggesting that particularly perceived demands and expectations from others, when not buffered, are crucial risk factors for parental burnout.

One protective factor from parental burnout, and from the detrimental effects of SPP on parental well-being, could be the general level of self-esteem, since it is shown to protect from many other life difficulties (Orth & Robins, 2014). Self-esteem is defined as “a global evaluation of the value of the self or self-worth” (Jordan et al., 2015, p. 522). Self-esteem is often considered a continuum with low self-esteem at one end and high self-esteem at the other (Jordan et al., 2015). High self-esteem has been shown to be associated with many positive outcomes, such as good interpersonal relationships (Orth & Robins, 2014), successful occupational paths (Baumeister et al., 2003; Kuster et al., 2013), well-being at work (Kuster et al., 2013), and good physical and mental health (Jordan et al., 2015; Orth & Robins, 2014; Stinson et al., 2008). Low self-esteem, in turn, is associated with less satisfying social networks (Marshall et al., 2014; Stinson et al., 2008), rumination after failures (Brown, 2010; Jordan et al., 2015), depression (Sowislo & Orth, 2013), and poorer physical health (Pruessner et al., 1999; Stinson et al., 2008). Furthermore, low self-esteem has also previously been identified as a risk factor for parental burnout (Aunola et al., 2020; Mikolajczak et al., 2018).

Nevertheless, it is unknown how these effects of self-esteem develop in the parenting context. Self-esteem has been found to be negatively associated with SPP (Flett et al. 1991; Klibert et al., 2005), and it is possible that self-esteem and SPP has interactive effect on parental burnout. For example, it is possible that when facing high expectations from others (e.g., high expectations for one’s parenting; Jordan et al., 2015), it is easier to ignore or diminish those expectations if one has high self-esteem. In contrast, low self-esteem and SPP together might reinforce the adverse effects of each other on parental well-being. Parents with low self-esteem may also perceive environmental cues in generally more negatively than those with high self-esteem and, consequently, perceive higher levels of SPP (i.e., those with low self-esteem may be vulnerable not only to the negative impacts of criticism from other people, but also to perceive criticism from others; see, for example, Jussim et al., 1987), which then increases the risk of parental burnout). We therefore hypothesized, in line with the demands/resources model (Mikolajczak & Roskam, 2018), that high self-esteem would be one resource factor for parent and protect against parental burnout, whereas SPP would increase the likelihood of parental burnout, but only when it exceeds protecting factors (i.e., in the case of the present study, when it is combined with low self-esteem). To the best of our knowledge, the effects of self-esteem and SPP on parental burnout have not been studied together in previous research. We wanted to examine whether self-esteem modifies the relationship between SPP and burnout.

We restricted the sample to mothers of infants to be able to concentrate on this high-risk period in the lives of women (Apter et al., 2011; Stowe et al., 2005). Even though the transition to parenthood may be experienced as challenging by mothers and fathers alike, the stressors are partly different in important ways. Because parenting a baby is a highly gendered activity with sex-specific physical experiences and gendered social expectations (Tummala-Narra, 2009), mothers and fathers should be studied separately to adequately address risk and protective factors of parental well-being in this period. Women go through the physical changes of pregnancy, childbirth, and postpartum, and various psychosocial changes that accompany those bodily

events. Furthermore, societal beliefs expose women to high expectations in early motherhood and beyond (Hays, 1996) and this may make the postpartum period even more challenging, predisposing mothers to low self-esteem, high expectations, and possibly contributing to the development of parental burnout.

Research questions

We aimed to answering the following research questions:

(1) To what extent is mothers' self-esteem associated with parental burnout over and above SPP? Because self-esteem is related to psychological well-being (Orth & Robins, 2014), we hypothesized that the higher the self-esteem, the less mothers reported parental burnout (Hypothesis 1).
(2) To what extent does self-esteem moderate the effect of SPP on parental burnout? Based on the demands-resources model of parental burnout (Mikolajczak & Roskam, 2018), we hypothesized that high self-esteem could also reduce the adverse effects of SPP on parental burnout and that low self-esteem could further amplify the effect (Hypothesis 2).

Method

Participants

The data were obtained from a larger study regarding Finnish parents' demands and resources (see Aunola & Sorkkila, 2018). Ethical approval for the study was obtained from the Ethics Committee of University of Jyväskylä before the data collection (23/2/2018). Prior to participation, all the participants provided informed consent to confirm their voluntary involvement in the study.

The sample for the present study comprised 479 mothers (all women with a one-year-old or younger child; age $M =$ 32.45 years, $SD = 4.97$ years; number of children $M = 2.14$, $SD = 1.48$). A total of 32% of the mothers were first-time mothers, and 68% had several children. A total of 74% of the participants had a university or college degree, 23% had a technical college degree, and 3% had a vocational school degree or no formal education after compulsory schooling. The educational level of participants was higher than in the general population (44.4% university/college degree; Official Statistics of Finland, 2018a), and the number of children was somewhat higher (the average number of children was 1.85 in families with children; Official Statistics of Finland, 2018b). A total of 4% of the sample estimated the financial situation of their family to be poor, 21% reported it to be less than average, 55% as average, and 20% as better than average. Different family types were represented: 88% of the mothers represented nuclear families, 2% single-parent families, 9% blended families, and 1.6% other. Participants completed the research questionnaire in 2018, either online (79.5%) or by paper-and-pen (20.5%), submitted by Child Health Care Centers' nurses in three cities in Finland. The participating Child Health Care Centers were geographically representative of the Finnish population since they are located in the Southern, Middle, and Northern parts of the country. All answers were transferred into IBM SPSS statistical software program (version 24), including answers to open-ended questions.

Measures and Procedures

Parental burnout

Parental burnout was measured with the Parental Burnout Assessment (PBA; Roskam et al., 2018), a questionnaire validated in Finnish (Aunola et al., 2020). The questionnaire consists of 23 items measuring different symptoms of parental burnout. Nine of the items measured exhaustion in one's parental role (e.g., *I feel completely run down by my role as a parent*), six measured the contrast with the previous parental self (e.g., *I don't think I'm the good father/mother that I used to be to my children*), five measured feelings of being fed up as a parent (e.g., *I can't stand my role as a father/mother anymore*), and three measured emotional distancing from one's children (e.g., *I do what I'm supposed to do for my children but nothing more*). Parents answered all items using a Likert scale with seven options (0 = *never* – 6 = *daily*). In the present sample, the Cronbach's alpha reliability for the mean score calculated based on all 23 items was 0.97. The Cronbach's alpha reliabilities for the four subscales of parental burnout were 0.94, 0.89, 0.89, and 0.74.

Self-esteem

Self-esteem was assessed with four items (e.g., *I take a positive attitude toward myself; I am able to do things as well as most other people*) from the Rosenberg Self-Esteem Scale (Rosenberg, 1979). The items were rated on a five-point Likert scale (1 = *not at all true of me;* 5 = *very much true of me*). The Cronbach's alpha reliability for the four-item scale was 0.80.

Socially prescribed perfectionism

SPP was measured with three items (e.g., *People expect too much from me*) derived from the Big Three Perfectionism

Table 1 Correlations, means (M) and standard deviations of observed variables

	1	2	3	4	5	6	7	8	9	10	11
1. Exhaustion (PB)	1.00										
2. Contrast (PB)	0.86	1.00									
3. Feelings of being fed up (PB)	0.82	0.80	1.00								
4. Emotional distancing (PB)	0.72	0.68	0.70	1.00							
5. Item 1 / SPP	0.35	0.32	0.28	0.22	1.00						
6. Item 2 / SPP	0.39	0.37	0.32	0.28	0.65	1.00					
7. Item 3 / SPP	0.21	0.22	0.18	0.16	0.50	0.50	1.00				
8. Item 1 / S-E	−0.23	−0.30	−0.23	−0.19	−0.14	−0.17	−0.11	1.00			
9. Item 2 / S-E	−0.31	−0.31	−0.27	−0.22	−0.17	−0.20	−0.06	0.43	1.00		
10. Item 3 / S-E	−0.44	−0.43	−0.38	−0.24	−0.27	−0.33	−0.12	0.51	0.46	1.00	
11. Item 4 / S-E	−0.45	−0.48	−0.44	−0.28	−0.25	−0.32	−0.13	0.43	0.39	0.73	1.00
M	16.52	8.93	5.93	3.54	2.61	2.65	2.11	4.38	3.85	3.71	3.45
SD	13.28	8.69	6.22	3.52	1.04	1.12	1.03	0.74	0.99	0.95	1.03

PB Parental burnout, *SPP* Socially prescribed perfectionism, *S-E* Self-esteem

Scale (Smith et al., 2016), where the items of Hewitt and Flett (1991) are modified into a general context. Answers were placed on a five-point Likert scale ranging from 1 (completely disagree) to 5 (completely agree). Cronbach's alpha reliability for the scale was 0.80.

Statistical Analyses

The research questions were analyzed using structural equation modelling (SEM). In the first model, each latent parental burnout variable (the four subscales of parental burnout as observed indicators) was predicted by two latent variables: SPP (see also, Sorkkila & Aunola, 2020) and self-esteem. Then, in order to examine the extent to which the level of mothers' self-esteem would moderate the association of SPP with parental burnout, a second model was constructed, including an interaction term of two independent latent variables, self-esteem and SPP, as a predictor of parental burnout.

The analyses were performed using the Mplus 8.0 statistical software program (Muthén & Muthén, 2017). The models were estimated using a maximum likelihood estimation with robust standard errors (MLR). By using the standard missing-at-random (MAR) approach, the parameters of the models were estimated with the full information maximum likelihood (FIML) estimation with standard errors that are robust to non-normality (MLR estimator; Muthén & Muthén, 1998–2010). By using this method, all available data (proportion of data present in terms of covariance coverage being 0.990–1.00) was used to estimate the parameters of the models without imputing missing values (i.e., each parameter of the model was estimated directly without filling in missing data values for each individual). The fit of the models was evaluated using four indices: Bentler's (1990) comparative fit index (CFI), the Tucker Lewis index (TLI), the standardized root mean square residual (SRMR), and the root mean square error of approximation (RMSEA). CFI and TLI values greater than 0.95 and RMSEA and SRMR lower than 0.06 were considered to indicate that the model fits the data well (Muthén & Muthén, 2017). The means (*M*), standard deviations (*SD*), and correlations between the latent study variables are shown in Table 1.

Results

The fit of the model, including latent self-esteem and SPP as predictors of latent parental burnout, was: $\chi^2(41)=101.758$, RMSEA = 0.056, CFI = 0.975, TLI = 0.966, SRMR = 0.038. The results showed that in addition to the expected positive effect of SPP (standardized estimate = 0.273, $p < 0.001$; see also, Sorkkila & Aunola, 2020), mothers' self-esteem was negatively related with parental burnout (standardized estimate = −0.427, $p < 0.001$): the higher the level of maternal self-esteem, the lower the level of reported parental burnout, and the lower the level of maternal self-esteem, the higher the level of parental burnout. Overall, SPP and self-esteem explained 35% of the variation in parental burnout ($p < 0.001$). The correlation between latent self-esteem and latent SPP was −0.400 ($p < 0.001$).

Next, an interaction term of two latent independent variables was included in the model as a predictor of parental burnout. The results of the model are shown in Fig. 1. The results showed that the interaction term was statistically significant (standardized estimate = −0.208, $p < 0.001$), suggesting that the association of SPP with parental burnout is dependent on the level of maternal self-esteem. A visual

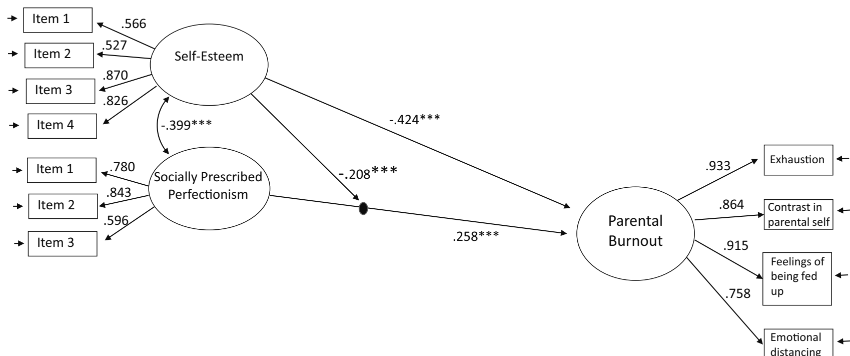

Fig. 1 The Results of Structural Equation Model (*Note*. ***$p < 0.001$)

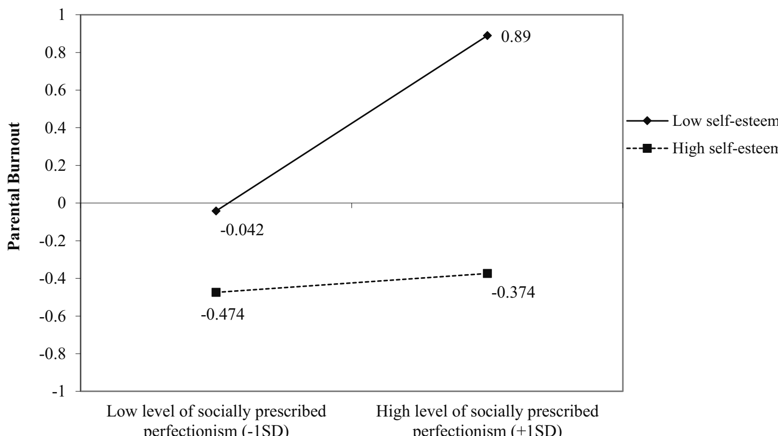

Fig. 2 The role of socially prescribed perfectionism in parental burnout among parents reporting low (−1 *SD*, low) and high (+1 *SD*, high) levels of self-esteem

representation of the moderating role played by mothers' self-esteem in the association of SPP and parental burnout is presented in Fig. 2.

To further test the effect of SPP on parental burnout among mothers with low and high self-esteem, median split was first used to divide the data into two groups according to the level of self-esteem. Then, multigroup model testing the effect of SPP on parental burnout among these two groups of mothers was estimated. In the tested model, factor loadings of the latent SPP and latent parental burnout were set equal across the two groups but path from SPP to parental burnout was freely estimated within groups. The model constraint command was used to test the statistical difference between the groups in the effect of SPP to parental burnout. The results (χ^2 (36)= 66.518, RMSEA = 0.060, CFI = 0.979, TLI = 0.975, SRMR = 0.059) showed that among mothers with low self-esteem ($n = 287$), SPP was positively associated with parental burnout (standardized estimate = 0.453, $p < 0.001$): the higher the level of SPP, the higher the level of parental burnout. However, among mothers with a high level of self-esteem ($n = 191$), the association of SPP with parental burnout was positive but weaker (standardized estimate = 0.220, $p < 0.05$). The found difference between the two groups was statistically significant (estimate = −4.880, S-E. = 1.523, $p < 0.001$). In other words, high self-esteem protected mothers from the negative impacts of SPP (see also Fig. 2).

In order to test whether the pattern of results would remain the same after controlling for the impact of different background variables, additional analysis was carried out where maternal education (a university or college degree vs. others) and age, number of biological children, and family type (single parenthood vs others) were included to the model and paths from them to latent parental burnout estimated. The results revealed that the main effects of SPP and self-esteem, as well as their interaction effect on parental burnout, remained all statistically significant even after taking into account the effects of the tested external variables.

Discussion

We aimed to investigating whether self-esteem is related to parental burnout among mothers of infants and, particularly,

whether it moderates the relationship between parental burnout and SPP. It has been previously found that low self-esteem (Aunola et al., 2020; Mikolajczak et al., 2018) and high level of SPP (Sorkkila & Aunola, 2020) both increase the likelihood of parental burnout. The results of the present study showed that the association of SPP with parental burnout was particularly strong for respondents with low self-esteem and statistically significantly lower for those with high self-esteem. It seems that high self-esteem may serve as a protective factor from the detrimental effects of SPP on parental burnout. The results confirmed our hypothesis that self-esteem moderates the effect between SPP and parental burnout. The findings are in line with the previous literature, suggesting that self-esteem could have severe effects on well-being, either strengthening the effect of adversities or protecting from them (Orth & Robins, 2014). Through lenses of the demands and resources model (Mikolajczak & Roskam, 2018), self-esteem may be a protective factor that outweighs some of the risk factors of parental burnout. However, as we do not yet know the relative counteractive effect of self-esteem in relation to other variables than SPP, future studies are needed to better understand the counterbalancing role of self-esteem in relation to different risk factors.

Our finding that general self-esteem is so clearly related to a context-specific disorder such as parental burnout is somewhat surprising. One explanation could be that parenting is generally relatively important aspect of mothers' self-concept (Nentwich, 2008) and struggling with parenting may be particularly detrimental for those mothers who doubt their worth already. It might feel like failing in life's most important task and that would explain why low self-esteem is so detrimental. On the other hand, high self-esteem might protect from feelings of failure and help finding other attributions to the difficulties than those related to the mother herself. The main finding of our study was that SE protected from the negative effects of SPP on parental burnout, indicating that parents with high self-esteem may be less vulnerable to other people's expectations and therefore, be less burned out as parents (i.e., their self-esteem and confidence in their own performance acts as a buffer). In addition, reminding herself of her own worth in other domains in life, a mother may better cope with difficulties with her baby.

While the present study shows evidence for the moderating role of self-esteem on the relationship between perfectionism and parental burnout, there are also limitations that need to be considered when interpreting the results. First, we studied mothers of babies during their first year after delivery, which is an especially vulnerable period due to hormonal changes, psychological transitions, and practical changes in life. We do not know if the results would hold for a longer period in life or if they are typical for the first year after the baby is born. Second, we measured self-esteem at one time point and did not investigate possible daily fluctuations that have been shown to be important for psychological postpartum morbidity (Franck et al., 2016). Longitudinal studies with fine-tuned means to measure self-esteem are needed to examine the role of self-esteem in the development of parental burnout over a longer time frame. The transitional period from late pregnancy to the end of the first year is a stage of complicated psychological processes that are yet to be fully discovered. Third, this study focused only on mothers. However, it is known that also fathers can burn out (Roskam & Mikolajczak, 2020) and, therefore, future studies should also assess the role of fathers' self-esteem on SPP and burnout. Finally, the sample of our study represented mostly highly educated mothers. Thus, we do not know if the reported findings are specific for highly educated mothers in particular. In future studies, the results should be replicated among different socio-economical groups before making generalizations and to better understand differences in trajectories of well-being during the transition to motherhood.

Overall, personality-related risk factors, such as multi-dimensional perfectionism, are important for the development of parental burnout. Our results suggest that it is important to recognize mothers with low self-esteem before childbirth or immediately after. It would be beneficial to pay attention to mothers' self-esteem in, for example, birth preparation classes and child health centers in order to recognize mothers at risk and to offer self-esteem enhancing support (e.g., cognitive reframing). Furthermore, discussion of social expectations of motherhood should be initiated with all mothers. From policy perspective, it would be important to change the culture of discussing childbirth and motherhood to be more open and less demanding in order to protect mothers from overwhelming stress. Future research should explore the role of self-esteem in a longitudinal setting where multiple time points and daily fluctuations are taken into account. It should verify the results in other populations and discover ways to overcome the effects of low self-esteem and SPP on parental burnout. For example, designing specific support programs for expecting mothers with low self-esteem and following up their possible effects could be possibilities in clinical practice and research. In order to avoid adverse effects accumulating in the postpartum year, it is also crucial to regularly screen parental burnout symptoms for early detection and prevention.

Acknowledgements This study was funded by a grant from the Alli Paasikivi Foundation (grant number 21000041571) to Kaisa Aunola.

Funding Open Access funding provided by University of Jyväskylä (JYU).

Compliance with Ethical Standards

Conflict of Interest The authors declare no competing interests.

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References

Aunola, K., & Sorkkila, M. (2018). Vanhemmuuden voimavara- ja kuormitustekijät -tutkimushanke (VoiKu). Ongoing research project. University of Jyväskylä.

Apter, G., Devouche, E., & Gratier, M. (2011). Perinatal mental health. *Journal of Nervous & Mental Disease*, *199*, 575–577. https://doi.org/10.1097/NMD.0b013e318225f2f4.

Ascigil, E., Wardecker, B. M., Chopik, W. J., & Edelstein, R. S. (2021). Division of baby care in heterosexual and lesbian parents: expectations versus reality. *Journal of Marriage and Family*, *83* (2), 584–594. https://doi.org/10.1111/jomf.12729.

Aunola, K., Sorkkila, M., & Tolvanen, A. (2020). Validity of the Finnish version of the Parental Burnout Assessment (PBA). *Scandinavian Journal of Psychology*, *61*, 714–722. https://doi.org/10.1111/sjop.12654.

Barclay, L., & Lupton, D. (1999). The experiences of new fatherhood: a socio-cultural analysis. *Journal of Advanced Nursing*, *29*(4), 1013–1020. https://doi.org/10.1046/j.1365-2648.1999.00978.x.

Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. D. (2003). Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles? *Psychological Science in the Public Interest*, *4*, 1–44.

Brown, J. D. (2010). High self-esteem buffers negative feedback: Once more with feeling. *Cognitive and Emotion*, *24*, 1389–1404.

Bentler, P. M. (1990). Comparative fit indexes in structural models. *Psychological Bulletin*, *107*(2), 238–246. https://doi.org/10.1037/0033-2909.107.2.238.

Demerouti, E., Bakker, A., Nachreiner, F., & Schaufeli, W. (2001). The job demands-resources model of burnout. *Journal of Applied Psychology*, *86*, 499–512. https://doi.org/10.1037/0021-9010.86.3.499.

Emmanuel, E., & St John, W. (2010). Maternal distress: a concept analysis. *Journal of Advanced Nursing*, *66*(9), 2104–2115. https://doi.org/10.1111/j.1365-2648.2010.05371.x.

Flett, G., Hewitt, P., Blankstein, K., & O'Brien, S. (1991). Perfectionism and learned resourcefulness in depression and self-esteem. *Personality and Individual Differences*, *12*(1), 61–68. https://doi.org/10.1016/0191-8869(91)90132-U.

Franck, E., Vanderhasselt, M.-A., Goubert, L., Loeys, T., Temmerman, M., & De Raedt, R. (2016). The role of self-esteem instability in the development of postnatal depression: a prospective study testing a diathesis-stress account. *Journal of Behavior Therapy and Experimental Psychiatry*, *50*, 15–22. https://doi.org/10.1016/j.jbtep.2015.04.010.

Hays, S. (1996). *The cultural contradictions of motherhood*. Yale University Press.

Hewitt, P. L., & Flett, G. L. (1991). Perfectionism in the self and social contexts: conceptualization, assessment, and association with psychopathology. *Journal of Personality and Social Psychology*, *60*, 456–470. https://doi.org/10.1037/0022-3514.60.3.456.

Hill, A. P., & Curran, T. (2016). Multidimensional perfectionism and burnout: a meta-analysis. *Personality and Social Psychology Review*, *20*(3), 269–288. https://doi.org/10.1177/1088868315596286.

Hubert, S., & Aujoulat, I. (2018). Parental burnout: when exhausted mothers open up. *Frontiers in Psychology*, *9*, 1021.

Jordan, C. H., Zeigler-Hill, V., & Cameron, J. J. (2015). Self-esteem. In Wright, J. D. (Editor): *International Encyclopedia of the Social & Behavioral Sciences (Second Edition)*, (pp. 522–528). Elsevier. https://doi.org/10.1016/B978-0-08-097086-8.25090-3.

Jussim, L., Coleman, L., & Nassau, S. (1987). The influence of self-esteem on perceptions of performance and feedback. *Social Psychology Quarterly*, *50*(1), 95–99. https://doi.org/10.2307/2786894.

Klibert, J. J., Langhinrichsen-Rohling, J., & Saito, M. (2005). Adaptive and maladaptive aspects of self-oriented versus socially prescribed perfectionism. *Journal of College Student Development*, *46*(2), 141–156.

Kuster, F., Orth, U., & Meier, L. L. (2013). High self-esteem prospectively predicts better work conditions and outcomes. *Social Psychological and Personality Science*, *4*, 668–675. https://doi.org/10.1177/1948550613479806.

Law, K. H., Jackson, B., Guelfi, K., Nguyen, T., & Dimmock, J. A. (2018). Understanding and alleviating maternal postpartum distress: perspectives from first-time mothers in Australia. *Social Science & Medicine*, *204*, 59–66. https://doi.org/10.1016/j.socscimed.2018.03.022.

Marshall, S. L., Parker, P. D., Ciarrochi, J., & Heaven, P. C. L. (2014). Is self-esteem a cause or consequence of social support? A 4-year longitudinal study. *Child Development*, *85*(3), 1275–1291. https://doi.org/10.1111/cdev.12176.

Mikolajczak, M., & Roskam, I. (2018). A theoretical and clinical framework for parental burnout: the balance between risks and resources (BR^2). *Frontiers of Psychology*, *9*, 886 https://doi.org/10.3389/fpsyg.2018.00886.

Mikolajczak, M., Raes, M.-E., Avalosse, H., & Roskam, I. (2018). Exhausted parents: Sociodemographic, child-related, parent-related, parenting and family-functioning correlates of parental burnout. *Journal of Child and Family Studies*, *27*, 602–614.

Muthén, L. K., & Muthén, B. O. (2017). *Mplus Users' Guide. 8th edn*. Los Angeles: Muthén and Muthén.

Nentwich, J. C. (2008). New fathers and mothers as gender troublemakers? Exploring discursive constructions of heterosexual parenthood and their subversive potential. *Feminism & Psychology*, *18*, 207–230. https://doi.org/10.1177/0959353507088591.

Official Statistics of Finland. (2018a). *Educational structure of population*. Helsinki: Statistics Finland. http://www.stat.fi/til/vkour/2017/vkour_2017_2018-11-02_tie_001_en.html.

Official Statistics of Finland. (2018b). *Families*. Helsinki: Statistics Finland. http://www.stat.fi/til/perh/2017/perh_2017_2018-05-25_tie_001_en.html.

Orth, U., & Robins, R. W. (2014). The development of self-esteem. *Current Directions in Psychological Science*, *23*(5), 381–387. https://doi.org/10.1177/0963721414547414.

Pruessner, J. C., Hellhammer, D. H., & Kirschbaum, C. (1999). Low self-esteem, induced failure and the adrenocortical stress response. *Personality and Individual Differences*, *27*, 477–489.

Read, D., Crockett, J., & Mason, R. (2012). "It was a horrible shock": The experience of motherhood and women's family size

preferences. *Women's Studies International Forum*, *35*(1), 12–21. https://doi.org/10.1016/j.wsif.2011.10.001.

Rosenberg, M. (1979). *Conceiving the Self*. Malabar, Florida: R. E. Krieger Publishing Company.

Roskam, I., Raes, M.-E., & Mikolajczak, M. (2017). Exhausted parents: development and preliminary validation of the parental burnout inventory. *Frontiers of Psychology*, *8*, 163 https://doi.org/10.3389/fpsyg.2017.00163.

Roskam, I., Brianda, M.-E., & Mikolajczak, M. (2018). A step forward in the conceptualization and measurement of parental burnout: the Parental Burnout Assessment (PBA). *Frontiers of Psychology*, *9*, 758 https://doi.org/10.3389/fpsyg.2018.00758.

Roskam, I. & Mikolajczak, M. (2020). Gender differences in the nature, antecedents and consequences of parental burnout. *Sex Roles*, *83*(7–8), 485–498.

Schaufeli, W. B., & Bakker, A. B. (2004). Job demands, job resources, and their relationship with burnout and engagement. *Journal of Organizational Behavior*, *25*, 293–315.

Smith, M. M., Saklofske, D. H., Stoeber, J., & Sherry, S. B. (2016). The Big Three Perfectionism Scale: a new measure of perfectionism. *Journal of Psychoeducational Assessment*, *34*(7), 670–687. https://doi.org/10.1177/0734282916651539.

Sorkkila, M., & Aunola, K. (2020). Risk factors for parental burnout among Finnish parents: the role of socially prescribed perfectionism. *Journal of Child and Family Studies*, *29*(3), 648–659. https://doi.org/10.1007/s10826-019-01607-1.

Sowislo, J. F., & Orth, U. (2013). Does low self-esteem predict depression and anxiety? A meta-analysis of longitudinal studies. *Psychological Bulletin*, *139*, 213–240.

Stinson, D. B., Logel, C., Zanna, M. P., Holmes, J. G., Cameron, J. J., Wood, J. V., & Spencer, S. J. (2008). The cost of lower self-esteem: testing a self- and social-bonds model of health. *Journal of Personality and Social Psychology*, *94*, 412–428.

Stowe, Z. N., Hostetter, A. L., & Newport, D. J. (2005). The onset of postpartum depression: Implications for clinical screening in obstetrical and primary care. *American Journal of Obstetrics and Gynecology*, *192*(2), 522–526. https://doi.org/10.1016/j.ajog.2004.07.054.

Tummala-Narra, P. (2009). Contemporary impingements on mothering. *The American Journal of Psychoanalysis*, *69*, 4–21. https://doi.org/10.1057/ajp.2008.37.

IV

“I FEEL MANY CONTRADICTORY EMOTIONS”: FINNISH MOTHERS’ DISCURSIVE STRUGGLES WITH MOTHERHOOD

by

Mirjam Raudasoja, Matilda Sorkkila, Aarno Laitila & Kaisa Aunola, 2022

Journal of Marriage and Family, *84*(3), 752–772.

https://doi.org/10.1111/jomf.12828

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Received: 20 October 2020 | Revised: 10 January 2022 | Accepted: 3 February 2022

DOI: 10.1111/jomf.12828

ORIGINAL ARTICLE

"I feel many contradictory emotions": Finnish mothers' discursive struggles with motherhood

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Funding information
Alli Paasikiven Säätiö, Grant/Award Number: 21000041571

Abstract

Objective: The aim of the study was to facilitate the understanding and interpretation of multiple aspects of working with mothers by examining Finnish mothers' mothering discourses and the interplay among these discourses.

Background: According to relational dialectics theory, discourses are systems of meaning that are coproduced in interaction. Although discursive research on motherhood has identified various discourses, research on the interplay among competing motherhood discourses is in its infancy.

Method: Qualitative questionnaire data from 479 Finnish mothers of infants were analyzed using contrapuntal analysis. Mothers' responses to three open-ended questions were analyzed inductively. Emerging themes were identified so as to represent different motherhood discourses, and the power struggle among discourses was addressed.

Results: Four discourses were identified. In the *Equality discourse*, parenting was presented as ideally shared between co-parents, and equality between family members and various family forms was promoted. In the *Familistic discourse*, traditional stay-at-home mothering, good housekeeping, and the unity of the family were emphasized. In the *Intensive Mothering discourse*, the importance of the mother to her child was highlighted. In the *Balance discourse*, the needs of all family members were presented as equally important, and flexibility in parenting choices was promoted. The results demonstrated discursive struggles within mothers' answers, suggesting that contemporary Finnish motherhood is a contested terrain of competing ideologies.

Conclusion: The findings suggest that Finnish mothers' mothering discourses are multivocal and often competing.

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The results contribute to the current understanding of motherhood ideologies and provide new insights to be utilized in counseling and clinical practice.

KEYWORDS
families, gender roles, motherhood, mothers, parenting, qualitative methodology

INTRODUCTION

Becoming a mother is a transitional time of identity construction (Mercer, 2004) and adopting a new social role. During that period, women encounter numerous messages regarding appropriate motherhood in their social environment (Choi et al., 2005). Mothers must negotiate their responsibilities to both work and family (Blair-Loy, 2003), as well as to various mothering ideologies (Abetz & Moore, 2018). Although previous research has demonstrated the coexistence of various mothering discourses in Western cultures (e.g., Dow, 2016; Hays, 1996; Perälä-Littunen, 2007), little is known about how mothers construct the meaning of motherhood through the interplay between these discourses. According to relational dialectics theory (RDT), discourses are systems of meaning that are coproduced in social interaction (Baxter, 2011). However, different discourses do not function on an equal playing field; some discourses are more dominant than others (Baxter, 2011). Discursive struggles are thus crucial elements when investigating whether and how cultural pressures manifest themselves among mothers' discourses. In the present study, we applied RDT to explore Finnish mothers' mothering discourses and the interplay between these discourses during the first year of mothering. The Finnish context provides a promising setting in which to study motherhood from an RDT perspective. In Finnish culture, ideologies of gender equality, individualism, and familism coexist and, thus, are likely to be in competition with one another in the mothering discourse (e.g., Lammi-Taskula, 2007). A strong egalitarian emphasis in politics (Ministry of Social Affairs and Health, 2017) and gendered parenting ideals in the culture (Jallinoja, 2006; Perälä-Littunen, 2007, 2018) may produce contradictory expectations in Finnish mothers. The results of the present study will increase our understanding of motherhood ideologies and provide new insights into the beliefs and cultural pressures that Finnish mothers experience in motherhood. Hopefully, the findings of this study will also provide insights that can be useful for any other cultures dealing with similar contradictory expectations and pressures.

MOTHERHOOD DISCOURSES IN CONTEMPORARY WESTERN CULTURES

The term "motherhood discourses" refers to the meaning systems of motherhood that circulate in a culture (Baxter, 2011). These discourses represent a given mothering ideology, defining "good mothering" and the role of motherhood in a woman's life (Gunderson & Barrett, 2015; Hays, 1996). Motherhood discourses are embedded in historical and cultural environments and, thus, are influenced by social orders, policies, and values attached to "family" in a particular society, as well as prevailing gender-equality beliefs (Gilbert, 2008). Cultures are positioned differently in the continuum between individualism and collectivism (Hofstede, 2001). Individualism refers to a general belief in personal responsibility for one's life, whereas collectivism refers to valuing the needs of the communal group (e.g., family, church, or nation) over those of the individual (Baxter, 2011; Hofstede, 2001). One would expect that the individualism of contemporary Western cultures would have freed women from "the constraints of marriage and

motherhood" (e.g., Rich, 1995). Indeed, the increasing gender egalitarian attitudes in Europe and the United States have challenged traditionalism, which favors gendered roles in society for men and women (Knight & Brinton, 2017). The development of gender equality has, however, halted since the mid-1990s (Cotter et al., 2011; Knight & Brinton, 2017). Some researchers even speak of a stalling of such (England, 2010) or the end of the gender revolution (Cotter et al., 2011) in Western societies and speak of a renaissance of familism. Traditionally, familism has referred to an ideology that promotes conventional family roles, with gendered responsibilities for earning and childcare (Cotter et al., 2011). More recently, however, the familism of earlier decades has been replaced by egalitarian familism, which supports stay-at-home mothering while also emphasizing gender equality and individual freedom of choice (Cotter et al., 2011).

Contemporary womanhood in the United States has been proposed to entail two competing cognitive schemas that are framed as incompatible (Blair-Loy, 2003): *devotion to work* and *devotion to family*. The schema of devotion to work implies that women should commit most of their time and energy to the occupational world and their careers. The schema of devotion to family, in turn, invites women to see family life as the most precious domain and sacrifice their own endeavors for the well-being of their husband and children. By devoting themselves to one schema, women may feel as if they are betraying the other, resulting in feelings of guilt and regret (Blair-Loy, 2003).

Some research findings suggest that mothers may reconcile contradicting motherhood ideals by reframing them. For example, Blair-Loy (2003) found that high-achieving US mothers decided to work part-time to respond to both work and family devotion schemas. Christopher (2012), in turn, found, among a diverse sample of 40 employed mothers in the United States, that mothers constructed "extensive mothering" as a form of good mothering. Extensive mothering included delegating a substantial amount of childcare to others and reframing good mothering as being ultimately in charge of one's children's well-being. Furthermore, according to Landry (2000) African American mothers cultivate commitment both to family, community, and career alike. In line with this, Dow (2016) demonstrated that African American mothers constructed integrated mothering, which was built on three expectations regarding motherhood (Dow, 2016): mothers should work outside the home, be financially independent, and use kin and community members as caregivers for their children (see also Barnes, 2008). Finally, Segura (1992) suggested that Chicana mothers (mothers of Mexican origin living in the United States) who work in white-collar jobs may need to balance between personal success and maintaining their culture. For these women, both job performance and caretaking work at home reinforce a sense of accomplishment of culture and ethnicity. Both types of work also help maintain gendered social relations.

Overall, contemporary Western mothers seem to be surrounded by many different discourses. Since the 1990s, many conceptualizations, such as "intensive mothering" (Hays, 1996; Henderson et al., 2016), "the mommy myth" (Douglas & Michaels, 2004), and "combative mothering" (Moore & Abetz, 2016) have been proposed. The Intensive Mothering discourse, advocated both by child-rearing experts and mothers themselves, conceptualizes children and mothering as sacred; it emphasizes the responsibility of mothers and intensive child-rearing methods, which require tremendous amounts of energy, time, and financial resources (Hays, 1996). It has been proposed as the dominant discourse in the United States since World War II (Gunderson & Barrett, 2015; Henderson et al., 2016) and described in other Western cultures as well (Henderson et al., 2016; Perälä-Littunen, 2018). Some US scholars claim that the standards for mothering seem to be ever escalating because of media portrayals of "good" and "bad" motherhood, misleading reports of childhood threats, and the marketing of "educational" toys and activities (Douglas & Michaels, 2004). These media influences have increased since the 1980s in the United States, in line with the rise of the intensive mothering ideology and antifeminist backlash in popular culture (Cotter et al., 2011). Social media has further facilitated a competition between mothers regarding who is best (Abetz & Moore, 2018). According

to Abetz and Moore (2018), mothering ideologies have multiplied and solidified, making it necessary to defend one's own parenting choices as the best for one's children.

In the previous literature, different mothering discourses have been identified, and their coexistence within the same culture has been demonstrated. However, research in cultural contexts outside the United States is rare. Moreover, little is known about how these various discourses function in relation to one another in mothers' accounts of motherhood. According to the RDT (Baxter, 2011), discourses can be understood as systems of meaning that are coproduced in interaction. In addition to identifying discourses, it is important to examine their functioning and interpenetration and thus address their power relations (Suter & Norwood, 2017). We argue that motherhood is an ideological terrain that is likely to invoke discursive struggles (Baxter, 2011), even in the most conventional settings (i.e., heterosexual, married, middle-class mothers). By understanding these struggles, it is possible to gain insights into what it means to be a mother in contemporary society.

THE FINNISH MOTHERHOOD CONTEXT

Finnish culture, like other Western countries, is highly individualistic (Hofstede, 2001). Finnish parenting policy follows the Nordic welfare state model (Määttä & Uusiautti, 2012). Public, state-funded childcare services are available to all children. However, staying at home with a child is financially supported. A maternity allowance—provided for 105 days—is a form of government-subsidized time for mothers to take care of children. The amount depends on mothers' income during the previous year. The first 56 days of this period can be compensated for with up to 90% of salary if the mother is employed. This subsidized period can be prolonged with a parental allowance (158 working days; KELA, 2021), which can be used by either parent but is overwhelmingly (90.5%) used by mothers (Official Statistics of Finland (OSF), 2019a). If the mother is employed during her parental leave and her employer pays her salary during parental leave, these allowances are paid to the employer (KELA, Social insurance institution of Finland, 2021). After maternity leave and parental leave, a parent (either mother or father) may still remain at home with a smaller child home care allowance until the youngest child turns three (KELA, 2021). The employment rate of Finnish mothers of children under age 6 is considerably lower than in other Nordic countries (Ellingsaeter & Leira, 2006). In 2019, only 32% of mothers of infants (children up to 12 months old) were employed (OSF, 2019b).

In Finland, gender equality in parenting, at home, and in the workplace, is considered advanced (Seierstad & Healy, 2012; World Economic Forum, 2010). The official gender equality politics aim to promote equality between women and men and prevent discrimination based on gender, identity, or gender expression (Ministry of Social Affairs and Health, 2017). However, mothers often take primary responsibility for childcare, even when they return to work after maternal leave (Närvi, 2012). Women in Finland also experience more work–family conflict than men do, despite their fewer hours spent on paid work (Öun, 2012). This may be related to the promotion of "modern familism," which has been increasingly popular in Finnish discourse since the turn of the millennium (Jallinoja, 2006). Based on her inductive analysis of newspaper entries, Jallinoja (2006) proposed that modern familism is built on two principal ideas: (1) "stay-at-home mothering," which stipulates that mothers should stay at home when their children are small and arrange communal childcare so as to be as home-like as possible (pp. 131–136) and (2) "good parenting," with the common belief that "lost parenting" (i.e., the overly permissive and neglectful parenting practices evoked by highly individualistic culture) results in "ill-being" for children, adolescents, and families (pp. 112–125). To avoid the consequences of "lost parenting," modern familism suggests that families should spend more time together, the upbringing of children should be family-centered yet aided by professionals, and parental control should be exerted more often to guide children's development. Jallinoja's

familism represents a form of egalitarian familism (Cotter et al., 2011) that promotes traditional family roles while at the same time emphasizing gender equality and individual freedom of choice. Finnish women may thus be exposed to competing cultural values concerning gender equality, independence, and family values. Competing cultural values are likely to provoke different discourses of motherhood. By exploring how discursive struggles manifest in women's written responses, it is possible to obtain insights into how mothers deal with cultural pressures and stress.

THE PRESENT STUDY

The present study aimed to identify Finnish mothers' own discourses of mothering and examine the interplay among those discourses. The data were comprised of Finnish mothers' open-ended written responses to survey questions about their mothering experience. The research questions were as follows: (1) What kinds of discourses of motherhood can be identified from Finnish mothers' open-ended responses to survey questions about their parenting resources, desired support, and other matters they wish to mention? (2) How do mothers construct the meaning of motherhood in their responses through the interplay among different motherhood discourses?

The first year after childbirth is a transitional period of changing relationship identity (Mercer, 2004), and therefore, this period was chosen as the scope of the present study. According to Baxter (2011), discursive struggles of relationship identity "can be identified in bold relief" (p. 94) in relationship transitions (such as having a baby). Indeed, Choi et al. (2005) proposed that new mothers struggle with the discrepancy between the myths and realities of motherhood, which may then foster feelings of guilt and shame and increase efforts to perform socially desirable motherhood. We expect that the women in our study will use complex methods to negotiate and shape their motherhood discourses and that these methods will follow hegemonic discourses, such as intensive mothering (Hays, 1996), modern familism (Jallinoja, 2006), and gender egalitarianism (Knight & Brinton, 2017). Because of the strong egalitarian emphasis in politics, it is likely that gender egalitarianism in Finnish mothers' discourse will stand more strongly in contrast with traditional discourses than in other cultures.

METHOD

Data collection

The data for the present study were obtained in the context of a larger study (Aunola & Sorkkila, 2018) addressing Finnish parents' demands and resources. From a larger sample of parents ($n = 1725$ parents; 91% mothers), infants' (≤1 year old) mothers were chosen as the focus of the present study ($n = 479$). The background information of the sample is presented in Table S1. The characteristics of the sample should be taken into account when interpreting the results of the present study. Most notably, the sample was ethnically and racially homogenous (99.4% Finnish). As compared to the general population, the educational level of the participants of the present sample was considerably higher (in the sample of the present study, 74% of participants had a university or college degree, whereas in the general population of Finnish women, 36.3% had a university or college degree in 2018; OSF, 2018). The number of children was slightly higher than in the average family (2.14 children in the sample of the present study vs. 1.84 children on average in families with children; OSF, 2019b). Also, participants were more often employed (50%) than mothers of infants in the general population (36%).

The mothers completed the research questionnaire in 2018, either online (79.5%), as advertised via various social media channels, or in person (20.5%) at Child Health Care Centers

located in three Finnish cities. At the Child Health Care Centers, nurses introduced the study to parents at the end of their appointments; the parents then completed the survey and returned it either by dropping it in a box marked for the research in the waiting room or mailing it to the researchers in a prepaid envelope. The survey included questions about parenting, such as questions regarding parenting styles, parental values, and parental burnout. Ethical approval for the overarching research project was obtained from the ethics committee of the relevant university (August 2018). To ensure informed consent, all participants signed a voluntary participation form and received written information about the study. They were informed that the study addresses Finnish parents' experiences about parenting demands and resources. They did not receive any compensation for participation.

In the present study, the answers of 479 mothers to three open-ended questions from the broader questionnaire were analyzed: (1) Resources (*Please write down things that give you joy in parenting and/or help you cope*); (2) Support (*Which kinds of things—for example, support and services—would best foster your well-being and happiness as a parent?*); and (3) Other (*Is there something else that you wish to mention regarding yourself, your family or your parenting?*). *Resources* were asked about only in the online version of the questionnaire, whereas the other two questions (*Support* and *Other*) were included in both versions of the questionnaire. The open-ended questions were situated in the middle (*Resources* and *Support*) and at the end of the survey (*Other*). Typically, responses ranged from one word to a few paragraphs in length. Of the mothers, 89% answered the question on *Resources*, 78% answered the question on *Support*, and 36% answered the question on *Other* matters. A total of 91% of participants provided answers to at least one open-ended question. All three open-ended survey questions contributed to exploring the research questions. Because parts of the broader questionnaire measured sensitive factors, such as attitudes concerning gender roles and parents' general well-being, it is possible that this context itself affected participants' answers to open-ended questions (i.e., it might have raised up particularly those kinds of discourses into the participants' awareness that relate on these specific topics). This may mean that the contradictions appear more pronounced than they would in a more neutral context.

The survey responses for open-ended questions were originally in Finnish, but the data exemplars were translated into English for the purposes of the present study. The authors played different roles in the design of the study (Authors 2 and 4), data analysis (Author 1), the interpretation of results (Authors 1 and 3), and the verification of results (all authors). None of the authors was directly involved in data collection.

Data analysis

In the data analysis, the RDT (Baxter, 2011; Baxter et al., 2021) was used as a theoretical framework. The RDT presumes that meanings are likely to emerge from the unequal playing field of various discourses. According to the RDT, discourses are both followed and resisted in communication, and their interaction is characterized by a struggle for meaning between competing discourses (Suter & Norwood, 2017). The benefit of the RDT is the ability to analyze more than one discourse at a time and how discourses are produced in interaction with one another. Different discourses are not equal; rather, dominant discourses hold power over marginalized discourses. Discursive power also reinforces social structures so that groups of people voicing dominant views hold power over less advantaged groups (Baxter et al., 2021). The goal of the RDT is to "open space for voices that are muted or dismissed" (Suter & Norwood, 2017, p. 294), which makes it a critical theory (Baxter et al., 2021).

Following the RDT framework, contrapuntal analysis (see Baxter, 2011) was applied to answer the research questions. To answer the first research question, the six phases of contrapuntal analyses were carried out (Baxter, 2011; Braun & Clarke, 2006): (1) immersing oneself in

the data; (2) initial coding and organizing themes; (3) formulating discourses; (4) reviewing discourses; (5) defining and naming discourses; and (6) locating exemplars. Some answers ($n = 40$; 4.5% of the total number of responses from the 479 mothers in the subsample) to open-ended questions were very short and did not include sufficient information (e.g., “No need for (more) support,” “I don’t know,” or “I can’t imagine”), commented on the practicalities of the research itself, or consisted of explanations of participants’ choices in quantitative sections of the questionnaire. Therefore, these answers were left out of the analysis. In the initial coding (the second phase of data analysis), the raw data were first categorized into elements that represented different subthemes, and then, the overarching themes of discourses (consisting of various subthemes) were identified. Discourses were formulated (the third phase of data analysis) by clustering themes into larger patterns: the discourses were color-coded in the data, and the process was continued until saturation was reached.

In most responses, several ideas could be identified and grouped in many discourse categories, and one textual segment could represent several coexisting discourse types. Because different discourses were expressed by the same participant, participants were not categorized into discourse categories. The identified discourses were tested against additional data, and discourse categories were further defined and named. As a result of this refining process, the themes were reorganized to form four discourses. Finally, the data were analyzed again to test these four categories of discourses. A negative case analysis (Lincoln & Guba, 1985) was performed to determine whether there were data segments that did not fit the findings. Finally, exemplars that captured the essence of a given discourse were identified from the data. Quoted persons were given pseudonyms to ensure the anonymity of participants. Throughout the analysis process, an audit trail was kept, including notes on analytical decisions, notes on discussions between researchers, the first analyst’s reflections on the topic and the analysis process, and descriptions of the findings.

To answer the second research question, the analysis was continued to investigate the interplay between the identified discourses. Participants’ alignment or misalignment with discourses was addressed, and discursive practices of addressing several discourses were identified. The power struggle between discourses was addressed by identifying which discourses were given the most legitimacy in each answer. *Monologue* is a type of answer in which only one discourse is expressed, and all other views are absent (Baxter, 2011). If several discourses are identified in one answer, they form a *synchronic interplay*, in which discourses can have a counterpoint relationship to one another in three ways: *negating*, *countering*, and *entertaining*. In negating, the answer lines up with one discursive position, and the alternative meanings are invoked only to be refuted. In countering, one discourse is centered, but limited legitimacy is granted to the alternative discourse(s). Countering is often characterized by particular lexical markers (terms such as “although,” “however,” “but,” “even,” and “only”) and adverbials (e.g., surprisingly) (for a full list, see Baxter, 2011). Finally, entertaining is interplay in which various discourses are in play on an equal plane. It is often marked by a tone of ambivalence, one characterized by certain lexical markers (e.g., “may,” “might,” “could,” “must,” and “either–or”) (Baxter, 2011). Sometimes, the interplay breaks free from the polemic centering and decentering of discourses and, as a result, *hybrids* (i.e., are mixtures of two or more discourses that no longer present the original discourses as competing) or *aesthetic moments* (i.e., transformations of two or more discourses into a new form where original discourses can no longer be identified) emerge (Baxter, 2011). Such elements stand in contrast with typical expressions because they do not reproduce the counterpoint relationship between discourses.

RESULTS

The first goal of the study was to determine which discourses of motherhood can be identified from Finnish mothers’ descriptions. The inductively identified themes of the discourse are

presented in Table S2. Two overarching themes regarding parenting, consisting of various subthemes, were identified: (1) parenting is rewarding, and (2) parenting is challenging. By categorizing the subthemes representing these two overarching themes into larger patterns, four discourses were identified: the Equality discourse, the Familistic discourse, the Intensive Mothering discourse, and the Balance discourse.

Equality discourse: Equal treatment and support from society matters especially for families who diverge from the norm

The Equality discourse presented parenting as a shared responsibility between parents. In this discourse, the rewarding aspects of parenthood were attributed to (1) sharing responsibilities between co-parents, (2) having other roles in life apart from parenthood, (3) treating parental leave as temporary, and (4) receiving support from the co-parent and society (see Table S2). For example, Jenna (26 years, one child) explained as follows:

> *[My] coping as a parent is improved by a spouse who is equal as a parent and who does housework so that everything does not fall on my shoulders, even though I stay at home with our baby.* (Jenna, Resources)

Jenna suggested that parenting and housework are *equal* responsibilities for mothers and fathers. This view was accentuated with her word choice, that is, preferring *parent* to *mother*. She explained that there should be an equal division of household labor so that "everything does not fall on my shoulders" like an avalanche. Suvi (34 years, one child) wrote:

> *My greatest joy is my child. I also appreciate that, in Finland, a mother does not need to give up working and being active in society even though she has children. It is important that my spouse agrees [regarding] how the family leave is distributed [between parents].* (Suvi, Resources)

Suvi appreciated that mothers can keep their jobs and remain active in society after having children. This was a resource for her. The word "mother" was used to explicate the fact that parents face unequal expectations in society. Suvi hinted at the international context by stating that, in Finland, a mother does not need to cease all other activities (unlike in some other countries). She proposed that parental leave should be distributed between partners by mutual agreement, thus stressing their equal status in this decision. Karoliina (33 years, four children) wrote the following:

> *[I would like] support for the relationship as a couple, time together, and respect for the challenging jobs of both partners. My studies [are a form of support for me].* (Karoliina, Support)

Karoliina explained that the professional lives of "both partners" should be respected equally. Via her word choice, she placed both the mother and the father as equally positioned regarding professional life, implying that women should not be expected to sacrifice more than men for the sake of the family. One shared feature of all themes that constructed parenting as rewarding in the Equality discourse was the negotiation of shared rights and responsibilities.

The challenging aspects of parenthood in the Equality discourse were attributed to (1) inequalities in society, (2) a lack of recognition for different parents and families, (3) expectations that do not fit the parent's own wishes, and (4) the inexperience of parents themselves. Heidi (37 years, one child) stated the following:

> *[…] The fact is that families are diverse and the roles of a woman and a man, which were also given importance in this questionnaire, are not an issue for everybody in the family or for every parenting couple in any way. [However,] for some, it surely is; there are many realities. Equal treatment and support from society matters, especially for families like ours and parents like us, who diverge from the norm. My situation is good, and I receive a lot of support from my friends and family. Otherwise, my divergent family form might be a factor that would make it even more challenging to process and accept difficult emotions related to parenting.* (Heidi, Other)

The Equality discourse could be identified in talk about family composition and attitudes toward families that are somehow different from the norm. For example, Heidi, who lived in a same-sex relationship, negotiated for the importance of legally recognizing all family forms. She proposed that equality and support matter the most for those who are not perceived as "normal," referring to heteronormativity and its effects in the society. She proposed that the "roles of a woman and a man" are not an issue for every parenting couple, suggesting that gendered expectations within a couple apply only to heterosexual couples. Elisa (32 years, two children) explained as follows:

> *We parents of today have no role model for being with children; we know nothing about that, really! When the first baby you can hold is your own, even though you are 30 years old already, you have no knowledge of children, so it is a shock how difficult and time-consuming children are, really. That's how it is, but it is true.* (Elisa, Other)

In the description offered by Elisa, parenting is presented as a shared experience that cannot or should not be divided by gender. Positioning all new *parents* as equally inexperienced regardless of gender served as a justification for what was expressed later: having no time for oneself after having children was described as a shock. Children were described as "difficult" and "time-consuming," which can be interpreted as a radical move in parenting discussions, that is, taking the perspective of the parent and not the child. Deep discontent with the all-encompassing nature of parenting was justified as inevitable: "That's how it is, but it is true." Elisa did not specify whether this all-encompassing parenthood applies similarly to women and men, but she certainly argued that parents can feel this way and not enjoy parenthood. In all challenges in the Equality discourse, an experience of invisibility and related distress was highlighted; challenging aspects of parenthood were attributed to the expectations of the society.

Familistic discourse: A clean house and happy children and spouse

In the Familistic discourse, parenting was approached from the perspective of motherhood. The rewarding aspects of parenthood were attributed to (1) the unity of the family and a good atmosphere in it, (2) the home and everyday life, and (3) the relationship between partners. Emma (22 years, one child) described:

> *[There is] a feeling of belonging together: we have a small family of our own.* (Emma, Resources)

Emma explained that a feeling of belonging together is what serves as a resource for her. Niina (33 years, four children) and Jonna (30 years, more than four children) described different rewards:

> *I am fortunate to have four healthy and obedient children and a husband who supports and helps in everyday life*. (Niina, Resources)

> *A clean house and happy children and spouse [is what matters]*. (Jonna, Resources)

Completed household chores could be framed as a resource in and of themselves, as in the response by Jonna. Housework, according to these types of responses, was "owned" by the mothers. Sometimes, as in the quote from Niina, husbands were described as taking part in the household duties, and sometimes, a wish for more participation was expressed; however, the language used to describe these strivings allocated the main responsibility to the mother herself. Husbands "helped" with the chores or "participated" in the housework. Traditional gender roles inside the family were thus unproblematized and presented as natural or justifiable. All themes that presented parenting as rewarding in this discourse were related to the family life and indicated positive feelings.

Challenges related to parenthood were described as (1) attitudes in society that devalue mothers' work, (2) the tiring amount of work at home, and (3) a lack of financial and practical support. Meeri (32 years, two children) proposed:

> *[What is needed is] the message from society that mothers who take care of their children at home provide the best and most precious early education. Now, mothers are wanted to [return to] work as soon as possible. Better financial support [for parents/mothers at home] and more [communal] services to the home, like someone to help with the household chores, [are needed]*. (Meeri, Support)

In Meeri's answer, parenting was presented as something that women do. Via word choice *mother/ing*, childcare, and household maintenance are framed as feminine duties. Meeri presents mothering as "the best and most precious early education," suggesting that home mothering is favorable to institutional childcare. She advocates for more money and support from the state or the commune, suggesting that support for mothers should be arranged institutionally. The partner's role in alleviating the work strain of the mother was not mentioned, and potential inequalities between partners were not addressed. Mariella (26 years, two children) presented somewhat similar ideas:

> *I have had both of my children when I was relatively young if you think of the typical age of becoming a parent in Finland. My spouse is working long hours and, each year, works approximately 70 days around the clock, so I am alone with our children a lot. I am a stay-at-home mother. I wish for more respect for stay-at-home parenting because it is very important and hard work. It should be better supported.* (Mariella, Other)

Mariella defined herself as *a stay-at-home mother*, choosing a gendered expression. She justified this position with the long working hours of her spouse. However, in asking for respect for stay-at-home *parenting*, she proposed that it is possible for men to stay at home with children as well. In this answer, it was not explicit who should stay at home; nevertheless, the roles of the breadwinner and the caregiver were separated, and more respect and support for the home parent were advocated. Laura (34 years, four children) asked for practical help at home:

> *Practical help for caring for the house and the children [would be useful]*. (Laura, Support)

In the Familistic discourse, all themes that constructed parenting as challenging addressed a lack of appreciation and support for stay-at-home parents. Being a stay-at-home mother was

presented as an important—perhaps the most important—role in life for a woman but not as a very respected one in society. In this discourse, the focus was on the practical aspects of housekeeping and mothering rather than reflecting on emotional contact with children. This could be understood as reflecting the reality of everyday mothering, legitimizing motherhood as hard work and, at the same time, opposition to the emotionally focused Intensive Mothering discourse.

Intensive Mothering discourse: Do I really love my child enough?

The Intensive Mothering discourse presents parenting as a gendered role, in which mothering is the most influential force in guiding children's growth. The rewarding aspects of parenthood were described using two themes: (1) the close and loving relationship between mother and child and (2) the mother's own developing parenting skills. Lilian (33 years, more than four children) suggested the following:

> *Parenting is the most significant task in my life. It has been the most influential thing forming me as a person, and it has most affected the way I am. It takes energy, but it also gives enormously. It is difficult to imagine a greater and more influential task than motherhood.* (Lilian, Resources)

Lilian stated that she enjoys parenting and prioritizes it among life choices. She began with the term "parenting," perhaps as a response to the question asked about parenting. However, at the end of her response, she shifted to the word "motherhood" when providing an overall evaluation of parenting's importance. This shift to gendered language, even after having begun with gender-neutral terms, reflected the Intensive Mothering well: a "mother" was described as the most important person in the life of a child. In addition, motherhood was presented as central to female identity, that is, "the most influential thing forming me as a person." Even when gender-neutral language was used, shared parenthood was rarely mentioned. Linda (30 years, one child) described the following:

> *I hope that I will remember the first night with my baby for the rest of my life. The surge of love that rushed my body when sniffing the baby was something confusing and unique. I would bestow that feeling upon everyone.* (Linda, Other)

Mutual love between mother and child was at the heart of Linda's description. Even without mentioning the gender of the parent, she might be suggesting that parenting is a gendered experience. "The first night" obviously refers to the immediate postpartum period, and presenting love as a bodily experience suggests that love has something to do with women's hormones after childbirth. Indeed, the common feature of themes that presented parenting as rewarding in the Intensive Mothering discourse was that motherhood was constructed as inherently enjoyable.

The challenges of parenting were attributed to (1) uncertain knowledge and related feelings of anxiety and guilt and (2) doubt about the quality of institutional day care. Annamaria (32 years, one child) described her experiences:

> *Nothing prepared me for parenthood and the feelings of guilt: "Do I really love and take care of my child enough; how can I make sure that my child is safe, happy, and feels loved?" I would do anything for my child and still I feel guilty and doubt whether I do enough and [do things in] the right way in regard to what is best for my child. [I wonder:] "Can I provide enough proper stimuli, sufficiently balanced food, and enough attention and love for my child?" One demands a lot of oneself, and advice*

> *and instructions from all around mix with one's own feelings about what would be best. [I ask myself:] "What if it is not the best way, will my child be ruined?" […] But smiles and the joy of my child give so much back, as does offering a consoling hug to them. I would not change anything.* (Annamaria, Other)

In Annamaria's answer, motherhood was presented as something that requires constant learning and effort to ensure taking care of one's children in the best possible way. Even when using the gender-neutral word *parenting*, it was the mother herself who was described as stressed. A need to be constantly learning expert-level knowledge and parenting skills was expressed, and co-parenting was not mentioned. However, the uncertainty and even anxiety of not knowing for sure what would actually be the best way forward was a challenge, and Annamaria worried about making "wrong" or "less than the best" decisions. Other potential sources—apart from herself—as influences on an infant's development were ignored in Annamaria's answer. From this perspective, feelings of doubt, worry, guilt, and fatigue can also seem to be natural inherent features of motherhood. Sari (34 years, four children) described guilt slightly differently:

> *I felt a great amount of guilt when I start working full-time and brought my children to day care. I had lived 8 years either as a stay-at-home mother or working part-time.* (Sari, Other)

Sari constructed stay-at-home mothering as best for small children and expressed doubts about the quality of day care, as well as guilt when her children attended day care. The responsibility for good childcare was placed on herself in this way. One common feature of themes in the Intensive Mothering discourse was that motherhood involves a great deal of responsibility that cannot be passed over or divided.

Balance discourse: There is no one single way to do it right

In the Balance discourse, the rewarding aspects of parenthood were described in terms of three themes: (1) parents can recognize their resources and actively take care of themselves, (2) other people are very important for the coping of parents, and (3) good things should be appreciated because they should not be taken for granted. In the first theme, the means of caring for oneself were not always specified, but relaxation was often mentioned in one form or another. A mother's responsibility for her own well-being was thus constructed as more active than in many other discourses. Ulla (36 years, two children) described the following:

> *The key thing for one's own coping is taking care of oneself. When my own needs and family life are in balance, I experience well-being and am a good parent. If one has had no chance to sleep, rest or take me-time, then one has no resources left over for children.* (Ulla, Support)

Ulla suggested that her well-being is on an equal plane with other family members' well-being. She proposed that everyone has the same basic needs and that, if these are not met, a parent may not function well in the parenting role. Katri (32 years, two children) and Emilia (39 years, three children) described the importance of support from other people:

> *[What helps me is the] awareness that there is nearly always help available.* (Katri, Resources)

> *In the moments when it feels difficult, it is good to hear from, for instance, the Child Health Care Center, neighbors, or relatives about how great and skilled my children are. Despite the mountains of laundry and piles of dust, the most important things are fine. It also helps me to cope when I have a phone call or am messaging with my mother, sisters, or friends or to take a walk in the forest or just get fresh air or be heard by the doctor or nurse at the Child Health Care Center, especially if I feel that my child is not well. With my firstborn, who suffered from heartburn (GERD), I happened to have a very kind public health nurse at the Child Health Care Center, and she saved many situations and was an important supportive person.* (Emilia, Resources)

The roles of other people in parents' well-being were highlighted in these answers. Katri suggested that an awareness that help is available is a resource in itself, and Emilia described situations in which she received support. They suggested that other people's empathy, support, and concrete help make coping easier when things become tough. Finally, an awareness that anything can happen was presented both as a resource in good times and as giving hope when everything was not fine. When one had easier times or some difficulty was overcome, it was easy to feel gratitude. In hard times, as Nea (36 years, two children, Resources) suggested, one could gain strength through the thought that "it will get easier one day."

Three themes could be identified in the Balance discourse as ways of presenting parenting as challenging: (1) external conditions; (2) too-high expectations for parents, especially mothers, with black-and-white opinions of parenting; and (3) a lack of understanding for parents from professionals, peers, or relatives or at the workplace. Johanna (27 years, three children) proposed the following:

> *One's own illness or husband's illness (he broke his leg) can put the well-being of the family at stake. In addition, sleeping problems (breastfeeding, teething,* etc.*) create more challenges. I would be a totally different person if I could sleep well!* (Johanna, Other)

The first theme suggested that anything can happen in life and that parental situations can become quite difficult for anyone. Johanna suggested that challenges are present sometimes and one cannot avoid them always. Aino (32 years, two children) asked for empathy from other people:

> *Generally, an empathetic attitude [would be needed] in society, where parents would receive encouragement instead of bad-mouthing and spontaneous help instead of angry looks when you are in trouble with small children in a public place. At work, [I would prefer if] they would not squeeze everything out of parents of small children but create possibilities for part-time work.* (Aino, Support)

The second theme consisted of critiquing rigid methods of understanding good parenting. The pressure to apply one kind of parenting and a lack of flexibility were presented as social pressures that contributed to parents' stress levels, which were resisted in this discourse. Aino suggested empathy and flexibility as solutions. Flexibility in parenting and career choices was constructed as being important: one parenting model is not appropriate for all families. A lack of understanding on the part of other people could leave parents feeling alone with their struggles. In sum, a compassionate attitude on the part of parents toward themselves and from other people was constructed as a prerequisite for parents' coping in the Balance discourse.

Interplay among discourses

The second research question aimed at determining how mothers constructed meaning through the interplay among motherhood discourses. This task requires identifying whether the text was characterized by discursive monologue or a synchronic interplay of multiple discourses (Baxter & Norwood, 2015), as well as whether the discourses were in a counterpoint relationship to one another. In the responses by the participants in this research, multiple discourses were often found. While monologue was mostly found in the shorter answers, interplay was found both in shorter and longer answers. Monologue was found in Anniina's (35 years, two children) description:

> *When having children, the thing that has most annoyed me is the attitude of the workplace. In the beginning of my last pregnancy, I was looking for a job where I could work between parental leave and [the upcoming] maternity leave in order to not be out of work entirely. One employer offered me a job but declined the offer when they heard of my pregnancy. I did not tell the next employer about my pregnancy, and I got the job.* (Anniina, Other)

Anniina described difficulties in having a job while being pregnant because of discrimination. She presented her desire for work as a wish "not to be out of work entirely," which presents unemployment in a negative light. The option of staying at home was not mentioned, but Anniina described herself as committed to finding work. Employers were presented as gatekeepers who may discriminate against women because of their pregnancy, and this was considered annoying (in addition to being illegal). In this case, the centered discourse was the Equality discourse. However, all four identified discourses were found alone in some answers. By exclusively emphasizing one discourse, participants effectively marginalized all other discourses. This could be interpreted as a way to affect the power relations between central and marginalized discourses, following the idea of the discursive power of defining reality. The hegemonic discourse of Intensive Mothering was the discourse that most frequently featured in monologues. However, no single mother produced only one discourse in her answers to all three questions; even when one answer was a monologue, the mother's responses (when provided) to other questions tended to be more discursively expansive.

Synchronic interplay in the responses was typical in the data. All three forms of synchronic interplay—negating, countering, and entertaining—were present in the data. First, although quite a rare occurrence in the data, *negating* existed in some answers. This is illustrated in Tiia's (30 years, one child) answer:

> *At the Child Health Care Center, their advice is to ask for help from extended family and parents, but what if you do not have any around? Sometimes, it feels that this advice from the Child Health Care Center lags decades behind, [as if in times past] when communities of families and extended families were closer.* (Tiia, Other)

In Tiia's answer, the legitimacy of the Familistic discourse, which presented supporting parents as the task of the extended family, was completely refuted as outdated and impossible for some families. In this example, no alternative was explicitly offered. What made Tiia's annoyance understandable was the implicit Balance discourse, which actually led nonunderstanding professionals to make parenting more difficult. Another proposition that could be offered as part of the Balance discourse was that parents should receive help that meets their needs. Advice that has no relevance to families today is simply not useful. Tiia's answer demonstrated that the Familistic discourse holds some power but is not so powerful that it cannot be questioned. This answer described the pressure to develop families' services that address the

needs of parents, and this could be understood as an attempt to alter various discourses' power relations.

Second, there were many cases of *countering* in the data. For example, in Pinja's (31 years, one child) answer: "I am really happy that we have a small, lovely daughter, but the change in life came as a surprise" (Pinja, Other). Here, the Intensive Mothering was the dominant discourse, which was accompanied by the more marginal Balance discourse. Pinja suggested that, in addition to feeling happy, new parents may also be surprised at how significant a change it is to have a child. This answer was thus discursively expansive, not limiting itself to reproducing the dominant discourse but also legitimating an alternative discourse. Typically, the Intensive Mothering discourse was centered in discursively rich answers, with a few exceptions. In Mari's (30 years, two children) answer, the Familistic discourse is centered:

> *I love my family above all. Doing things together is great, and we are a good team with my husband. Our baby is cared for at home, and thanks to our collaboration, we both work for pay so that we can cope financially. I stay at home most of the time, but I can also work so that [my/our] income level has not fallen after the [better compensated] parental allowance period [before the extended period that is much less compensated].* (Mari, Other)

Descriptions of love and belonging in the family were presented as essential in Mari's answer, which represented the Familistic discourse. Childcare at home, mostly performed by the mother herself, also represented the Familistic discourse. However, Mari's chance to work was also presented as important financially. This could be understood as part of the Equality discourse, in which both partners' work is presented as valuable. However, in this answer, the discourses were not in a conflicting relationship but, rather, a complementary one: collaboration between partners and a separation of time at home and at work helped to manage seemingly contradictory discourses. Through these means, alternative discourses were legitimated, which reduced the power of the dominant discourse.

Third, the answers that included *entertaining* were found in responses to all questions. Frequently, they took the form of a list, that is, either a list of resources or a list of the things that a mother should be able to do. Sanna (32 years, one child) lists the following:

> *[My resources are] following the development of my child, witnessing the joy and insights of my child, receiving support from people close to me, support from grandparents, studying and success in my studies, moments when I can be alone and do my own things, quiet time, my relationship as a couple when we support each other, breaking everyday routines with a trip to a museum or restaurant.* (Sanna, Resources)

In her response, Sanna presented her resources in terms of the Intensive Mothering (joy related to the child), the Familistic (support from friends and grandparents, the couple's relationship), the Equality (studies), and the Balance discourses (solitude and quiet time). One cannot claim that one idea is more important than another; rather, these discourses function on an equal plane. Roosa (28 years, two children) describes contradictory emotions:

> *I have suffered from mental health problems/diseases since the birth of my second child, since 2008. I feel many contradictory emotions concerning motherhood and my work as an entrepreneur. Contradictions between my own needs or desires and the requirements of the environment feel like a never-ending challenge and burden.* (Roosa, Other)

Roosa began with the Balance discourse when describing her mental health problems, mentioning a condition that affects her well-being in motherhood and other areas of life. She continued by contrasting motherhood and work and described having contradictory emotions that pulled her in different directions. Contradictions were also described between the mother's own needs or desires and the requirements of the environment. Even though her description did not explain those pressures in more detail, it could be assumed that Roosa meant that she perceives herself as being pressured to be a perfect mother, which represents the Intensive Mothering discourse. However, one could also interpret this situation as involving pressure to work long hours, which could represent the Equality discourse, regarding the occupational success of women. It is not clear which version was the intended meaning or if Roosa meant both types of pressure. However, her own needs and desires were described as in contradiction with the requirements of her environment. This represents the Balance discourse: a mother must take care of herself as she cares for others. This response had a tone of ambivalence because no one discourse was emphasized above the others.

Occasionally, the discursive struggle was temporarily solved, and discursive hybrids (i.e., mixtures of two or more discourses that no longer present the original discourses as competing) emerged from the data. The qualities of the original discourses were identifiable, but their coexistence formed a new meaning that has analogously been described as discursive "salad dressing" (Baxter, 2011). Katja (38 years, four children) explained:

> *I have always returned to the workplace [after parental leave] once the youngest in the family reached about 1 year of age. My husband has a demanding job that occasionally requires long stays away [from home]. Despite this, it feels like our everyday life goes smoothly and we have succeeded in combining a family with several children and work. We share household chores and childcare, and I feel that we enjoy having four children. We spend a lot of time with our children, but we also try to arrange time together as a couple. Sometimes, I honestly wonder why parenting is so often experienced [by others] as difficult and challenging.* (Katja, Other)

In this example, Katja began with explaining that, after a 1-year period spent on family leave on several occasions, she had always returned to the workplace. In one sentence, she introduced both the family and the work as spheres that belong to her life, although differently at different times. She framed the work of her husband as challenging and requiring long stays away from home, which may mean that she takes most of the responsibility for the children and home (the Familistic discourse). However, she challenged this interpretation and explained that she and her husband divide the household chores and childcare. In these first sentences, she thus balanced between the Equality discourse and the Familistic discourse, which were not framed as opposites. On the contrary, adopting traditional roles between spouses was framed as temporary (parental leave and her husband staying away at times) and different from other situations in which household chores and childcare were shared, which represented the Equality discourse. Later, she asserted that the couple spends a great deal of time with their children, an expression representing the Intensive Parenting discourse. Time together as a couple was not framed as oppositional to having time for the children, even though this required some active "trying" to arrange. Balancing the roles of mother, worker, and wife was presented as a scheduling decision: different roles were central at different times. Katja had a happy tone in her response, and in the end, she wondered why parenting was so often experienced as challenging by others.

DISCUSSION

The aim of the present study was to analyze Finnish mothers' mothering discourses and interplay. As a result of contrapuntal analysis, we identified four types of discourse and found that these interplayed among one another in complex ways. The result differs from previous research in important ways. Specifically, our research shows that Finnish mothering discourses may be more varied than previously thought (see, e.g., Perälä-Littunen, 2018). Moreover, they often occur in a counterpoint relationship to one another, forming discursive struggles.

It has been proposed that the intensive mothering is the prevalent norm regarding motherhood in contemporary Western societies, particularly in White, privileged populations (Gunderson & Barrett, 2015; Hays, 1996; Rizzo et al., 2013). This discourse is constructed around the idea that the quality of mothering is of essential importance in the development of children (Hays, 1996). In line with this previous research, the Intensive Mothering discourse was also identified in the present study. The finding is in line with earlier Finnish research (see also Närvi, 2012; Perälä-Littunen, 2007; Sevón, 2007) suggesting that the Intensive Mothering discourse is hegemonic in the Finnish context. However, the three other identified discourses (the Equality, the Familistic, and the Balance discourses) served to negotiate for different meanings of motherhood.

Ideologically, the discourse most similar to the Intensive Mothering was the Familistic discourse, which is constructed around the idea of the mother as project leader in the house. The unity of the family and a good atmosphere in it resembled what Jallinoja (2006) identified as central for Modern Familism. It could be argued that the Familistic and the Intensive Mothering discourses are derived from mutually similar assumptions and should thus be treated as one and the same discourse (see Hays, 1996). However, separating the ideas behind these discourses allows us to examine the cultural shifts that have been observed in women's roles within the family more precisely (Green, 2015). In the current research, various themes were incorporated into those discourses to construct motherhood as rewarding and challenging. While the Official familistic ideology assumes that women are to primarily serve their husbands and keep the family functioning, the Intensive Mothering assumes that women will put their children foremost and sacrifice themselves for their children's happiness (Green, 2015). However, both of these discourses may be easy to adopt for mothers of infants in Finland. Government subsidies of parents/mothers staying at home may have impacted how mothers engaged with different discourses, reinforcing either the Familistic or the Intensive Mothering discourses. Thus, structural support can affect how women think and feel about motherhood and parenting.

Our findings suggest that Finnish mothers must find a balance between various discursive constructions of womanhood that encompass both motherhood and other areas of life. Indeed, the two competing schemas suggested by Blair-Loy (2003) were visible in discursive struggles in the present research as mothers tried to position themselves in relationship to both standpoints. The importance of studies, occupation, and career was negotiated in the Equality discourse, which served to negotiate acceptance for a modern, career-focused, or self-fulfilling mothering style and various family forms. This discourse was in line with the Finnish state's official politics on equality (Ministry of Social Affairs and Health, 2017), which are built on the ideal of dual-earner families with equal childcare responsibilities for both parents. This expectation for mothers to work for pay is also similar to the expectations for Black mothers in the United States (Dow, 2016; Landry, 2000). This finding underscores the importance of studying mothering in different cultural contexts: Finnish mothers' responses were often somehow positioned regarding the Equality discourse, either legitimizing or delegitimizing it.

Somewhat unexpectedly, the Balance discourse, consisting of acknowledgment of and respect for the mother's personal limits, was also identified. As the only discourse to explicitly create a gap between ideals and reality, the Balance discourse introduced a new framework for constructing motherhood. The main focus in this discourse was on balancing resources and

managing everyday life. Christopher (2012) introduced somewhat similar ideas in the United States by demonstrating that work is sometimes presented as personally beneficial for the mother, thus moving beyond the child-centered assumptions of the Intensive Mothering. However, in our data, the idea was broader because it also encompassed many themes, from balancing the needs of all family members to challenging the authority of care professionals. In our sample, the Balance discourse could be interpreted as political because it mostly centered around negotiations for change, addressing the perceived expectations of others. Mothers complained that the expectations regarding motherhood were often set too high, and they consequently offered an alternative framework for understanding motherhood. However, this type of discourse also contributed new dimensions to the "ideal worker – ideal mother" dichotomy (Blair-Loy, 2003). In the present study, mothers seemed to alternate between depictions of the "independent woman" and the ideal mother, rather than between the "ideal worker" and the ideal mother. In addition to work, hobbies, leisure, and "me-time" were also mentioned in the replies.

The second aim of our research was to analyze the functions of the various discourses and their interplay. Research that describes the multivocality of different discursive resources in constructing motherhood is rare. The few studies that have been carried out (see, e.g., Elvin-Nowak & Thomsson, 2001) have shown that, in order to have other roles in life apart from motherhood, women must often reframe the Intensive Mothering discourse in a more flexible way. A common theme of many studies has been that often women frame paid work and other activities that take them away from their children as ultimately beneficial for the children (Christopher, 2012; Dow, 2016; Elvin-Nowak & Thomsson, 2001), justifying their decisions. The results of the present study are in line with these findings, showing that mothers either actively opposed the intensive mothering, reframed its assumptions, or expressed guilt when not performing according to its standards (see Guendouzi, 2006). For example, delegating childcare to others was framed in many ways in our data, some of them more judgmental and others accepting or favorable. Future research is needed to determine the extent to which fathers use similar justifications in countries where gender equality is advanced. It is suggested that, in Sweden, for example, intensive parenting applies to fathers as well as to mothers (Collins, 2019).

Another similar feature between our data and that of Dow (2016) is related to occupational roles: mothers felt that they were expected to work outside the home and be financially independent. However, in Finland, it is typical for mothers to stay at home for an extended time after childbirth; among children between 9 and 24 months, 41% were still cared for at home in 2020 (OSF, 2021). This practice could contribute to the strategy used by many mothers: they treated maternity leave as a time when gendered roles were acceptable, in opposition to other times when they expected more equal roles. This strategy is likely a contributing factor to the diversity of discourses that were found in Finnish mothers' answers. However, favoring one discourse at one time and other discourses at other times is a discursive practice that allows for little interaction among discourses. The likely consequence of this practice is that power relations between discourses are resistant to change. In the Finnish mothering context, this may mean that dominant discourses such as the Intensive Mothering and the Familistic discourses are especially powerful for mothers and that they become less so when/if the mother returns to paid work. Moreover, government-subsidized child home care allowances may contribute to the practice of compartmentalizing discourses by encouraging families to see home care periods as separate from other periods in life.

Our findings suggest that discursive struggles are very common in Finnish motherhood discourse. In addition to the discursive monologues present in some answers, synchronic interplay was more common and realized through negating, countering, and entertaining. Mothers addressed conventional ways of defining motherhood when they described parenting discussions of the past and the present; they also addressed the anticipated evaluations of others when

providing justifications for their own views. Occasionally, discursive hybrids emerged, and the struggle for meaning was temporarily dissolved. Discursive struggles manifested themselves among all of the four discourses, suggesting that Finnish mothering discourses occur in counterpoint to one another in multiple and refined ways. However, the Balance discourse was usually identified as a request for change rather than a fully adopted attitude, which may reflect the relatively powerless position of mothers in regard to influencing prevailing cultural concepts (Choi et al., 2005). This can be interpreted to reflect the unequal playing field of discourses: some discourses are more powerful than other discourses. In the present research project, identifying the Balance discourse as a separate discourse can be understood as an attempt to underline the solutions proposed by the mothers themselves to alleviate the contradictions among ideologies.

A limitation of our study was that the sample consisted of highly educated women and the results could have been different in less advantaged groups. Stress factors, for example, may be different in different groups of mothers (e.g., less educated mothers may have more financial concerns). In particular, it would be interesting to study the Balance discourse further. It is possible that there are differences among groups of mothers or situations where this discourse is produced. For example, family size or ethnic group may affect the discourse. However, the mothers in the present research produced rich data, which is a strength of the study. Furthermore, investigating power relations among discourses provides interesting and valuable insights about motherhood. In future research, it could also be insightful to also study samples that somehow deviate from the norm, such as sexual minorities, poor mothers, adoptive mothers, immigrated mothers, and disabled mothers, both in the Finnish context and internationally. Studying fathers and mothers of older children could provide valuable information on the power relations between discourses.

Overall, the present study directs the attention from identifying motherhood discourses to understanding their power relations and interplay and this way expands previous knowledge of motherhood discourses. The findings suggest that Finnish mothers use complex negotiations to navigate through personal and cultural discourses of motherhood. However, cultural idealizations of motherhood may be a significant source of stress for many mothers and may be difficult to resist. The findings can facilitate an understanding of the cultural environment of Finnish mothering and may be useful when planning parental support programs that aim to balance contradictory emotions. For example, realizing that cultural expectations are contradictory may reduce the pressure of mothers to adhere to perfectionist standards. The results can be applied to counseling and clinical practice, especially when working with mothers' parenting stress. Hopefully, the findings can also be utilized in other cultures where similar contradictory pressures for parents are present.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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REFERENCES

Abetz, J., & Moore, J. (2018). "Welcome to the mommy wars, ladies": Making sense of the ideology of combative mothering in mommy blogs. *Communication, Culture & Critique*, *11*(2), 265–281. https://doi.org/10.1093/ccc/tcy008

Aunola, K., & Sorkkila, M. (2018). Vanhemmuuden voimavara- ja kuormitustekijät -tutkimushanke (VoiKu). Ongoing research project. University of Jyväskylä.

Barnes, R. J. D. (2008). Black women have always worked: Is there a work–family conflict among the Black middle class? In E. Rudd & L. Descartes (Eds.), *The changing landscape of work and family in the American middle class: Reports from the field* (pp. 189–209). Lexington Books.

Baxter, L. A. (2011). *Voicing relationships*. Sage.

Baxter, L. A., & Norwood, K. (2015). Relational dialectics in theory. In D. O. Braithwaite & P. Schrodt (Eds.), *Engaging theories in interpersonal communication* (2nd ed.). Sage.

Baxter, L. A., Scharp, K. M., & Thomas, L. J. (2021). Original voices. Relational dialectics theory. *Journal of Family Theory & Review*, *13*(1), 7–20. https://doi.org/10.1111/jftr.12405

Blair-Loy, M. (2003). *Competing devotions: Career and family among women executives*. Harvard University Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Choi, P., Henshaw, C., Baker, S., & Tree, J. (2005). Supermum, superwife, supereverything: Performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology*, *23*(2), 167–180. https://doi.org/10.1080/02646830500129487

Christopher, K. (2012). Extensive mothering: Employed mothers' constructions of the good mother. *Gender & Society*, *26*(1), 73–96. https://doi.org/10.1177/0891243211427700

Collins, C. (2019). *Making motherhood work: How women manage careers and caregiving*. Princeton University Press.

Cotter, D., Hermsen, J. M., & Vanneman, R. (2011). The end of the gender revolution? Gender role attitudes from 1977 to 2008. *American Journal of Sociology*, *117*(1), 259–289. https://doi.org/10.1086/658853

Douglas, S. J., & Michaels, M. W. (2004). *The mommy myth: The idealization of motherhood and how it has undermined all women*. Free Press.

Dow, D. M. (2016). Integrated motherhood: Beyond hegemonic ideologies of motherhood. *Journal of Marriage and Family*, *78*, 180–196. https://doi.org/10.1111/jomf.12264

Ellingsæter, A. L., & Leira, A. (2006). *Politicising parenthood in Scandinavia: Gender relations in welfare states*. Policy Press.

Elvin-Nowak, Y., & Thomsson, H. (2001). Motherhood as idea and practice: A discursive understanding of employed mothers in Sweden. *Gender & Society*, *15*(3), 407–428. https://doi.org/10.1177/089124301015003005

England, P. (2010). The gender revolution: Uneven and stalled. *Gender & Society*, *24*(2), 149–166. https://doi.org/10.1177/0891243210361475

Gilbert, N. (2008). *A mother's work. How feminism, the market, and policy shape family life*. Yale University Press.

Green, F. J. (2015). Re-conceptualising motherhood: Reaching back to move forward. *Journal of Family Studies*, *21*(3), 196–207. https://doi.org/10.1080/13229400.2015.1086666

Guendouzi, J. (2006). "The guilt thing": Balancing domestic and professional roles. *Journal of Marriage and Family*, *68*(4), 901–909. https://www.jstor.org/stable/4122883

Gunderson, J., & Barrett, A. (2015). Emotional costs of emotional support? The association between intensive mothering and psychological well-being in midlife. *Journal of Family Issues*, *38*(7), 992–1009. https://doi.org/10.1177/0192513X15579502

Hays, S. (1996). *The cultural contradictions of motherhood*. Yale University Press.

Henderson, A., Harmon, S., & Newman, H. (2016). The price mothers pay, even when they are not buying it: Mental health consequences of idealized motherhood. *Sex Roles*, *74*(11–12), 512–526. https://doi.org/10.1007/s11199-015-0534-5

Hofstede, G. (2001). *Culture's consequences: Comparing values, behaviors, institutions and organizations across nations*. Sage.

Jallinoja, R. (2006). *Perheen vastaisku: Familistista käännettä jäljittämässä* [*The Family strikes back: In search of the familistic turn*]. Gaudeamus.

KELA (The Social Insurance Institute of Finland). (2021). Child care allowances. https://www.kela.fi/web/en/child-care-allowances

Knight, C. R., & Brinton, M. C. (2017). One egalitarianism or several? Two decades of gender-role attitude change in Europe. *American Journal of Sociology*, *122*(5), 1485–1532. https://doi.org/10.1086/689814

Lammi-Taskula, J. (2007). *Parental leave for fathers? Gendered conceptions and practices in families with young children in Finland*. Stakes. http://urn.fi/urn:isbn:978-951-44-7122-3

Landry, B. (2000). *Black working wives: Pioneers of the American family revolution*. University of California Press.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Määttä, K., & Uusiautti, S. (2012). How do the Finnish family policy and early education system support the well-being, happiness, and success of families and children? *Early Child Development and Care*, *182*(3–4), 291–298.

Mercer, R. T. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship*, *36*(3), 226–232.

Ministry of Social Affairs and Health. (2017). *Government action plan for gender equality 2016–2019*. http://urn.fi/URN:ISBN:978-952-00-3951-6.

Moore, J., & Abetz, J. (2016). “Uh oh. Cue the [new] mommy wars”: The ideology of combative mothering in popular U.S. newspaper articles about attachment parenting. *Southern Communication Journal*, *81*(1), 49–62.
Närvi, J. (2012). Negotiating care and career within institutional constraints – Work insecurity and gendered ideals of parenthood in Finland. *Community, Work & Family*, *15*(4), 451–470. https://doi.org/10.1080/13668803.2012.724827
Official Statistics of Finland. (2018). *Educational structure of population*. Statistics Finland. http://www.stat.fi/til/vkour/2018/vkour_2018_2019-11-05_tie_001_en.html
Official Statistics of Finland. (2019a). *Families*. Statistics Finland. http://www.stat.fi/til/perh/2019/perh_2019_2020-05-22_tie_001_en.html
Official Statistics of Finland (2019b). Labour force survey. Employment and unemployment in 2019. Statistics Finland. http://www.stat.fi/til/tyti/2019/13/tyti_2019_13_2020-05-07_kat_002_en.html
Official Statistics of Finland (2021). Kelan lapsiperhe-etuustilasto 2020. Helsinki: Kela. https://helda.helsinki.fi/bitstream/handle/10138/330043/Kelan_lapsiperhe_etuustilasto_2020.pdf?sequence=3&isAllowed=y.
Öun, I. (2012). Work-family conflict in the Nordic countries: A comparative analysis. *Journal of Comparative Family Studies*, *43*(2), 165–184.
Perälä-Littunen, S. (2007). Gender equality or primacy of the mother? Ambivalent descriptions of good parents. *Journal of Marriage and Family*, *69*, 341–351. https://doi.org/10.1111/j.1741-3737.2007.00369.x
Perälä-Littunen, S. (2018). Childcare and work: Exploring the views of Finnish mothers and fathers. *Community, Work & Family*, *21*(2), 209–225. https://doi.org/10.1080/13668803.2016.1274289
Rich, A. (1995). *Of woman born: Motherhood as experience and institution* (Paperback ed., reissued). Norton.
Rizzo, K., Schiffrin, H., & Liss, M. (2013). Insight into the parenthood paradox: Mental health outcomes of intensive mothering. *Journal of Child and Family Studies*, *22*(5), 614–620. https://doi.org/10.1007/s10826-012-9615-z
Segura, D. A. (1992). Chicanas in white-collar jobs: “You have to prove yourself more”. *Sociological Perspectives*, *35*(1), 163–182. https://www.jstor.org/stable/1389373
Seierstad, C., & Healy, G. (2012). Women’s equality in the Scandinavian academy: A distant dream? *Work, Employment and Society*, *26*(2), 296–313. https://doi.org/10.1177/0950017011432918
Sevón, E. (2007). Narrating ambivalence of maternal responsibility. *Sociological Research Online*, *12*(2), 30–42. https://doi.org/10.5153/sro.1527
Suter, E. A., & Norwood, K. (2017). Critical theorizing in family communication studies: (Re)reading relational dialectics theory 2.0. *Communication Theory*, *27*(3), 290–308. https://doi.org/10.1111/comt.12117
World Economic Forum. (2010). *The global gender gap report 2010*. World Economic Forum. https://www.weforum.org/reports/global-gender-gap-report-2010

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How to cite this article: Raudasoja, M., Sorkkila, M., Laitila, A., & Aunola, K. (2022). “I feel many contradictory emotions”: Finnish mothers’ discursive struggles with motherhood. *Journal of Marriage and Family*, 1–21. https://doi.org/10.1111/jomf.12828