

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.



DISCOURSES OF GRIEF: THE DEATH OF THE MOTHER

Daphne Anne Manderson

A thesis presented in fulfilment of the requirements for the degree of Doctor of Philosophy

Massey University
New Zealand
1999

ACKNOWLEDGEMENTS

During the years of this study so many people have given me support, and encouragement. I wish to acknowledge my gratitude to the women I interviewed. They are an inspiring group of women and I admired their openness as they explored with me their understandings of grief. My hope is that this thesis will in some way give validation to their time and contribution so willingly given.

My particular thanks go to my supervisors, Dr Judith Christensen and Dr Victoria Grace. Judith for the many academic challenges that you presented me, and for your wisdom and friendship over these years. Victoria, for the academic challenge, as well as your support and encouragement as my local supervisor. Thank you both for challenging me to explore the concepts of “poststructuralism” and “discourse analysis”, and for in effect turning my world upside down!

I acknowledge the huge contribution to my life given by my mother. I thank her for her being and her constant strength. To my twin Doris Manderson, thank you for always believing in me, your support and interest in my studies has never wavered. And, to my family thank you for your support in so many ways.

I also wish to thank Associate Professor Livia Käthe Wittmann, of the Feminist Studies Department at Canterbury University for the contribution that she has made to my learning over many years. And

Kaye Cederman, for her friendship, and for the debate as we both worked on our doctoral studies.

I wish to acknowledge Lesley Spence, Ray Wootton, Bev Rayna and Dee Ferris who have been long time mentors and role models for me of excellence in nursing. I thank each one of you for nurturing my interest in nursing education and research.

And to my friends and nursing colleagues who have been supportive of my research, thank you. I especially wish to thank Cathy Andrew, Ann Blackie, Paula Collett, Penny Carnaby, Marion Cross, Barbara Fox, Elizabeth Griffin, Dr Dame Jean Herbison, Marco and Teatske Kuchlein, Dr. Merian Litchfield, Joseph Manderson, Dr Marjorie Manthei, Dr Elizabeth Plumridge, Archdeacon Ronnie Plaistowe, Val Quinn, Vi Sharpe, Jenny and Paul Stewart, Winifred and Archdeacon Robin Smith, Janetta Skiba, Carole Spencer, Carol Struthers, Canon Ron Taylor, Rosemary Tredgold, Mary Wade, Debra Wilson, and Eileen and Rob Whitmore.

I acknowledge with thanks the help I have received during this research from the Massey University Library staff. Their willing and courteous assistance throughout the whole of this time has been unreal. My particular thanks go to Janice Russell, who has 'gone the extra mile' so willingly. I also wish to thank Patricia Jordan at The University of Canterbury Library for her professional advice and support.

I am indebted to Tim Kuchlein for his assistance with the various crises that I have had with my computer. Thank you Tim, for your time so willingly given.

Most importantly, I am indebted and grateful to the Directorate of Christchurch Polytechnic, John Scott, Lyn Brash, and Ralph Knowles who supported my request for full time leave for doctoral study. Thank you for the financial support that Christchurch Polytechnic provided toward this study opportunity. Without your support I would not have had the privilege or opportunity to have undertaken this research.

DEDICATION

To my mother

Dorothy Amelia Manderson

ABSTRACT

This purpose of this study was to explore the grief of daughters on the death of their mothers. I interviewed fifteen women. This study draws on feminist post-structuralist insights into subjectivity as constructed in the interplay, and between socially available discourses. I identified three interrelated and co-existing discourses through which the metadiscourse of grief arose. These discourses were continuity, discontinuity and silencing. Two distinct patternings of the discourses were identified within the corpus of the text, and these seemed to be shaped primarily by the age of the woman when her mother died.

These discourses are considered and collated within the social/historical context in which medical and psychological notions of grief have been hegemonic, and other subordinated and lay discourses are emerging. I suggest the understanding of oneself as a daughter in grief changes over time. The women interviewed in this study showed a 'desire' not to 'get over it' and disconnect, but to incorporate a continuing bond with the mother. How this is achieved is explained.

CONTENTS

ACKNOWLEDGEMENTS	I
DEDICATION	III
ABSTRACT	IV
CHAPTER ONE	
REFLEXIVITY: THE EMERGENCE OF THE RESEARCH PROBLEMATIC	1
<i>Introducing Kate</i>	1
<i>Evolving nursing practice</i>	3
<i>The advent of feminism</i>	7
<i>Clarification of the research</i>	10
<i>Thesis structure</i>	12
CHAPTER TWO	
HEGEMONIC LITERATURES ON DEATH AND GRIEF	14
<i>The medical/psychodynamic paradigm</i>	15
Literatures on grief.....	18
Literatures on the death of a mother.....	31
<i>Literatures from social sciences and humanities</i>	34
CHAPTER THREE	
FEMINIST CRITIQUE OF THE MOTHER DAUGHTER RELATIONSHIP AND CHALLENGES TO THE MEDICAL DISCOURSE ON GRIEF AND DEATH	40
<i>Feminist critique of the mother-child relationship, and it's cessation</i>	40
<i>Challenges to dominant discourses of death and on grief: Surfacing the silencing and confession</i>	56
CHAPTER FOUR	
THE RESEARCH APPROACH	66
<i>Informing the research: Epistemological and ontological understandings</i>	66
<i>Understanding discourse and discourse analysis</i>	70
<i>'Subjectivity' and 'subject positions'</i>	72
<i>A politics of grief</i>	77
CHAPTER FIVE	
THE RESEARCH PROCESS	81
<i>Research aims</i>	81
<i>Ethics and values associated with this research</i>	82

Nursing ethics.....	82
Feminist ethics	85
<i>Recruiting participants and gaining informed consent</i>	86
The criteria for inclusion in the study.....	86
The participants.....	87
Obtaining consent.....	90
<i>Data Collection</i>	90
<i>Data analysis</i>	92
Step one: Identifying general discursive parameters.....	94
Step two: Determining the discursive structure.....	95
Step three: Identifying the resources and techniques of discourse.....	96
<i>Generating the outcome</i>	97

CHAPTER SIX

THE METADISOURSE OF GRIEF: CONTINUITY, DISCONTINUITY AND SILENCING 99

<i>Introducing the three discourses</i>	100
Continuity.....	100
Discontinuity	103
Silencing.....	105
<i>The metadiscourse of grief: Discourses of continuity, discontinuity and silencing</i>	106
The discourse of continuity	107
The discourse of discontinuity.....	109
The discourse of silencing.....	113
Family silencing	115
Institutional silencing.....	115
I need to know, it's my right to know	115
Schematic representation of the research outcome	119
<i>Schematic representation of how discourses are drawn on by women who were children when their mother died</i>	120
<i>Schematic representation of how discourses are drawn on by women who were adults when their mother died</i>	121

CHAPTER SEVEN

INTRODUCING THE PARTICIPANTS WHO WERE BEREAVED AS CHILDREN..... 123

<i>Sarah</i>	123
<i>Holly</i>	124
<i>Kate</i>	125
<i>Margaret</i>	125

CHAPTER EIGHT

SILENCING DISCOURSE IN THE TALK OF WOMEN BEREAVED AS CHILDREN	127
<i>Childhood silencing: Questions unanswered and unasked</i>	<i>128</i>
Family politics of silencing	129
Institutional politics of silencing	136
<i>Adult silencing: The struggle with silence</i>	<i>142</i>
<i>Adulthood: Rejecting the silencing and creating connection</i>	<i>148</i>

CHAPTER NINE

DISCONTINUITY AND CONTINUITY DISCOURSES IN THE TALK OF WOMEN BEREAVED AS CHILDREN	154
<i>Childhood discontinuity: The absent mothers</i>	<i>154</i>
<i>Transition to adulthood: The desire for the 'good' or 'archetypal' mother</i>	<i>163</i>
<i>Adulthood: Making connection</i>	<i>168</i>

CHAPTER TEN

INTRODUCING THE PARTICIPANTS WHO WERE BEREAVED AS ADULTS	175
<i>Em</i>	<i>176</i>
<i>Ann</i>	<i>176</i>
<i>Jane</i>	<i>177</i>
<i>Megan</i>	<i>178</i>
<i>Val</i>	<i>179</i>
<i>Julie</i>	<i>180</i>
<i>Cathy</i>	<i>181</i>
<i>Alice</i>	<i>182</i>
<i>Elizabeth</i>	<i>182</i>
<i>Catherine</i>	<i>183</i>
<i>Jean</i>	<i>184</i>

CHAPTER ELEVEN

CONTINUITY AND DISCONTINUITY DISCOURSES IN THE TALK OF WOMEN BEREAVED AS ADULTS	185
<i>Continuity: The motif of mutuality, self in relationship</i>	<i>188</i>
<i>Discontinuity: The challenge to continuity by the mother's illness and death</i>	<i>199</i>
The beginning of loss: Illness and hospitalisation	200
The betrayal: Mothers don't die	210
The physical loss: The body in death	213
<i>Changing connections: Recovered continuity</i>	<i>218</i>

CHAPTER TWELVE

SILENCING DISCOURSE IN THE TALK OF WOMEN BEREAVED AS ADULTS	226
<i>Adult silencing: Victimhood, betrayal and complicity.....</i>	<i>227</i>
<i>Critiquing silencing: Moving between victimhood, complicity and resistance.....</i>	<i>234</i>

CHAPTER THIRTEEN

THE FINALE: REFLECTIONS ON HEGEMONY, RESISTANCE AND TRANSFORMATION	254
<i>Subversion of the hegemonic.....</i>	<i>255</i>
<i>The potential for transformation.....</i>	<i>257</i>
<i>The potential for nursing practice</i>	<i>259</i>
<i>In conclusion.....</i>	<i>263</i>
BIBLIOGRAPHY	264
APPENDIX A	287
INFORMATION SHEET.....	287
APPENDIX B	290
<i>Consent form.....</i>	<i>290</i>
APPENDIX C.....	292
<i>Interview prompts.....</i>	<i>292</i>
APPENDIX D	293
<i>Themes.....</i>	<i>293</i>
APPENDIX E.....	295
<i>A selection of key words and phrases from the text depicting connection and continuity</i>	<i>295</i>
APPENDIX F	299
<i>A selection of key words and phrases from the text depicting discontinuity.....</i>	<i>299</i>
APPENDIX G	301
<i>A selection of key words and phrases from the text depicting silencing.....</i>	<i>301</i>

CHAPTER ONE

REFLEXIVITY: THE EMERGENCE OF THE RESEARCH PROBLEMATIC

My interest in the subject of death resulted from a pivotal nursing experience some months after I graduated in the early 1970s. I was working night duty on a medical ward, and like most newly graduated nurses, I thought that 'my' ward was the most important. One night I arrived for duty to be told that I was to be replaced and to take charge of the paediatric ward for a few nights. I was not impressed. I wanted to remain on 'my' ward, but of course I went.

Introducing Kate

I was given the usual 'hand over' and, walking from bed to bed, I met a young girl I shall call Kate. Kate was ten years of age, her face was pale and drawn, her hair soft and long. I was given her diagnosis and told that she was very ill, that she needed rest and sleep. I did what was prescribed, settling her comfortably in the darkened ward and observing her silently from the windowed office, when I was not in the ward. Kate did not sleep well. She was always asking for something and seemed to want attention, and to have someone with her. I grew uneasy and felt nursing care should offer Kate more. On the third night I broke with convention. I transgressed the rules for nursing behaviour at that time, and sat on her bed and just talked. During this talk I asked her if she was worrying about anything. She said "Oh Mandy, I'm so scared of the

dark, I'm scared to close my eyes". We talked at length about "the dark", which I felt was a metaphor for death in Kate's talk. As we spoke together about "the dark", I was aware at that moment that I was again transgressing because only doctors spoke to patients about their dying. Nevertheless, Kate and I arrived at an understanding. I was informed that Kate's mother was not to be contacted during the night as she had heavy family demands and spent her days at the hospital, so Kate was alone at night. She knew that I would look out for her during the night and that she could rest and sleep. I felt that we had a relationship. Later on in that week, when I arrived and stood by her bed, I sensed a change. I felt that she was going to die. Nothing had changed in terms of her treatment or recordings; no briefing or medical indication suggested death was imminent. In the early hours of the morning Kate had a cardiac arrest and died. All of us who attempted to resuscitate her were devastated. So was Kate's mother when I contacted her.

I was told by the night supervisor that someone else could come and lay Kate out because I had had quite a week, and that I could go off and have a meal. This was not what I wanted. I declined to be shut out. I felt involved, implicated, because 'we', Kate and I, had been in this together. I wanted to lay Kate out, and to speak with her mother. I was shocked to find that 'the body' I laid out was significantly different from the Kate I had known, and that she looked much more like a child than I had ever seen in life. At this point protocol required that I contact an orderly and:

Respectfully place [the] deceased on [a] trolley, and proceed quietly to the mortuary... Relatives should be encouraged to see the deceased at Funeral Director's Chapel rather than at the Hospital Mortuary Chapel. (Nursing lecture notes, 1969)

This felt quite wrong. I wrapped Kate in a soft blanket, and I did not ring the orderlies to come with a trolley to collect 'the body' and trundle through the hospital corridors to the morgue. Instead I took Kate, who

now simply looked like a child asleep and carried her in my arms to the chapel at the mortuary, accompanied by another registered nurse.

Kate's mother arrived at the ward, tired, contained, and expecting to collect Kate's few small things and go. We spoke for some time as we had not met before, and I told her about the events of the last few evenings. In effect, I was filling in the gaps of information regarding her daughter and our brief relationship. I asked her if she would like me to take her to see her daughter, suggesting that it might be helpful. I discussed with her how amazed I was at how Kate now looked in death. Kate's mother went with me to see her daughter. I stood by her for support, feeling there was little I could say as she faced such a loss. She cried, and cried, and cried. After some time she said she would always carry in her memory the view of her daughter in the Chapel, because she had been sick for so long and, in this early morning, she looked so different in death.

Kate was my first significant teacher in understanding death and grief. She taught me of the pain that can come from silencing in the face of death, and of the violence done by protocols to remove the dead person, physically and socially, from the experience of the living. Kate's mother pointed me to the longing of the living for connection with the dead, of her longing to integrate the immediate past into her present memory. Kate also taught me about the need to transgress the protocols, processes and politics of silencing around death, and she demonstrated to me the key role that nursing can play in the presence of death and grief.

Evolving nursing practice

The ensuing 24 years of witnessing patients and relatives dealing with death and grief, and of talking with people in the community, have confirmed the lessons learned from Kate.

During my training to be a nurse, undoubtedly, medical discourse informed our understandings. The focus of our education was on

supporting the practices of medicine, surgery and obstetrics. A quotation from nursing notes at the time indicates something of the commodification of death that still exists within Western society, within medicine, and by default, also within nursing:

Relatives are escorted from the bedside. A doctor or registered nurse must verify that death has occurred. Record time of death... When relatives are more composed ...Direct to Head Orderly who can advise about funeral arrangements if necessary. (Nursing lecture notes, 1969)

Indirectly, we were taught that the body was an object, an object to be treated and, if death occurs, to be disposed of and removed from the ward as promptly as possible by orderlies, people who had not been involved with the dying person. However, at the same time, the teaching of a number of the tutor sisters, as they were then known, somewhat subverted, or at least balanced, this powerful medical view. They focused on the importance of good communication, and on the need to develop a 'therapeutic' relationship with the person who was unwell. Some emphasised the importance of understanding the social context of the individual lives to whom our nursing care was delivered. Nurses at that time were proscribed from talking about dying with patients, yet I witnessed the fear of a number of doctors about engaging with such talk. There were many times during my training, and later as a registered nurse, when I was asked by a patient "Am I dying?" This was an acutely painful dilemma. I tried to link a doctor into the situation, often only to see him or her avoid, or try to avoid, what was clearly felt as an uncomfortable confrontation. I sometimes fell back on returning the question to the patient, which often led to talking despite formal prohibitions.

Many doctors still feel out of their depth when dealing with death and grief. This was reinforced again for me in a survey of 207 medical and nursing students that I was involved with in 1992. Medical and nursing students were asked to respond to a series of questions on clinical vignettes about care of the dying, situations they could expect to face in

the near future. The research focused on the students' educational preparation for situations involving issues of death and grief, and on determining how prepared the students felt for this. The greatest difference between the medical and nursing students was in the area of attitudes towards death. Nursing students *perceived* they had more ability, and were more aware of grieving processes than their medical colleagues (Charlton, Ford and Manderson, 1995). The following comments from the study are from fifth and sixth year medical students:

As far as my experience is concerned, I would be grateful if more time were spent in clinical years on developing skills in telling patients they are dying or relatives that a patient has died and providing us with guidelines for dealing with the consequences of such situations. (Med.5, p.14)

We have a little teaching about death and grieving. Very few role models on how to deal with it and those I have seen are appalling – I must do better than that please. (Med.6, p.15)

Teaching should begin at the start of the second year and be integrated into all areas. It is important that medical students realise the limitations of medicine and know how to cope/deal with situations that cannot be cured.

(Med.6, p.16)

The students' comments reflect their awareness and concern about the continuing silence around issues of grief and loss, and their sense of inadequacy because of medicine's focus on 'the body' and the control of diseases and symptoms. While the spoken and unspoken rules that say that doctors should 'break' the 'good' or the 'bad news' to people may continue, it appears that, in many situations, senior medical students still do not feel able to cope with this well, nor do they see good role models (Charlton et al, 1995).

My experience as a nurse dealing with bereaved relatives, and as a nurse educator working in the hospital and the community, has been that people do not 'get over' bereavement, do not want the dying person removed either metaphorically or physically, and do want to integrate

the death into their ongoing lives. In short, my experience has negated what my training said 'should' happen, and the 'rules' about grief.

Whilst undertaking graduate study in 1984 I spent my elective work in Wellington at Te Omanga Hospice and the Mary Potter Hospice for the terminally ill. These were two of the first hospices in New Zealand. At that time the focus of Te Omanga was to manage the dying person's symptoms, provide support to relatives and care givers, and enable the person to return back to their home. They had a very effective home care support service. This experience gave me the opportunity to observe and learn from the staff, and also to speak with day patients about dying, and with their families about grief. I was struck with the fact that a number of relatives continued to visit after the death of their family member and to support the work of the hospice. Once again I became aware that many people want to maintain continuing bonds, and to retain ongoing connections, with people who will talk about and remember the family member who has died.

In 1989, during a period of leave, I chose to work at St Christopher's Hospice in London, primarily in order to reflect further on hospice care which was becoming more available as an option of care in New Zealand. I had the opportunity to meet and talk with Dame Cicely Saunders who is acknowledged as the founder of the modern hospice movement within the Western world. I was particularly impressed at St Christopher's by their policy of not immediately admitting a new patient to the bed of someone who was recently deceased. The bed of the deceased person was left empty for a period of twenty-four hours. This was done as a mark of respect for the person who had died, and also so that staff had the opportunity to think about and acknowledge their feelings about the person who had died. This is the only hospice/hospital that I know of that has this practice. It taught me that a physical removal need not become a metaphysical absence; that removal does not have to be a forgetting, but can surprisingly be a means of integration. The empty bed on the very busy wards was a salutary reminder for all.

As part of my ongoing learning about grief I attended a conference on grief and loss with Dr. Elisabeth Kübler-Ross in Taupo in 1985. This resulted in Dr. Kübler-Ross asking me to organise a conference on 'Life, Death and Transition' in Christchurch in 1986. Both of these conferences gave me a further opportunity to reflect on issues of grief and loss, and on the prevailing belief that there is a need for catharsis and for moving on with life. I have great admiration for Elisabeth, and for what she has achieved in her life time. Her work has helped people to talk about death and dying, and has helped to overcome the silence which surrounds death and the experience of loss. Nevertheless, her assumptions about 'the good death', and by implication 'good grief', are posited on the notion that, correctly done, dying and grief over death are surmounted and that one can and ought to 'get over it'. At Elisabeth's workshops I saw what I have termed the 'Lazarus' experience: people unbound and 'freed' from the experience of the wound of grief. But, I also sensed their need to include the experience into their lives, and this was not necessarily dealt with in the context of the workshop where the focus was on healing and on letting go.

The advent of feminism

By the mid 1980's I was still teaching on grief and death, but still uneasy. I was constantly aware of the dislocation between the formal theoretical knowledge I imparted and the informal wisdom I had gained since my experience with Kate. Of course, much had changed in nursing practice and teaching. One of the greatest winds of change was feminism. This has led me to rethink the fundamental parameters of nursing, and to challenge some of the positivist and unitary constructions of our disciplinary knowledge. Jenny Carryer (1997), a feminist nurse researcher, argued that a search of the "nursing literature reveals almost no critique of the biomedical model by a profession which purports not to subscribe to it" (p.29). I have found the same absence of discussion and debate in respect to understandings of

grief and loss. Yet, in teaching female registered nurses on various courses, I have heard them speak of different contextual understandings of loss. This led me to want to explore women's experiences of grief as I was increasingly becoming aware that their validation and experience were at odds with the views of a number of well known grief theorists (Bowlby, 1971, 1975, 1980; Volcan, 1981; Rando, 1992; Raphael, 1984).

I decided to specifically undertake research on the death of the mother as a result of my discussions over the years with registered nurses and students of nursing. In class discussions about death I heard a number of experienced registered nurses comment on how devastating the death of their mother had been. These women were acquainted with death; they had not been 'protected' because of their work as nurses. However, they spoke about grief arising from their personal loss, and about the mother-daughter bond. Women talked of how their mother had always 'been there' for them 'no matter what', how they had 'looked out' for each other, and how they had supported each other in different ways. Following the death of their mother they realised how much they had lost and recognised that there was a quality of loving or care that was different from anything else. Other women, whose relationship with their mother had for some reason been fraught, spoke of different experiences, of 'disappointment', of 'relief' and of 'being glad it was over'. All women spoke of their mothers with passion. These conversations highlighted for me that women are willing, even longing, to talk about the death of their mothers.

I also became aware of a lack in my teaching. In class I often spent time discussing issues surrounding 'sudden death' such as suicide, or the death of a child, but I had omitted, and perhaps 'taken for granted', the death of a parent. This, together with the influence of feminist teaching within my undergraduate and postgraduate university studies, led me to decide to explore this topic further. In canvassing the literature on death and dying I was astounded to find, even after extensive literature

searches, that there was a dearth of information surrounding the death of the mother, especially the experiences of daughters.

Focusing on the bereavement of daughters, I searched the databases in published literature: Cinahl, Psych LIT, Sociological Abstracts, Social Science Index, Index New Zealand and Medline. I also searched for unpublished theses, and book reviews both on databases and through the world wide web. There were very few published articles and monographs specifically dealing with the grief experience of daughters. In general, the information was dominated by psychological and medical approaches, or tended to be anecdotal and descriptive rather than analytic.

I started to recognise that much of the literature surrounding the grief experience was couched in a medical frame, and that in fact there was little information available for daughters or for the health professionals who wanted to understand something of what the death of the mother means for daughters. Given the tomes of information written around the subject of death and loss, it raised the question for me as to why so little has been written on the dissolution of such a primary relationship.

I also witnessed the influence of Hope Edelman's book *Motherless daughters* (1994), which she wrote as a result of her experience of the death of her own mother. I first saw Hope Edelman interviewed on television while she was here in New Zealand to promote her book, and was fascinated to learn that she wrote *Motherless daughters* as a response to her inability to find any helpful information. This confirmed me in my choice of doctoral topic because the popular need for information supported what I had become aware of as a tutor. Edelman, like Kübler-Ross, has helped to open up the silence that surrounds grief, loss and death. In particular, she calls for more information, and dialogue, about the impact on daughters of the death of their mothers.

Clarification of the research

I was now able to clarify some of the questions that had troubled me for so long. Professionally, I wanted to find out if the medical view, that decathexis or disengagement are necessary for 'good grieving', is reflected in the grieving of women who have lost their mothers through death. I wanted to ascertain how these women view death, what their understandings are. I was also interested in learning if the women's knowledge about the circumstances or condition of their own mother's life influences their grief experience. Robbins (1990b), in one of the few studies undertaken on the death of the mother, considered that the women she interviewed experience more grief over their mothers' lives than over their deaths.

I was seeking to determine the extent to which the women's 'local' or 'lay' knowledges reflect or subvert the dominant medical and nursing understandings that surround grief. In other words, the research problematic involved my determining what the nature of grief is for bereaved daughters. I wanted to find out in what way, if any, medical discourses impact on women's lives. This meant understanding what the 'rules' are that constitute and regulate the women's expression of their grief.

In order to ascertain how women construct their understanding of grief and loss, this research has involved identifying the discourses that women position themselves in, and the subject positions they take up. This focus emerged towards the end of the first year into the project, when I became aware that I could not sustain a humanist and unitary positioning, and that I needed to consider how language and representation construct how the grief experience is understood.

Thus, the aims for this research were to analyse the narratives of women whose mothers have died to explore:

1. How grief is understood and articulated by these women;

2. What major discourses dominate and constitute the women's understandings of both grief and loss, and to understand what primacy is ascribed to the mother-daughter relationship within these discourses; and
3. The implications for nursing practice of this discursive approach to grief.

Although grief and loss are some of the most universal of human responses encountered by registered nurses, these concepts are some of the least accounted for in the areas of nursing theory and practice. A timely reminder of the importance of, and the need to question, the traditional ideas surrounding death and grief comes from the writing of Parker and Aranda (1998), editors of the book *Palliative care: Explorations and challenges*. In the introduction, Parker challenges the concept of "simplistic and routinised practices" (p.xxi) that can surround the care of the terminally ill. She suggests that nurses need to work within "the complex, ambiguous, contradictory and personally threatening issues surrounding terminal illness" (p.xxi). This research opens up such complexities and ambiguities, so that nurses can reflect on them and develop strategies for dealing with potentially threatening issues. My intention, as a result of analysing the data, was to focus on the major discourses utilised by the women to describe their grief experiences, and to identify how personal power is negotiated within the institutions of the family and of medicine. In this way I was seeking to encourage nurses to clarify a role or function that nursing care can assume in dealing with grief.

The research problematic and focus on women's subjectivity¹ is of relevance to nursing as there seems little doubt that the death of the mother is a life event of great significance; it is an event played out in institutions where nurses play a key role at a time of great human need.

¹ Burr (1995) writes of how in western society the concept of personality remains static, the individual is perceived to have a "unified personality, a coherent and unified self" (p.18). This

Because nursing is premised on and around the care of people², the research is a timely, relevant and necessary critique of the dominant discourses of medicine and gender which so often dominate nursing.

This thesis explores the experience of grief associated with a mother's death within a European New Zealand frame. While the significance of Maori understandings of grief are fully acknowledged, and New Zealand is clearly a country of many cultures, within institutional present day thinking on grief New Zealand remains predominantly Euro-centric, that is, it reflects much of the philosophical tradition of European/American thought and practice. So I determined to interview women whose responses should most be constituted by these theories. The grief models utilised by Field, Hockey and Small in *Death, Gender and Ethnicity* (1997), support this viewpoint that 'grief management' is largely Euro-centric. They go on to suggest that death is shaped by one's "social position in ...society" (p.2), and by issues of "age, ethnicity, gender, social class and sexuality" (p.2), all of which profoundly affect one's understanding and experience of death.

Thesis structure

The outcome of this study is presented in the following structure:

Chapter 1 has dealt with issues of reflexivity and how my nursing praxis attuned my concerns with the nature of grief as experienced by daughters bereaved of their mothers. I have outlined both the research problematic and research aims.

Chapter 2 deals with the way the hegemonic discourses of medicine have constrained and proscribed the grief experience.

essentialist view equates to the individual having their own particular essence or nature. This viewpoint is challenged in postmodern thinking, see Chapter Four.

² See Bruni (1991) who discusses how "notions of care" can "constitute the subject position of the nurse" (p.185). Lawler (1991) discusses the nature of nursing practice. She writes of how nurses are "not only concerned with the body as an object and its associated symbolism, they are also concerned with what we call the lived body in illness experience" (p.162).

Chapter 3 discusses potentially subversive approaches to grief enabled by feminist and post-structuralist theorising and critiques.

Chapter 4 outlines the general research methodology, as informed by post structuralist and feminist theorising, which facilitated the identification of a metadiscourse of grief functioning through an articulation of the three discourses of continuity, discontinuity and silencing.

Chapter 5 deals with the practical processes of the research including ethical issues and recruitment of participants. It deals with the process by which the parameters, structure, and discursive resources were revealed to the research gaze.

Chapter 6 examines the nature of the metadiscourse of grief, comprising three discourses of continuity, discontinuity and silencing as core elements, then exploring the discourses as contextualised in talk. The importance of the narrative form is also discussed.

Chapters 7,8,& 9 deal with the discourses of women bereaved as children they introduce the participants and illustrate how the discourses were played out.

Chapters 10,11,&12 repeat the process for these women bereaved as adults.

Chapter 13 deals with the potentials of this research: on the one hand it offers the possibility of different modalities of 'resolution' of grief, and on the other it offers both a potential and a challenge to nursing in the 'management' of grief.

CHAPTER TWO

HEGEMONIC LITERATURES ON DEATH AND GRIEF

In western culture it was psychology which...dominated the study of grief and bereavement during the 20th century and, overall, the problem of grief, like death before it, became medicalised and individualised and subsequently fell under the control of medical personnel. Thus the priest was ousted from the aftermath of death in favour of the doctor and grief was treated (in all senses of that word) as a private and segmented emotion.

Prior, *The social organisation of death*.

In this chapter I argue that contemporary understandings of grief and practices associated with death have been shaped by powerful discourses arising largely from medicine and psychoanalysis. I use insights deriving from feminist poststructuralism to deconstruct the way these discourses function, and to detect how the women in this study comply with or strategise to challenge or subvert the hegemony of these dominant knowledge claims.

While the popular models of grieving have emerged predominantly from the psychoanalytic and medical literatures, the sociological and anthropological literatures propose different paradigmatic

understandings to structure understandings of grief and loss. My intention is to briefly outline these alternate and also dominant theories, and their differing ontological assumptions. For example, medical discourse suggests on the one hand, that “the body” is the “site” for understanding and managing grief and death; on the other hand, the sociological view is of grief and death being “socially structured and socially patterned ...[and] controlled and distributed in terms of social ritual” (Prior, 1989, p.134-8). During the discussion I will introduce selected nurse writers to indicate a nursing perspective, and also suggest that nursing has been influenced by the medical/psychodynamic views. Finally, this chapter also introduces key literatures specific to the theme of mother-daughter death.

The medical/psychodynamic paradigm

Buijs (1997) discusses how Dürer’s concept of melancholy “had its roots in antiquity”(p.148). In *The imperfect woman*, Buijs discusses Albrecht Durer’s etching “*Melencolia I*”, dated 1514, as a work that has been given many interpretations over time. However, Buijs’ interest is in the fact that it has been “taken for granted” (p.146) that the presence of melancholy is embodied in, and depicted as, belonging to a woman. She notes that, prior to the writing of Descartes, “physicians and philosophers did not perceive the body and mind as distinct from each other” (p.148). From the turn of this century melancholia became increasingly objectified under the gaze of medicine as a result of “expert” medical knowledge³. It is timely, as we approach the 21st century, to deconstruct prevailing understandings surrounding death and grief, particularly in terms of their medicalisation since the 18th century.

Jackson (1986) writes that the term *melancholia* is derived from a Latin transliteration of a Greek term for a mental disorder “involving prolonged fear and depression” (p.4). This term was in turn “derived

³ See Kuipers (1988) for a discussion on views of language and power in medicine.

from ...[the Greek] *melaina chole*, translated into Latin as *atra bilis* and into English as *black bile*" (Jackson, 1986, p.4). Meyer (1904, cited in Jackson, 1986) attempted to eliminate the term "melancholia" and replace it with the term "depression".

If instead of melancholia, we applied the term depression to the whole class, it would designate in an unassuming way exactly what was meant by the common use of the term melancholia. (p.6 my emphasis)

The view held here is that language can signify something as being universal and stable, as opposed to the postmodern⁴ viewpoint that regards language as socially constructed and culturally variable.

From an ontological perspective, Jackson (1986) suggests that melancholia historically has been viewed as an illness/disease. Causal theories include "demonic possession" or physiological theories which date "back to the humoral theory of the Hippocratic writers and Galen" (p.13). The medical viewpoint was that sadness led up to a pathophysiological state.

Jackson's research indicates that historically "over the centuries fear and sadness" (p.15) were usually the central descriptors of melancholia. Sadness was considered a "cardinal symptom" of melancholia with "tristitia (sadness, sorrow)... [considered] one of the cardinal sins of the Christian church" (p.15). The following quotation indicates how understandings of melancholia have changed throughout the centuries.

Mention of the loss of a loved ones as a possible cause of melancholia became relatively infrequent in eighteenth-century medical writings. But it became somewhat more common in the nineteenth century, periodically being listed as one of the possible precipitating factors in the etiology of melancholia. The twentieth-century medical literature on melancholia and depression has continued this trend of periodic mention of bereavement as

⁴ Harvey (1989, cited in Anderson 1995, p.3) usefully and succinctly summarises postmodernity as derived from a breakdown of the 'Enlightenment project,' which "lasted from the latter part of the eighteenth century until the twentieth [where it was taken] as axiomatic that there was only one possible answer to any question ... This presumed that there existed a single correct mode of representation. ... This was what scientific and mathematical endeavours were all about" (p.4).

one among a number of possible precipitants....The emergence of the twentieth-century category of reactive depression made a nosological home for a substantial number of depressions that occurred in the wake of bereavements, perhaps a higher percentage being classified as pathological than previously as a result of a too inclusive use of the category. (Jackson, 1986, p.320)

Descartes supported a physiological explanation of what he termed “the passions”, and he incorporated the view of the church, that is, its teaching and culture in respect to knowledges regarding the soul, and the viewpoint of medicine, with its focus on disease as located within the body. He located the link between soul and body within the pineal gland, viewing “somatic factors as the root causes of the passions” (Jackson, 1986, p.21). Horsfall (1997) suggests that it is these historically constituted Cartesian dualisms that have “permeated mainstream European sciences and philosophy during the last three centuries... [with] western medicine being marked by the mind-body divide at both epistemological and practice levels” (p.185). Horsfall charges medicine with opting “for materialist ‘explanations’ of psychiatric conditions” and mental health nursing with adhering to these premises (p.185). In the 19th century, grief was understood as related to conditions of the spirit or soul. Whereas, in the 20th century, ‘pathological’ grief has been linked to those who maintain ‘relationships’ with the dead.

The psychoanalytic theories of Freud (1917) and Klein (1940) drew a distinction between what was to be considered ‘normal’ and ‘pathological’ loss. These theories have greatly influenced understandings of grief. However, Freud did not, as is noted in the above discussion, “initiate the practice of differentiating mourning from melancholia...[rather] he went on to ask: ‘With these different conditions being as similar as they are, just what is the nature of the difference?’ ” (Jackson, 1986, p.321). Another key influence was Lindemann (1944) who further reinforced the link to the body in his creation of a ‘symptomatology of grief’. These

theories, which I suggest have influenced how grief has been understood this century, are now briefly outlined together with more recent key writings on grief.

Literatures on grief

Freud's writing on *Mourning and Melancholia* (1917) is one of the earliest theories to detail the phenomena of grief and loss, and to propose a distinction between 'normal' and 'pathological' grief. He described grief as a process whereby the individual gradually withdraws the energy that ties them to the deceased person, lost object or ideal. Freud (1917) states that

...mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one such as ...an ideal, or so on. In some people the same influences produce melancholia instead of mourning and we consequently suspect them of a pathological disposition. (p.243)

Grief is viewed as a normal reaction that involves withdrawal of ties towards the deceased person, a process Freud termed "decathexis". In mourning, the ego initially resists withdrawal from the deceased through denial and is preoccupied with, and searching for, the lost object. Later, having worked through the process of "decathexis," the mourner is able to invest energy into other relationships. Freud (1917/57) claims that, in this instance, the "work of mourning is completed [and] the ego becomes free and uninhibited again" (p.245). Freud identified that, in mourning, "it is the world which has become poor and empty" whereas, "in melancholia it is the ego itself...[which is] poor and empty" (p.246). Indeed, Freud utilises the medical metaphor of an "open wound" when he locates the problem of melancholia in the body (p.253). His theory incorporates the need to understand the unconscious processes, and the place of desire which, he suggests, is constructed by the unconscious.

Silverman & Klass (1996) suggest that Freud is theorising here not about adult bereavement, but about the child and its separation from its

Oedipal love object, “the parent” (p.5). Their interpretation of Freud’s 1917 work is that it relates to mourning for lost oedipal relations rather than relating to death.

He theorised that grief is different from depression in that he thought depression is caused by internalizing the parent, who then remains as a critical voice in the ego ideal. Grief, as Freud saw it, frees the ego from the attachment to the deceased: “When the work of mourning is completed the ego becomes free and uninhibited again” (1917/196a, p.245). Freud never applied this theory to cases of grief after a significant death. (p.5)

In my reading this viewpoint is rarely put forward, yet it helps to explain Freud’s later comments on his own personal bereavements when he emphasised the “inconsolable” nature of loss in death. Freud (1929/1961), reflecting on the death of his 27 year old daughter Sophia in 1920, wrote to Binswanger, a Swiss psychiatrist, the following comment:

Although we know that after such a loss the acute stage of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. (p.386)

Jackson (1986) notes that, following *Mourning and Melancholia*, the subsequent focus of any following publications tended to be directed “at melancholia and clinical depression” (p.322), the ‘pathology’ of illness/disease, and the need for treatment. Horacek (1991) claims that it is from Freud’s seminal work on grief that most of the theories on grief are derived.

Silverman & Klass (1996) assert that psychoanalysts this century have considered that the bereaved need to disengage from loved ones. Jackson (1957, cited in Silverman & Klass, 1996) viewed the maintenance of ties with the deceased as “a form of regression and psychological incorporation that should be discounted and discouraged. Regression is not cured by accepting it. It must be actively opposed, for it becomes worse if it is encouraged” (p.65). Silverman & Klass (1996) argue that psychoanalysts failed to examine their data regarding the

maintenance of bonds with the dead. Rather, they viewed the “internalising of the dead” as a beginning stage before “letting go” (p.8).

Klein’s (1940) work is important for two reasons. Firstly, as Kahane (1992) writes, although Klein was a one-time disciple of Freud, she re-defined Freud’s drive theory by suggesting the mother as the “central figure” (p.285). The theorists of that time focused on centralising and privileging “the maternal object as central to the vicissitudes of the developing self... [offering] an alternative paradigm to the Freudian Oedipus complex with its emphasis on the father, the Phallus and castration” (p.284). Klein focused on “the work” of mourning, viewing the “depressive position” as associated with the child’s difficulty over weaning (p.153). Secondly, as Prior (1989) suggests, Klein reinforced the medical paradigm by viewing grief as a pathological state that reflects or “apes the manic-depressive state” (p.134).

Klein (1940) proposes that “the child goes through states of mind comparable to the mourning of the adult, or rather that this early mourning is revived whenever grief is experienced in later life” (p.153). Klein’s interest was in how children understood objects (people) in relation to each other. Middleton, Raphael, Martinek and Misso (1993) support the view that Klein considered people who suffered pathological grief as having “never successfully overcome the infantile depressive position or established a good object relationship that would allow them to feel secure within their inner world” (p.46). Craib (1994) suggests that, for Klein, the loss of the parent represented a threat to the “good internal objects which we had been able to make of our parents” (p.17).

In her original paper on *Mourning and its relation to manic-depressive states*, Klein (1940) claims:

The fundamental difference between normal mourning on the one hand, and abnormal mourning and manic-depressive states, on the other, is this. ... that they [the person who fails in the work of mourning] have been unable in early childhood to establish their internal ‘good’ objects and to feel secure in their inner world. ... In normal mourning, however, the early depressive

position, which had become revived through the loss of the loved object, becomes modified again. (p.153)

Freud's work is considered to have influenced Lindemann (1944) to write what is now considered a classic paper on grief. Prior (1989) writes that Lindemann was the first person to "place the study of grief on an empirical footing, and the first to establish a symptomatology of grief" (p.135). Lindemann, a physician working in the psychoanalytic tradition, identified, in a seminal paper entitled *Symptomatology and Management of Acute Grief* (1944), the pathognomonic characteristics of grief as somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions and loss of habitual patterns of conduct. He describes, as Freud does, a pattern of grief that includes shock and disbelief, acute mourning, and resolution. Lindemann links the physiological nature of the grief experience to psychological manifestations of loss and, in doing this, he seeks to reduce grief to a somatic state.

According to Horacek (1991), Freud and Lindemann share two key assumptions regarding the grief process, namely that "grieving is time limited or time bounded, [and that] ...one of the main tasks of grieving is to achieve decathexis" (p.461). Horacek challenges these assumptions. His major objection relates to the concept of 'task completion' within a certain time frame in order to achieve 'decathexis' following the grief experience. Silverman and Klass (1996) suggest that Freud never applied his theory on *Mourning and Melancholia* "to grief after a significant death" (p.5). Yet, whilst grief theory was not central to Freud's writing, the thesis of *Mourning and Melancholia* has impacted significantly on the writings of Lindemann (1944), Parkes (1986), Bowlby (1971), and Raphael (1984), all prominent grief theorists who view the grief process as time limited.

To conceptualise the grief process as continuing, and not time bound, is to challenge the premises of these prominent theorists, and others like

Volkan (1981), Parkes (1986), and Worden (1982). For Horacek (1991), the question is: Should the inability to recover to a state of one's former self be considered as 'maladaptive', 'complicated' or 'pathological' grief? Silverman and Klass (1996, p.4) cite a number of theorists who maintain that disengagement "*is*" necessary, including some who suggest that failure to disengage leads to psychological problems: Abraham (1927); Clayton, Desmarais, & Winokur (1986); Edelstein (1984); Furman, (1984); Hofer (1984); Peppers & Knapp (1980); Pollock (1975); Rando (1986); Sanders (1989); Weizman & Kamm (1985); Dietrich and Shabad (1989); Horowitz, Wilner, Marmor, & Krupnick (1980); Jackson (1957); Miller (1971).

Horacek (1991) argues that models suggesting disengagement "fall short of explaining realistically the complicated reality of mourning" (p.470). His interest in "high-grief-death mourning", a term that refers to the death of a significant person, is important in the light of recent writings on the mother-daughter relationship e.g. Ainley (1994); McLoughlin (1994); Edelman (1994); and Harris, (1995). These authors all indicate that grief related to the death of a mother is far from ever finished with, and that the 'reality' of grief is complex. Ironside (1996), writing on bereavement, also challenges the commonly held belief that exists within medicine that "good grief" involves disengagement and getting on with your life.

However, current thinking by contemporary grief theorists suggests that mourning is finished when the tasks of mourning are accomplished. Worden (1982) states that this is when the bereaved "adjust to an environment in which the deceased is missing [and]...withdraw emotional energy and reinvest in another relationship" (p.14-15). This viewpoint appears to be derived from Freud's (1917) view that "mourning has a quite precise psychical task to perform: its function is to detach the survivors' memories and hopes from the dead" (p.65). Worden (1982) does revise this position but the implication is that the deceased person has to be "relocated" in order to develop other relationships.

Worden asserts that he would be “suspicious of any full resolution that takes under a year and, for many, two years is not too long” (p.16). Pathology is clearly attached to the concept of maintaining a relationship with the deceased. Success for Worden relates to one reinvesting into life and living; there is little place for the dead. According to Horacek (1991), these assumptions are “flawed” and fail to explain “realistically the complicated reality of mourning” (p.471).

The psychiatrist Colin Murray Parkes (1965, 1975) viewed grief as a mental disorder, and utilised the developmental metaphor to describe the grief process. Hockey (1997) quotes Bowlby (1981), another theorist who has written extensively on attachment and loss, as saying Parkes is “giving an authoritative description of what today we believe we know about grieving in both its healthy and less healthy forms [writing which] ...was legitimated by its grounding within scientific, medical discourse” (p.95). Hockey (1997) is one of many researchers today who challenge the categorisation of grief as either ‘healthy’ or ‘pathological’. She expresses concern over the ‘psychiatrisation’ of loss (p.97). Prior (1989) supports this viewpoint when he argues that Parkes utilises a disease model to describe the experience of grief, and he cites Parkes’ (1965) statement that:

... grief is a mental disorder there can be no doubt, since it is associated with all the discomfort and loss of function which characterises such disorders. (p.1)

This is in contrast to Parkes’ (1975) later claim that:

On the whole, grief resembles a physical injury more closely than any other type of illness... But occasionally... abnormal forms arise, which may even be complicated by the onset of other types of illness. (p.19)

Here Parkes metaphorically likens ‘normal’ grief, as did Freud (1957/1917), to physical injury.

Kerr (1994) cites the findings by Horowitz et al. (1981) that, among grieving adults presenting for therapy, 90% indicated depression was an issue. Kerr suggests these findings indicate “the serious nature of

potential bereavement outcomes” (p.348). Equally, the findings could indicate how individuals are socially constituted. This is more fully explained in Chapter Four, but suffice to say here that I am suggesting it is equally possible that understandings of depression can be viewed as historically and culturally relative and in part constructed through language (Foucault, 1978; Weedon, 1987; Hollway, 1989).

Kübler-Ross (1969) suggests that ‘grief’ be can be understood through her concept of stages. Her book *On death and dying* has had a significant impact within the western world, and has become a classic work on the care of the dying. Daily Camera, an American paper, on August 18, 1981 stated that Kubler-Ross’ book “initiated the revolution in our society’s handling of the terminally ill - a revolution that has lifted old taboos ...Her work has generated hundreds of hospices for the terminally ill, 125,000 courses in death and dying in the U.S. alone, and a workshop/lecture schedule that keeps her travelling a quarter-million miles a year” (p.8). Kübler-Ross’ major contribution, I suggest, has been in her creation of dialogue about death and dying, particularly at the lay or non professional level. Her work, whilst severely critiqued by Moller (1996), is still exceedingly well known and used, especially amongst nurses, doctors and social workers⁵. Moller suggests that her writings and lectures have “assumed the status of modern thanatological commandments” (p.61). Her theoretical framework proposes five psychological stages of dying: denial, anger, bargaining, depression and acceptance. These stages may be progressed through until the stage of acceptance is achieved. Kübler-Ross did not view these stages as purely linear, although many view them in this way.

John Bowlby’s (1961,1971, 1975, &1980) work has also been influential in ‘western’ thinking, particularly his theory of attachment and loss. Bowlby supports the concept of severing bonds, conceptualising grief as a

form of separation anxiety. In his numerous books and papers on attachment and loss he, like Kübler-Ross, considers that there are phases to be worked through, from protest to despair. His work has greatly influenced the writing and practice of Beverley Raphael (1984) who, when writing about the absence of a loved one, states:

...the environment is scanned, and the bereaved also searches, as it were, for the lost object... There is an expectant set looking for the return of the absent person. Thus the bereaved may believe he hears the return at a familiar time, sees the face in a familiar place, feels the touch of a body, smells a familiar perfume, or hears a familiar sound. These perceptual misinterpretations reflect the intense longing and, like dreams, are a source of wish fulfillment. (p.40)

Raphael goes on to suggest that, when efforts to “restore the bond fail”, the searching behaviours become extinguished and, as Bowlby suggests, the behaviour remains latent, but “constantly primed” (p.69). Raphael goes on to say that

...it may be in some instances the relationship persists in altered form in fantasy... and this for some may be the preferred solution. In others it may be that the chronic stress or distress persists, leading to ill health. (p.69)

Raphael does not say that there is no place for fantasy. She does, however, suggest that this behaviour could lead to “chronic stress and distress” (p.69). Silverman and Klass (1996) say that Raphael views any interaction with the deceased as an “hallucination”, claiming that “for her fantasy serves no purpose except to shield the person from reality” (p.13). The issue of importance is the categorising and pathologising of this type of experience. In her aptly named book *The Anatomy of Bereavement*, Raphael (1984) outlines the risk of “pathology” in adult child-parent relationships.

⁵ See Downe-Wamboldt & Tamlyn (1997) who found, in their research on international trends in teaching on death education, that despite recent criticism of Kubler-Ross’s model she was the most frequently used theorist.

Pathological adult partnerships, such as the intense symbiotic closeness that develops between adult children and a parent, are likely to lead to a major and often pathological pattern of grief and mourning... Depressive illness is common following such bereavements, indicating a need to consider this group at high risk. (p.227)

Raphael goes on to assert that the “key issue for the individual, and indeed *his* society, is to learn to bear the pain of loss that must inevitably be faced; to keep *his* passionate involvement in humanity and human relationships” (p.405, my emphasis).

According to Raphael there are ‘rules’ of ‘good’ bereavement, and she writes of the need for therapists:

*To facilitate and consolidate a satisfactorily resolving bereavement;
To provide a framework for specific preventive intervention with bereaved who are at a high risk of malresolution;
To provide a framework for specific intervention with pathological bereavements so that these may possibly be diverted to a more adaptive course. (p.367)*

These ‘rules’ constitute the subject position of the ‘good griever’. This position, I suggest, is created by, and results from, ‘western’ individualism and current management ideology. In this discourse ‘the problem’ is ‘the body’, and any malfunctioning needs to be identified (diagnosed) and rectified by appropriate ‘management’ objectives to overcome the problem.

Doka (1995) adds to the knowledges on grief in his depiction of the concept of rules of grief. He suggests that societies have “sets of norms - in effect, ‘grieving rules’ - that attempt to specify who, when, where, how, how long, and for whom people should grieve” (p.217). His interest is in the nature of disenfranchised grief. Doka suggests that grief pertaining to the parental relationship is “socially recognised and sanctioned” (p.216). This assumption appears to assume that there is no silencing or expected curtailment of mother-daughter grief within

society. There is no support in this research for the viewpoint that mother-daughter grief is well sanctioned or understood.

Strobe, Gergen, Gergen, and Strobe (1996) claim that, in modernity, a breaking of bonds with the deceased is required. They challenge the assumptions surrounding universalising theories on grief, suggesting that there is doubt about mental health treatment programmes that hold to universalising ideologies, as does Foucault (1965). Averill and Nunley (1993) challenge the conception of grief as a disease, and the need for decathexis. I suggest that, within modernism, the epistemologies that discursively site death as within the body create tensions that appear to be related to the disenfranchisement of the 'social' loss. This post-modern critique of the use of universalising theories is supported by Badinter (1980) who, in the area of mother-child relationships and bonding, demonstrates how sentiment surrounding the relationship is socially and historically constituted.

Craib (1994) maintains that medicine has gone about its work of systematically analysing and classifying grief as an illness. He indicates that 'medicine' has an historical advantage in that it already had control over 'the body', and death. Using a Foucauldian perspective⁶, Craib suggests this makes medicine's association with, and control over, grief management and psychoanalysis appear 'normal'. He asserts that, in accomplishing this, medicine has added to the orbit of its achievements and professional power. Craib also makes an important point in suggesting that this argument has both a "dark side and a light side" (p.20). He acknowledges the genuine concern of the profession for the individuals concerned, yet suggests that the answer lies:

...less in the development of knowledge than in the development of professional boundaries and the need for the profession to carve out areas of expertise for themselves. As medicine extends its effectiveness over already recognised pathologies, it moves on to 'pathologising' new areas

⁶ The relationship of Michel Foucault's work to this study is explained in Chapter Four.

that were not generally recognised as problematic. ... where do we draw the line - do all losses involve mental illness? (p.21)

Craib challenges the modernist concept of 'good grief'⁷, suggesting that we fail to deal with, or acknowledge, the importance of disappointment and death in our lives. He suggests that health professionals "tame" and manage grief, and that therapists today have:

... a clear idea of what grieving involves and what the patient should be doing The standards of identifying pathological mourning are external, not a perception of the individual mourner, and to move towards 'functional impairment' as a criterion gives everything over to the rapidly changing society that creates the intensified problem of grief in the first place. (p.25)

The subject positions that are available for the bereaved to take up depend on societal views surrounding death and grief. Lofland (1978) critiques the medical profession's influence over the dying. She identifies the factors that shape the dying process, including: a high level of medical technology; early disease detection; a complex definition of death; and active intervention into the dying process, all of which can lead to the prolongation of the dying process. These factors are so prevalent within secular discourse now that it is possible to see how 'we' have created a sequestration of death (Mellor & Shilling, 1993). Davies (1991) points out the power of such discourses on the individual:

One can only ever be what the various discourses make possible, and one's being shifts with the various discourses through which one is spoken into existence. The individual or heroic "I" is understood as a discursive construction, not stemming from the particular characteristics of that person but from the subject positions made available to her/him. (p.43)

The basis of nursing practice involves respect for, as well as a belief in, the importance of incorporating the individual's perspective (subjectivities) into the nursing practice partnership. Despite this philosophical stance within nursing, there is little written by nurses on

⁷ See Staudacher (1987); Ward (1993) and Lee (1994).

death and grief, which is surprising given our major involvement in supporting both individuals and families during the dying process. There is virtually no critique of the biomedical depiction of 'grief', despite the fact that nurses purport to not subscribe to the medical model. It is possible that, by default, 'we' in nursing support the production of certain understandings surrounding grief, and its management, thereby excluding other possibilities.

Downe-Wamboldt and Tamlyn (1997), in an international survey of death education in faculties of nursing and medicine, argue that knowledges surrounding death education are accessed primarily from within the medical paradigm. Their research supports my perception as a nurse educator within New Zealand. I have come to the realisation that much of what I have taught is reductionist and has been primarily sited within the medical paradigm.

Lawler (1991) identifies the privatisation and sequestration of death as problematic for nursing. She notes that, as a result, the work of nurses is "privatised and removed from public view" (p.193). This position, she suggests, helps neither the nurse or the dying patient. Her research indicated that nurses have "fears and uncertainties about death" and that nurses themselves reflect the silence surrounding "death, dying, and the dead body....areas which are not often discussed in our culture" (p.192). Lawler found no generalised pattern of understanding about dying in her research on "the body" other than to suggest that death is a time "when it is not appropriate to be anything other than serious and dignified" in the care of the dying person (p.192). Lawler's research supports my belief that there is a need in nursing for research on and about death, and that current understandings about death need to be deconstructed.

This viewpoint is supported by Horsfall (1994), one of the few nurses who has worked to deconstruct and destabilise concepts surrounding "depression", a 'condition' which has influenced and impacted on current

understandings of grief. Horsfall (1997) links the diagnosis of "depression" to societal views that prize independence and the maintenance of function. She asserts that "westerns society forbids misery, sloth, tiredness and the [recognition of the] reality of our inevitable death" (p.177). Her research deconstructs how depression has become pathologised and casts appropriate doubt on the viewpoint that depression can be reduced to a "medical description or reductivist symptoms" (p.178). For example, in understanding grief, within the affective domain, 'depression', 'sorrow', and 'sadness' are used in reference to the grieving person by: Horowitz et al, (1981); Carter (1989); Cowles & Rodgers (1991); Kimble (1991); Horacek (1991); and Parkes (1972). Horsfall (1997) cites the American Psychiatric Association's (1994) diagnostic criteria that state that "depression includes lowered mood, diminished pleasure, insomnia, slow movements, fatigue, guilty beliefs, difficulty in concentration and thoughts of death" (p.177). Hoagland (1983) suggests that the descriptors of grief actually mimic those of depression, while Horsfall (1997) asserts that the problem lies in "epistemologically uncoupl(ing)" and abstracting the experience from the individual's "interpersonal, political, economic and ecological milieu" (p.195).

Another nurse, Kerr (1994), researched the meanings that adult daughters attach to the death of a parent. Her research places an emphasis on the social and relational dimension of grief. She was interested in how meaning might influence the duration of grief. This is the only major research undertaken by a nurse on mother-daughter grief that I have been able to locate in nursing literature searches using the keyword 'daughters'. Kerr explored daughters' perceptions of their parent's death, their lifelong parent-daughter relationship, and the life changes that occurred after the death. She suggests that little is known about the adult reaction to parental death, and that a reason for this may be that parental death might be viewed as "ordinary" or "natural". She also cites Katzenbaum's (1977) research which indicates that

“prolonged grief is neither expected or encouraged” in western society. Kerr recommended that “the subjective experience of grief may be an important area for further research as well as for assessment and intervention” (p.347).

Graham (1995), a New Zealand nurse, utilised grounded theory to analyse letters and responses from women contacted through two New Zealand women’s magazines. She suggests that daughters considered that there was a gender differentiation in how their mothers viewed them. Sons were regarded as “other” and differentiated, whereas mothers were said to “relive, through their daughters both their own childhood and their own mother’s identity” (p.14). She identifies themes of caring, guilt and loss as key issues, and discusses the dangers of nurses making assumptions about mother-daughter relationships. Graham also refers to the mothering “tasks” that daughters experience as having been lost to them following their mothers’ death.

Literatures on the death of a mother

The literatures related to the death of the mother are few. De Beauvoir’s (1969/1983) book entitled *A Very Easy Death* is a moving account of her relationship with her mother. De Beauvoir’s writing highlights a need to understand more fully the primacy of the mother-daughter relationship - the psychical link between mother and daughter. Although De Beauvoir says she was not close to her mother, she gives a powerful account of her death. She states that when her father died she did not cry at all, and tells her sister:

It will be the same for Maman. (p.28)

And yet following her mother’s death she writes:

I had understood all my sorrows until that night: even when they flowed over my head I recognized myself in them. This time my despair escaped from my control: someone other than myself was weeping in me. (p.28)

De Beauvoir's poignant writing suggests something of the uniqueness and nature of the mother-daughter relationship within the western world.

In 1990, Martha Robbins claimed that no systematic study had been undertaken to explore the mother-daughter relationship from the perspective of a daughter's experience of her mother's death. This absence in the literature is, in itself, a topic worthy of investigation. Robbins researched the effect of the death of the mother from a psychodynamic, constructive-developmental and family system perspective. She cites Loewenstein's (1981) and De Beauvoir's (1983) writing as the only personal accounts of the death of the mother that were available. Robbins (1990) found to her surprise that the women experienced more grief over "the *lives* of their mothers than their actual deaths" (p.150). She suggests that there are two layers to the mourning process. The first involves the daughters grieving over the "actual" death of the mother, the second is related to "the women's sense of self-in-relation to mother, world, and God that coalesced in their myths of motherhood" (p.150).

The grief of the women Robbins interviewed was also influenced by the absence of "maternal thinking" in the personal, socio-political and religious dimensions of the women's lives. Robbins defined the daughter's experience of grief as being multidimensional, intergenerational and transgenerational in respect to mourning.

In coming to terms with their grief over their mothers' lives, what they could have been, and the effect this had on their own lives, many women had to come to terms with the patriarchal context of their mothers' lives and the changing cultural perceptions of the identity and roles of women... Many of the women felt that they did not really know their mothers, or knowing them, devalued their lives as they judged them by their own culturally influenced perceptions of what it is to be an effective woman today (p.156-157).

Robbins' research contributes to an understanding of the grief within the mother-daughter relationship, in that she considers the issue of culture

and intergenerational grief that is carried by daughters, and the dialectic that surrounds understandings of “self and society” (p.157).

My understanding is that Popek and Scharlach (1991), like Kerr (1994), found a ‘direct’ link between the daughters’ grieving and the quality of relationship they had with their mother in life. When grief relationships remain unresolved between one to five years after the mother’s death, the relationships were likely to have been “ambivalent, conflictual, or emotionally distant” relationships in life (Popek and Scharlach, p.79). They suggest their findings “provide new evidence of the important influence that mother-daughter relationships have throughout women’s lives” (p.79). Kerr (1994), on the other hand, reports the opposite effect, namely that women whose grief lasted less than a year describe a negative parent-daughter relationship, whereas the women who “described a positive parent-daughter relationship ...described grief enduring as long as 3 years after the parent’s death” (p.357). A major issue in both of these studies is the definition of grief. Cowles (1994b) questions Kerr’s concept of “duration of grief”, and Kerr’s response is that:

...it was the respondents themselves who decided whether they had accepted their parents’ death or whether they were still continuing to grieve... understanding how grief may be differentiated from periodic painful memories may require observation and data collection over a prolonged period of time. (p.365)

This issue is important because it relates to the historical universalisation of the definition of grief using what I have previously suggested is an historically male standard. Elizabeth Grosz (1990) suggests that, although women have sexual equality, the male standard remains the norm to which women should aspire. Since Freud, writings which encompass medical and psychoanalytic theory have entrenched within them a patriarchal ideology which defines the boundaries of what is acceptable behaviour for women.

Ainley (1994) and Edelman (1995) have both written books for ‘motherless daughters’ with the intention of bringing out into the open

issues of loss that needed to be acknowledged. They both recognise that the death of the mother is one of the most profound experiences in a woman's life, and they note particularly the issues and grief for women who experience this bereavement in their youth.

Literatures from social sciences and humanities

Mourning is not a natural movement of private feelings wounded by a cruel loss; it is a duty imposed by the group. One weeps, not simply because one is sad, but because one is forced to weep.

Durkheim, 1915.

I have chosen selected literatures from sociology, anthropology, and history to expand the discussion on grief because of their different paradigmatic understandings of grief and loss. These traditions have not been well utilised as a resource for either nursing or medicine. This lack of consideration of alternative traditions has, in effect, supported the pathologising of grief. The sociological and anthropological literatures tend to support the viewpoint that the 'social' environment is the determinant of sentiment. Grief is not viewed as a unique experience, but rather as a phenomenon that is constituted through 'the group'.

Prior (1989) writes of the debt owed to the sociologists David Emile Durkheim, Marcel Mauss, and Robert Hertz for their life long critique of the primacy of biology. These researchers proffer the idea that grief, mourning and death are essentially social processes. Durkheim (1915) defines mourning as "not the spontaneous expression of individual emotions", but rather that mourning is a social obligation "sanctioned by mythical and social" responsibilities or penalties (p.397)⁸. Hertz (1960), following on from Durkheim, suggested that the body was influenced by

⁸ This viewpoint is also made by Hockey (1997) and Hallum (1997).

culture. In his writing of *Death and the right hand*, Hertz suggested that the pre-eminence of right handedness helped support a belief in dualistic thinking. He saw the “preponderance of the right hand [as] obligatory, imposed by coercion, and guaranteed by sanctions” (p.93). Hertz proposed that it was from this type of thinking that order and superiority became imposed. The left hand represented that which was female, profane and impure, whilst the right hand represented the male, the sacred and the pure⁹. Interestingly, the majority of the ethnographic facts on which Hertz’s well cited research is based, were gathered in 1895 and the early 1900’s by Best, an ethnographer researching in New Zealand amongst the Tuhoe Maori (p.155). A current notion at that time was “that the right is the ‘side of life (and of strength)’ while the left is the ‘side of death’ (and of weakness)” (p.101).

Prior (1989) cites the research of Hertz (1960) and Levi-Strauss (1969) to support the view that “grief is distributed and redistributed according to social principles” (p.133). Of significance is Prior’s view that, whilst these claims were developed within social anthropology, they were not considered within medicine.

... during the 20th century, they [the claims] were absolutely and entirely ignored by those who studied the manifestations of grief in western cultures – a study which ... fell under the control of a normalising psychology ... grief and sorrow were normalised and medicalised during the 20th century. (p.133)

Prior cites Wilson’s (1957) study of the Nyakyusa which indicated ways in which their grief practices were dependent on a socially constructed formula; thus supporting Durkheim’s thesis that “normality” was both socially imposed and an obligation. “Broadly speaking ‘the women wail and the men dance’, and the funerary ritual emphasised male strength against female fear and trembling” (p.139). Prior also cites the research on the Lo Dagaa tribe in West Africa by Goody (1962), noting that they

⁹ See Hertz (1960), pages 99-113.

“display no public grief at the death of an unweaned child, for it is not yet accorded human status” (p.139). In this instance certain types of grieving responses such as crying are considered inappropriate as the child is not considered to have a soul. Thus, sentiment can be viewed as being shaped by gender, ethnicity, position in society, and the belief systems about life and social status.

Bauman (1992b) deconstructs understandings surrounding death in a way which explains, in part, some of the difficulty the women in this study expressed in relation to ‘silencing’, or to the absence of talk about death. He suggests some possibilities as to why death remains a difficult and, for many, a ‘taboo’ subject, and focuses on the problem we have in perceiving and representing death.

Death is the absolute other of being, an unimaginable other, hovering beyond the reach of communication; whenever being speaks of that other, it finds itself speaking, through a negative metaphor of itself... Death cannot be perceived; still less ... ‘represented’. (p.2)

Bauman proposes that one modern strategy for understanding mortality focuses on “survival”.

The first activity of culture relates to survival - pushing back the moment of death, extending the life-span, increasing life expectation and thus life's content-absorbing capacity; making death a matter of concern, a significant event - lifting the event of death above the level of the mundane, the ordinary, the natural; directly or indirectly (yet still more importantly), making the job of death somewhat more difficult. (p.6)

Bauman goes on to argue that:

... there is hardly a thought more offensive than that of death ... After all this part of our knowledge defies radically and irrevocably, our intellectual faculties. Death is the ultimate defeat of reason, since reason cannot ‘think’ death. (p.12)

Bauman's second strategy relates to “immortality”, which involves “denying the moment of death its final say, and thus taking off some of its sinister and horrifying significance” (p.6). The post-modern strategy,

Bauman suggests, involves various “techniques of exorcism” (p.173). The two techniques he outlines are of “crossing that bridge once we come to it” (p.173) and yet, expecting to postpone the time of crossing. He gives the current interest in *cryonics* as an example of this type of hope. According to Bauman, the more favoured approach is to make life a game of constant bridge-crossing.

All bridges seem by and large alike, all are - comfortably - part of one's daily itinerary, so that no bridge seems to look ominously as the 'ultimate' one. (p.173)

Thus, no loss is irretrievable and immortality itself can become mortal.

Aries (1981), a French scholar-historian, reviewed a thousand year landscape of documented studies on death. He considered that in the middle ages death was “tamed” because death was very much part of community life. Until the twentieth century, death was “a public event” that literally and figuratively involved society as a whole, whereas today “society...no longer observes a pause; the disappearance of an individual no longer affects its continuity” (Aries, 1981, p.560). Aries categorised the death experience as either: tame, remote, invisible or, in its later evolution, that which occurs to “the other”. He also maintains that religious discourse has changed in accordance with societal change. For example, following Vatican 11 the Catholic church “changed the traditional name of ‘Extreme Unction’ to the ‘Anointing of the Sick’” (Aries, 1981, p.563). This action, he suggests, forms part of the west’s denial of death, and has links to the subsequent empowerment of the medical profession. Thus, death now becomes isolated within the confines of hospital or laboratory.

Badinter (1980) reviews the place of the child within the ‘modern family’. She attributes to Jean-Jacques Rousseau, in his 1762 publication of *Emile*, the ideas that “launched the [concept of] the modern family—the family founded on mother love” (p.30). Badinter demonstrates how, as a result of changing discourses, there has been a change in how mothers are regarded and how they relate to their children. Previously, there

were clear indications about how “little the child counted within the family circle....At best, the child was unimportant. At worst, he aroused fear” (p.30). Badinter outlines how “the power of the father was far stronger than the power of love. The reason for this was simple: The entire society was based on the principle of authority” (p.8). According to Badinter, prior to this the three powerful voices of Aristotle, the church and politics had combined to support the authority of the father.

Aristotle ...demonstrated that authority was natural; theology, ...affirmed that authority was divine; and finally the political theorists, ... used both arguments at the same time... According to Aristotle, woman lacked ontological character; the theologians made her into an evil creature, or at best a frail being. Men would remember this lesson well into the twentieth century. (p.8-14)

Badinter describes how, over time, the mother became responsible for the care of the child, and how Rousseau and his successors had a powerful discursive influence in creating advocacy for the child. Relationships moved from the power of the father over the wife, to a new social reality, a triangular relationship that included the child.

However, Badinter also argues, as a result of her historical research, that mother love is more than a “natural and spontaneous” (p.64) sentiment. She outlines how the giving of love was “selective”, and cites the example of French law wherein the eldest son was privileged, and as a result “became the object of an exemplary concern” (p.65). Daughters were not considered “profitable”, and she suggests that “no special sympathy seems to have developed between the typical mother and daughter” (p.65). So, if Badinter’s research proves that ‘natural’ mother love does not exist for all children, and mother love is therefore a social construction, then it seems reasonable to expect that the nature of the relationship between mother and daughter will be influenced by the context in which it occurs.

In this chapter I have suggested that the trend for over the past 100 years has been toward a 'normalisation' and medicalisation of grief. The metaphor of the 'diseased body' as appropriate for understanding the management of grief is one which extends back to the Hippocratic writings on humoral theory, to modern beliefs about depression (Horsfall, 1997) and 'pathological grief' (Raphael, 1984). The following chapter outlines how differing understandings on relationship, grief and death are now subverting these hegemonic literatures.

CHAPTER THREE

FEMINIST CRITIQUE OF THE MOTHER DAUGHTER RELATIONSHIP AND CHALLENGES TO THE MEDICAL DISCOURSE ON GRIEF AND DEATH

We need to know how not to know - how to avoid getting closed in by knowledge, knowing how to not understand, while never being on the side of ignorance. It is not a question of not having understood everything, but of not letting oneself get locked into comprehension.

Cixous, *Seminars*.

In this chapter I begin by exploring selected writings by key feminists on the mother-daughter relationship, its nature, development and cessation. I then move to a discussion of the works of selected writers who critique and challenge the dominant discourses which, shaped by a commitment to a positivist ontology, have shaped medical understandings of grief and death for the past 100 years.

Feminist critique of the mother-child relationship, and its cessation

Feminist literatures advocate difference and plurality, and challenge the dominance of "materialist theoretical perspectives, focusing in their

place on processes of symbolization and representation” (Kemp and Squires, 1997, p.7). As suggested by Cixous in the above quote there is a danger in accepting, or, in her words, being “closed in” or “locked in” by certain knowledges and understandings.

Within the last two decades of feminist thought, “disciplinary divisions” have crumbled and there has been a looking to other paradigms which better support feminist understandings. According to Kemp and Squires (1997), there has been an incorporation into “the tools” within feminist thinking of “Derridian deconstructive reading, Lacanian psychoanalysis, and Foucauldian discourses of power and corporeality” (p.8). In particular, feminist writers on grief, such as Cline (1995) and Hockey (1997), challenge the current theories of bereavement and suggest they fail to consider the sexual politics surrounding understandings of death and grief. Hockey describes current cultural representations of grieving women as being universalised, gendered, and “stereotypical” (p.98). She found little published research on western women’s actual experience of grief. She challenges the way in which women’s grief is depicted through the media, and the “significance of such representations for the female rather than the male viewer” (p.106). “True femininity” is depicted as requiring “emotional expressiveness”, compared with the masculine opposite of “rationality and emotional” control (p.90). Hockey argues that, in practice, women who grieve overtly “contravene the requirements of male-controlled funeral behaviour” (p.105). She cites from the data in her 1993 research on the need to present an “acceptable face” when grieving:

...one girl started crying and the girl next to her started crying and by the time I'd finished I was dealing with this hysterical crowd of girls ...and so I really had to sort of say 'That's it. No more of this. This is silly. And I really had to do that, which is not exactly how you like to do a funeral ...you just have to be the big, brave, nasty horrible vicar who ...and stop it.
(p.143)

Other researchers who have commented on the lack of attention given to understanding the grief experience surrounding the death of the mother are: Rich (1976); Douglas (1990-91); Moss and Moss (1983-4); Dane (1989); Robins (1990); Kerr (1994) and Edelman (1994). Given the centrality of the mother in child care and child raising within the western world, this absence of representation is concerning. Perhaps we have been 'locked in' to the popular knowledges and stereotypes.

Feminists have revitalised thinking about the worth of the mother-daughter relationship, pointing to the politics of silencing that has existed about this, a silence seen also in the traditional medical theories of grief. In her book *Of Women Born* (1977), Rich drew attention to the silence that surrounds the mother-daughter relationship. She wrote that the "cathexis between mother and daughter - essential, distorted, misused - is the greatest unwritten story" (p.225). In describing the intensity of the mother-daughter relationship, she suggests that "there is nothing in human nature more resonant with charges than the flow of energy between two biologically alike bodies, one of which has lain in amniotic bliss inside the other, one of which has laboured to give birth to the other" (p.225-6).

Rich compares the diminution of the mother-daughter relationship, through silence, with the texts on the "eternal" mother-son dyad - a relationship that is written of in theological doctrine, psychoanalytic theory, art, and social theory. She claims that, regardless of gender, "most of us first know love and disappointment, power and tenderness, in the person of a woman ... [and that] we carry the imprint of this experience for life, even into our dying" (p.11). Rich accounts for the diminution of the mother-daughter relationship primarily because of the processes of patriarchy, institutionalized heterosexuality, and motherhood. She suggests that, for daughters to become 'normal' women, they must direct their "most intense psychic and physical energies ...towards men" (p.219). This silence, which Rich wrote of twenty years ago, is now being broken.

Psychoanalytic writing has made a significant contribution to the knowledges surrounding the mother-daughter relationship. Hirsch (1981) writes of the beginning proliferation of knowledges about the relationship, claiming that current writing was documenting it “from its most personal resonances to its most abstract implications” (p.201). These new insights on silencing have been further developed by detailed analyses of mother-daughter relationships undertaken by women primarily working within the field of psychoanalysis. Hirsch identified three trends which have emerged within psychoanalytic theory since the 1960s that are still relevant today. The first draws on the Freudian oedipal paradigm and neo-Freudian theory, particularly that of object-relations psychology. The second trend is the growth in Jungian studies that consider the archetypal images of the mother and daughter. The third emergent trend is the theoretical contribution of French feminists such as Irigaray, Kristeva and Cixous who have challenged concepts of the “sameness and unity of the symbolic order that has excluded women, [after having worked to redefine the individual subject and create] a discourse of plurality” (Hirsch, 1981, p.211).

The Freudian and neo-Freudian paradigms, in particular, have influenced medical discourse here in New Zealand, whilst the French and American psychoanalytical schools of thought, which have focused on recognising the importance of the mother-daughter relationship, have not been well incorporated into medical and nursing curricula, or writings on grief and death. However, all of these knowledges have the potential to contribute in different ways toward a greater understanding of the grief experience. For example, the American writings on object relations provide a useful tool for clinical practice, whilst the French theorists challenge understandings of relationship, difference and subject position, thereby creating the potential for different understandings.

Traditions outside the North American Anglo-Saxon tradition have valorised the mother-daughter relationships by pointing to the insights

of subjectivity as socially constructed by and through language. Whereas, in the American feminist tradition, the influence has primarily come from a continually growing interest in British Kleinian analysis and object relations theory. While I do not have a comprehensive knowledge of the writing of the French psychoanalytic tradition, it is important that I acknowledge their influence and focus on understanding mother-daughter connectedness and their vision for a maternal genealogy that is both recognised and valued.

Kemp and Squires (1997) note that voices like those of Julia Kristeva, Helen Cixous, and Luce Irigaray have “dominated debates within Western academic feminism” (p.9). All three women acknowledge a debt to Freud, and to Lacan, especially in their understanding of the relationship between language and the unconscious. According to Rowley and Grosz (1990), Lacan considers our subjectivity as linguistically and socially produced. For Lacan, there is no concept of personhood, or of humanistic concepts such as human ‘essence’ or ‘soul’; there is “no natural being outside society - outside language; there is no natural sexuality. Its existence is a socially specific construction” (p.183). Lacan considers the differences between the sexes as a psychological issue rather than an anatomical issue, and utilises the concept of the phallus not as an organ but as “*a signifier*, the key signifier in the symbolic order” (Rowley & Grosz, 1990, p.184). It is in their challenging the exclusion of women from the ‘symbolic order’, as non-possessors of the phallus, that the need for the daughter to separate and individuate from the mother has also been challenged and reframed.

Irigaray (1981) writes of some of the difficulties within the mother-daughter relationship. She indicates that we do not know who woman is because of women’s lack of maternal genealogy and lack of subject position within the symbolic order. Whitford (1991) writes of how feminists realised the need to “liberate themselves *within their mothers*” (p.26). In Whitford’s (1992) account of Irigaray’s work, she suggests that Irigaray’s essay has been read [can be read] as both “a lyrical celebration

of the mother-daughter relationship [and more often] as the daughter's struggle for life and autonomy" (p.263). Irigaray deplores the ambivalence that women can have toward their mothers in *And the One Doesn't Stir without the Other* (1981), she writes of this confusion/fusion of identities. Her themes are of daughters being over-protected, being unable to separate from the mother yet wanting to individuate. At the same time, a focus of her work is the issue, and valuing, of the continuity of the mother-daughter relationship.

You take care of me, you keep watch over me. You want me always in your sight in order to protect me. You fear that something will happen to me. Do you fear that something will happen? But what could happen that would be worse than my lying supine day and night? Already full-grown and still in the cradle ...I would like us to play together at being the same and different. You? I exchanging selves endlessly and each staying herself. Living mirrors....You look at yourself in the mirror. And already you see your own mother there.....And the one doesn't stir without the other....And what I wanted from you, Mother was this: that in giving me life, you still remain alive. (p.60-67)

Hirsch (1981) stresses the importance of Irigaray's emphasis on woman's "multiplicity, plurality, and continuity of being" (p.209) for the continuity and entrenchment of the mother-daughter relationship. In *When Our Lips Speak Together* (1980), Irigaray captures these aspects of mother-daughter interrelatedness through the use of the double pronoun.

We-you/I-are never open nor closed. Because we never separate simply, a single word cannot be pronounced, produced by, emitted from our mouths....For one is never separable from the other. You/I are always several at the same time....Let's do without models, standards, and examples. Let's not give ourselves orders, commands, or prohibitions....If you/I sit in judgement, our existence comes to a stop. And what I love in you, in myself, no longer takes place for us: the birth that is never completed, the body never created once for all time, the face and form never

definitively finished, always still to be moulded. The lips never open or closed upon one single truth. (p.72-78)

Irigaray (1994) attributes the lack of valuing of interconnection to the male economy we live in. She suggests it is an economy that fails to recognise its debt to the mother, for life; that focuses on the physical and cultural separation of mothers and daughters in order to prepare them to enter the “male economy and law” (p.7). She writes of the loss of many of the great mother-daughter myths, and of the loss of representations of the mother-daughter couple, particularly within the institution of the church. Irigaray encourages understanding of the subjective experience as an element of knowledge. She speaks of the need for women to “be able to express herself in words, images and symbols [in her] intersubjective relationship with her mother and with other women” (p.20), and of the need to move from the position of object to become subjects capable of speaking and utilising a female genealogy.

This ...special economy of woman's identity must be permitted, known and defined. It is essential to a real culture. It means supporting, not destroying, the mother-daughter relationship. It requires not believing that the daughter must turn away from her mother to obey her father or love her husband. (p.20)

In discussion with the biologist H. Rouch, Irigaray in *je,tu,nous* (1993), writes of how, within language, “the feminine” has become abstracted into a “non existent reality...[that] the value of the feminine” is reduced to that of the “non-masculine” (p.20). This perspective of incorporation is also challenged in respect to the mother-child relationship. In writing on the maternal order, Irigaray utilises the actual functioning of the placenta as a relational metaphor and discusses how the placenta mediates between the mother and child within uterine life.

The placental economy is therefore an organised economy, one not in a state of fusion, which respects the one and the other. Unfortunately, our cultures, split off from the natural order – and the scientific methods used to get back to it more often than not accentuate that distance – neglect or fail

to recognize the almost ethical character of the fetal relation. (p.40, my emphasis)

Together Irigaray and Rouch critique what they term an “ignorance of the placental economy on the male cultural imaginary” (p.42). They discuss the psychoanalytical justification of the imaginary fusion as an extension of the organic fusion of pregnancy. Rouch suggests that the psychoanalytical interpretation that pregnancy is a “fusion” of the mother and child is incorrect; the foetus is not parasitic. Rather than theorising the relationship between the mother and the foetus as one of fusion and struggle, it is better understood as reciprocity and interdependence and entwinement. She goes on to outline how “rupture” of this fusion by a third force in the symbolic order, variously called “the father”, or “the law” or the “Name of the Father, ... facilitate[s] entry into the symbolic, and access to language” (p.42), is not necessary as “differentiation between the mother’s self and the other of the child, ...is already in place” (p.42).

Kristeva (1986) deconstructs and challenges the writings of the Judaeo-Christian tradition, which she views as having shaped western understandings of sexual difference. She argues that Christian and Judaic teachings have established a “male, paternal divinity and a pantheon in the image of the family (father-mother-son)” (p.140). Kristeva views the Judaic creation of a “symbolic and paternal” community with its monotheistic loyalties as repressing, “along with paganism, the greater part of agrarian civilizations and their ideologies [regarding] women and mothers” (p.141). She claims that no other civilisation has so clearly established religious and political law on the basis of sexual difference. Kristeva suggests that the expectations of the symbolic order create conflict, exclusion and a state of ‘otherness’ for women, unless they turn to and identify with the “patriarchal order”.

The symbolic order – the order of verbal communication, the paternal order of genealogy – is a temporal order. For the speaking animal, it is the clock of objective time: it provides the reference point, and, consequently,

all possibilities of measurement....if I project not the moment of my fixed, governed word, ruled by a series of inhibitions and prohibitions (ranging from rules to sexual taboos and economic, political and ideological constraints),... which I repress in order that I may enter the socio-symbolic order. (p.153)

In *Black sun: Depression and melancholia* (1984), Kristeva suggests that we can never be whole within ourselves, as the loss of the 'other' is always grieved. This desire for the other that Kristeva speaks of supports the concept of self being known within relationship.

I ...awaken echoes of old traumas, to which I realize I have never been able to resign myself. I can thus discover antecedents to my current breakdown in a loss, death, or grief over someone or something that I once loved. The disappearance of that essential being continues to deprive me of what is most worthwhile in me; I live it as a wound or deprivation... my grief is but the deferment of the hatred or desire for ascendancy that I nurture with respect to the one who betrayed or abandoned me.... It follows that any loss entails the loss of my being – and of Being itself. (p.4-5, my emphasis)

Here, Kristeva's writing supports the concept of continuity and of the relational self. The loss of the social relationship remains a deprivation to be constantly confronted.

Kristeva challenges the view of depression as simply a pathology, and suggests that the practice of depression is also discursively learned. Currently, it is viewed as a psychiatric malady in need of drugs, and is commonly labelled or diagnosed as "psychotic" or "neurotic" or, according to another classification, "anxious", "agitated", "retarded", or "hostile" (p.10). She outlines how language fails to support the depressed in

... what pertains to a common experience of object loss and of modification of signifying bonds. The bonds, language in particular prove to be unable to insure, within the melancholy/depressive composite. (p.10)

Kristeva suggests that, within the 'depressive' state, the individual cannot easily talk themselves into an interest in life, and that this can in part be attributed to current Western values and a loss of the social self.

Kristeva is consistent with Freud's and Lacan's views when she stresses the importance of understanding the "subject in process", rather than trying to create the unified, essentialist subject. According to her, women's access to the "symbolic paternal order" is achieved through the daughter's repression of the strength of the mother-daughter link. This involves a censoring of the women's maternal sexuality or, as Kristeva indicates, of her maternal "jouissance". According to Grosz (1992), Kristeva's contribution is in her understanding of the "overlap between psychoanalysis and semiotics" (p.194). She writes of 'the semiotic' (*Le semiotique*) as "the unspoken and unrepresented conditions of signification ...[distinguishing the semiotic from the symbolic] from the order of social and signifying relations, of law, language and exchange" (p.194). An example of this experience can be found in the prevailing silences and absences of women from the history and language of western culture. Kristeva's theory emphasises language, rather than biological difference, as constituting subjectivity. Her theorising is one example outside essentialist humanist discourses.

Freudian psychoanalytic theory still greatly influences current psychodynamic thinking. Freud's theory of the unconscious and of desire has had a considerable impact on shaping understandings of the concept of relationship. He views the individual as being partly constructed by unconscious processes, in contrast to the essentialist view of the 'self' as being "coherent and unified" (Burr, 1995, p.18). Freud did not view the self as autonomous, unified and authentic. Although Freud's work is criticised for its phallogentric emphasis, and its lack of attention to the prescribed role of the mother, writers like Mitchell (1974), Dinnerstein (1976/87), Chodorow (1978), and Benjamin (1990) would claim that it is too significant a theory to dismiss.

Freud accounts for the daughter's turning to the father as the object of her libidinal interest, and away from the mother, through his theory of the 'castration complex'. Chodorow (1978) challenges the basis of Freud's theory, but Mitchell (1974) defends Freudian psychoanalysis from criticism of its biological determinism by some feminists. She supports Freud's theories of the unconscious and sexual difference. Mitchell suggests that Freud's writing on the 'castration complex' had been misinterpreted and that his writing explains the humanisation of the child in its sexual differences.

The Oedipus complex is the repressed ideas that appertain to the family drama of any primary constellation of figures within which the child must find its place. It is not the actual family situation or the conscious desire it evokes. (p.63)

I interpret the often quoted "lack" embodied in this theory as related to the patriarchal dominance of men over women in society, specifically the dominance of the male within the oedipal triangle. Chodorow (1978) asserts that Freud "tends to stress contempt even more than anger in a girl's rejection of the mother" (p.145). Hirsch (1981) notes that Freud, in his later writing on female sexuality in 1924 and 1931, revised his theory on early child development and stressed not contempt and anger but rather "the importance of the pre-oedipal attachment to the mother" (p.206). He then emphasises that daughter's attachment to the mother "is never totally superseded by the desire for the father; neither is the oedipal rejection of the mother ever overcome" (p.206). Hirsch claims that this tension within the mother-daughter relationship remains a primary force in the lives and relationships of daughters, binding them ineluctably to their mothers. This viewpoint is further supported by Chodorow's (1978) research in object-relations theory.

Chodorow (1978), Dinnerstein (1976), and Flax (1978b) all consider the pre-oedipal period as important to the developing child. Hirsch (1981) suggests that Chodorow and Flax consider that the child internalises the

“interpersonal field of relationships”, which results in the child viewing the mother “as an important inner object throughout adult life” (p.206).

Research by both Chodorow (1978) and Flax (1978b) on interpersonal fields suggest that mothers identify more with their daughters than with their sons, and that daughters’ boundaries are less well defined. This perspective supports Hammer’s (1975) research which raises issues regarding separation and individuation within the mother-daughter relationship. Hammer concluded that both mothers and daughters need a point of separation from each other. In her research with seventy-five women Hammer found that,

...for the vast majority of mothers and daughters, this emergence remains only partial. At some level mothers and daughters tend to remain emotionally bound up with each other in what might be called a semisymbiotic relationship, in which neither ever quite sees herself or the other as a separate person. (p.162)

She considers that both mothers and daughters need to develop ego boundaries and a greater sense of themselves.

Likewise, Chodorow (1978) claims “mother and daughter maintain elements of their primary relationship which means they will feel alike in fundamental ways. Object-relations and conflicts in the oedipal period build upon this preoedipal base” (p.110). She also suggests that

...women as wives and mothers reproduce people - physically in their housework and child care, psychologically in their emotional support of husbands and their maternal relations to sons and daughters....In a previous period, and still in some stable working class and ethnic communities, women did support themselves emotionally by supporting and reconstituting one another. However, in the current period of high mobility and familial isolation, this support is largely removed, and there is little institutionalized daily emotional reconstitution of mothers....Men are socially and psychologically reproduced by women, but women are reproduced (or not) largely by themselves...as it is currently constituted no one supports and reconstitutes women affectively and emotionally - either women working in the home or women working in the paid labor force....What there is depends on the accidents of a particular marriage, and not on the carrying out of an institutionalized support role. (p.36)

I have spoken to a number of women either partnered or single, who have stated that “the most devastating loss” to them has been the death of their mother. Is it possible that the comments about the death of their mother could signify the loss of the person who most reconstituted and psychically supported them in their lives? Is one of the issues over the death of one’s mother perhaps the loss of an unspoken support and psychic connection that is not reproduced elsewhere? In stating this, I am conscious that some women express relief following the death of their mother. What are the grief issues for these women?

The parameters of the mother-daughter relationship extend from intimacy to distance, from love to hatred. For some, the death of their mother can be viewed as possibly giving freedom. Lowenstein (1981) cites her own conflicted relationship with her mother, which she describes as “a particularly painful example of this most primordial of all relationships” (p.3). At the time of her mother’s dying, Loewenstein writes:

[I] sat next to my mother's bed with an icy and armoured heart and waited for the day to pass to return to Boston, to my friends, family and community work, waiting until I could flee in terror lest her spirit would invade me and defeat my lifelong struggle to be separate and different. (p.3)

Rich (1976) defines this experience as Matrophobia, as a “splitting of the self, in the desire to become purged once and for all of our mothers” (p.236). Women’s subjective experiences of their relationships with their mothers appear not to be recognised within current understandings of grief. Loewenstein (1981) states that “my mother generally did not perceive other human beings as separate from her own needs, least of all me. She never knew me as ‘other,’ as distinct from herself” (p.8). These comments support Chodorow’s (1978) research on differentiation between mother and daughter. Loewenstein’s (1981) own experience raises a number of issues. For example, she speaks of spending her life trying to be individuated and free of her mother, yet was unable to achieve this. Loewenstein was unable to get close to her mother in her

dying. She said "I was this little girl who might be devoured by this hungry woman" (p.8). Despite distance and non-communication with her mother, Loewenstein recognised that she had remained poorly differentiated from her. She writes that "...you can see how my mother's spirit has entered me in many ways, and I must be forever on guard lest I take on her identity" (p.10). Women have spoken to me of "taking on the spirit of their mothers"; others of "relief at their mother's death", and some of the importance of their maintaining a psychical link.

Perhaps this is not surprising as a number of women feminists have pointed to how 'self' is known through the 'other', including Chodorow (1978), Flax (1978), and Gilligan (1986). Gilligan (1986) challenges the view of an autonomous subjectivity. Her ongoing research supports understanding subjectivity from a relational perspective. She writes of responsibility, obligations and responsiveness as being related to a moral ethic of care. Gilligan suggests that the "self is known in the experience of connection, defined not by reflection but by interaction" (p.241). The issue of being ontologically linked is important in that it supports why daughters might not want to 'get over it', that is, to detach from any of the forms of psychical linking that they might have to their deceased mothers. It is equally possible that it is, in part, the maintenance of 'continuing bonds' that helps facilitate the grieving process, and prevent a *significant* fragmentation of understandings of the 'self'. As for most people in Western society, their parents are, at the very least, the most known constant within a changing world.

Whilst feminist authors, including Chodorow (1978), Dinnerstein (1976), and Flax (1978), consider that shared parenting would go a long way toward ameliorating many societal and parental issues, their concept of the power of the mother is of significance, as is their interest in researching issues of connection or intersubjectivity within the mother-daughter relationship. Chodorow (1997) comments that "the women's self in relation is a potential strength ..., [however, she] acknowledge[s] many women's very difficult problems with establishing differentiated

selfhood, autonomy, and an agentic subjectivity" (p.186). All of these theorists stress the concept of continuity within the mother-daughter relationship, as does Freud in his later works.

Benjamin (1988) goes further than most object relation theorists with her view that domination is a complex psychological problem of relationship rather, than of nature. She reframes Freud's often quoted question of "What does woman want?" (p.86), by "shifting attention from the object of desire, ...to the subject, she who desires" (p.87).

For Freud, woman's renunciation of sexual agency and her acceptance of object status are the very hallmark of the feminine. And though we may refuse his definition, we are nevertheless obliged to confront the painful fact that even today, femininity continues to be identified with passivity, with being the object of someone else's desire, with having no active desire of one's own....The aspect of will, desire, and activity – all that we might conjure up with a subject who is an "I" – was assigned to the male gender alone. (p.87-88)

Benjamin maintains that female desire has to be recognised and understood in order to disentangle relational bonds, and allow for personal and social transformation, and recognition. She revisits these understandings in *Like subjects and love objects* (1995), acknowledging the "manifold" (p.24) ways in which meanings about the unconscious and relationships can be understood. Benjamin acknowledges that psychoanalytic theory has "been largely unable to conceptualize the mother as a separate subject" (p.88). These understandings, in part, explain the absence of the mother also in theories and writing on grief.

According to Benjamin, new understandings about knowledge now acknowledge and allow for difference.

The unknowability and uncertainty that we consciously acknowledge, our sense of the multiple possibilities of interpretation in any moment (as well as of the limits of our knowledge), our realization of the likelihood that we will communicate our subjectivity whether we wish to or not. (p.24-25)

Benjamin makes a significant contribution toward understanding tensions that can exist within the mother-daughter relationship in her delineation of the problem of difference, and the tension between complementarity and mutuality.

The initial response to the discovery of the difference between my will and your will is a breakdown of recognition between self and other: I insist on my way, I refuse to recognize you, I try to coerce you. I therefore experience your refusal as a reversal: you are coercing me.....There is now a space between the mother and child that symbolically contains negative feelings such that they need not be projected onto the object ("she is dreadful") or turned back upon the self ("I am destructive"). (p.93)

Benjamin explores understandings surrounding mother-child separation and the issues surrounding the fantasy of the "perfect mother" (p.109), and she suggests that the task for feminist consciousness today is to "transform the space of inevitable separation and loss into a space of creation" (p.111).

In her second book *Letters From Motherless Daughters* (1995), Edelman acknowledged that women thirty years after their mother's deaths, spoke of still both missing and needing their mothers. She writes of how death is supposed to be coped with, and of how a thirty year old woman who was fourteen when her mother died described her concern over her deviant behaviour.

More than a decade after my mother's death, I still converse with her.... For years this dialogue was my secret, the glaring evidence, I was certain, of a daughter whose mourning had gone awry. The discovery that I was not a mutant griever but was, in fact, quite normal for a daughter who'd lost her mother was a moment of pure liberation and relief. (p. xii)

Edelman claims that academic texts "fail to acknowledge that part of the adjustment process after the death of a loved one includes maintaining a relationship—albeit a new relationship—with that person" (p.x). This viewpoint was also expressed by the participants in this study. It

appears that the relationship continues in a different form, despite a medical view that disengagement is necessary.

Does Chodorow's (1978) conceptualisation of the way in which mothers and daughters psychically reconstitute each other, link with the daughter's refusal to separate from the mother following her death? Is it the daughter's ongoing but reconstituted relationship with the mother that is unrepresented? If not, how does one explain the grief of a bereaved daughter who refuses to disengage psychically?

Feminist writings within the paradigms of psychoanalysis and poststructuralism have challenged traditional understandings surrounding the concept of the autonomous and rational self. Through suggesting that meaning is constantly being created and renewed, they have also challenged beliefs about the stability of language. As discussed, some feminists refute the ontological separation of self from the other, and advocate a re-conceptualization of understandings of gender, and the mother-daughter relationship.

Challenges to dominant discourses of death and on grief:

Surfacing the silencing and confession

In this section I argue that both silencing and confession are central components of discourses on death and grief that have rarely been acknowledged directly in texts influenced by the dominant medical discourse. Heidegger (1967) writes about the evasion and concealment of death, and thus its effective silencing. Crotty (1997) suggests that Heidegger, as a phenomenologist, is "definitely not concerned with inherited and prevailing cultural understandings ...[but is] single-mindedly on track of Being" (p.89). Nevertheless, he has helped to develop recent insights into the discourse of grief. Heidegger (1967) has pointed to the importance of 'silencing', and writes of the workings of "*the they*", that is, family, friends and perhaps health professionals.

The 'they' gives its approval, and aggravates the temptation to cover up from oneself one's ownmost Being-towards-death. This evasive concealment in the face of death dominates everydayness so stubbornly that, in Being with one another, the 'neighbours' often still keep talking the 'dying person' into the belief that he will escape death and soon return to the tranquillized everydayness of the world of his concern. Such 'solicitude' is meant to 'console' him [her]. ...In this manner the 'they' provides [besorgt] a constant tranquillization about death. At bottom, however, this is a tranquillization not only for him [she] who is 'dying' but just as much for those who 'console' him [her]. (p.297-8, my emphasis)

Death becomes that which is the province of the "Other" (p.298). Heidegger is contemptuous of the actions and responses of the "they", within modernity. "Death is 'known' as a mishap which is constantly occurring—as a 'case of death'. Someone or other 'dies', be [s]he neighbour or stranger" (p.296).

Heidegger recognised how the "they" cover up many of the disturbing features that surround death. When he uses the medical metaphor of "tranquillization" (p.298), Heidegger encapsulates one of the functions of silence.

...along with this tranquillization ...the 'they' at the same time puts itself in the right and makes itself respectable by tacitly regulating the way in which one has to comport oneself towards death. It is already a matter of public acceptance that 'thinking about death' is a cowardly fear...the 'they' does not permit us the courage for anxiety in the face of death. (p.298)

Tierney (1997), a present day critic of Heidegger, points to Heidegger's often overlooked insight "that death, despite its concealment, nevertheless remains a constant issue in a culture" (p.51), and suggests that there is what might be termed 'a concealed awareness' that exists around death. Death is not spoken about but establishes itself through avoidance.

Every kind of priority gets noiselessly suppressed. Overnight, everything that is primordial gets glossed over as something that has long been well known. Everything gained by a struggle becomes just something to be

manipulated. Every secret loses its force. This care of averageness reveals in turn an essential tendency of Dasein which we call the "levelling down" [Einebnung] of all possibilities of Being... (Heidegger, 1967, p.165)

Heidegger's insights into how death is are important because he has identified both the evasion and constancy of death in western culture. These understandings influenced postmodern/poststructural writings.

Foucault, in *The Birth of the Clinic* (1973/86), identified the power of discourse/language to constitute human subjectivity. He was concerned with analysing inherited and prevailing cultural understandings around illness. His research showed how individuals were constituted through the operations of dominant discourses within their everyday material practices, and explicated a genealogical approach through historically locating his research and examining prevalent discourses in their relation to power. Foucault researched issues of contemporary social life, population surveillance, and governing discourses and illuminated how understandings of death and grief have been produced within the medical gaze. He portrayed "the clinic" as a site of "bio-power," allowing the potential for the pathologisation of grief in western society.

The space of configuration of the disease and the space of localization of the illness in the body have been superimposed, in medical experience, for only a short period of time—the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy. This is the period that marks the suzerainty of the gaze. (p 3-4)

Foucault also suggests that death was understood as a natural phenomenon in the eighteenth century, whereas the nineteenth century brought the invention of the 'bio-medical' death. Death became a different type of phenomenon. With the advent of hospital medicine the 'natural' death discourses started to become subjugated to discourses that represented death as a pathological process. Foucault identified how the social conditions of life provide the culture for certain representations, and how, once a particular discourse is appropriated, it is able to be used by the holders of power. Death started to be viewed as

a pathological process, and as contained within oneself. 'Natural' discourses that named death as occurring outside of the embodied self lessened. With this change came the potential to pathologise grief. Medicine controlled the "operations of the body". This process was aided by the practice of psychology with its focus on internal processes. Anthropological or other discursive viewpoints, which consider explanations from outside of the body, were rarely considered.

In *The Archaeology of Knowledge* (1972), Foucault explicates how the body became the site that reflects the dominant form of social practice.

The great book of Man-the Machine was written simultaneously on two registers: the anatomico-metaphysical register, of which Descartes wrote the first pages...and the technico-political register, which was constituted by a whole set of regulations and by empirical and calculated methods relating to ...the hospital, for controlling or correcting the operations of the body.
(p.136)

Armstrong (1984) suggests that Foucault's insights into death are not fully exploited within contemporary understanding. He argues that Foucault's contribution is his identification that it was *the form* of the medical "gaze" that had changed, and that it was "the body itself that has become ill" (Foucault 1973/1986, cited in Armstrong, 1984, p.737). According to Armstrong, it was from this point that "the now familiar techniques of clinical examination were embedded into medical practice" (p.738). This created the emergence of "surveillance medicine" which contributed to a reworking of understandings around illness and grief (Armstrong, 1995). The physician was then not required to be a classical scholar, rather, he was to "address the problems of the practical management of illness" (p.393).

Hospital Medicine was clearly an important revolution in medical thinking. Also known as the Clinic, pathological medicine, Western medicine and biomedicine, it has survived and extended itself over the last two centuries to become the dominant model of medicine in the modern world. (p.393)

A number of postmodern writers, including Foucault (1975, 1981), Illich (1976), Bauman (1992), Tierney (1997) and Reaney (1991) indicate that medicine is partly accountable for the sequestration of death from modern life in its focus on limiting or stabilising bodily threat. Reaney encapsulates this view in the following quotation:

We can ignore death only because we have sanitized its image and hidden its victims in hospitals and cemeteries. We have restricted our contacts with it to those few shocking occasions when it springs upon us unbidden. But the shadow is there, always. This is the terrible price nature exacts from us for the privilege of consciousness. (p.3)

This viewpoint comes from the belief that the body is both the site and signifier for explaining and localising death (Foucault, 1975; Armstrong, 1987). Prior (1989) asserts that:

...the individualisation of the dead also results in an individualisation of grief and bereavement...the same medicalisation process which has converted death into a pathology — a break and a rupture from normality — has further extended its influence to the mourner in such a way that grief and bereavement are also capable of being viewed as pathogenic processes. (p.132)

Craib's (1994) understanding supports this view. He claims that, within modernist thinking, the grieving person is viewed metaphorically as a machine, with grief having to be "tamed" and managed. In keeping with management discourse, Craib suggests that "the technical job is to get the machine back on the road" (p.25). Likewise, Bauman (1992) suggests that our concern with the body and everyday life enables individuals to more easily deny existential concerns about death. Previously, the romantic view was that the bonds between the bereaved and a loved one could not be broken, even in death.

Poststructuralist insights take issue with the concept of a 'true' or 'stable' understanding of grief. Prior (1989) has done much to elaborate and illustrate how the meaning of grief changes according to cultural influences and responses. His research indicates how changes to

medicolegal understandings of death have helped erase the more obviously personal and social factors from understandings surrounding death.

...grief at least in its public manifestations, is socially variable ...the social location of a deceased person has much to do with the manner in which grief is expressed. I ...claim that all public expressions of grief act as a mirror in which private feelings are reflected, and as the public expressions wax and wane so does the social base of the sentiments behind them.
(p.141).

While, on the one hand, death is viewed as sited in the body, and as individualised and silenced, on the other hand, Armstrong (1987) argues that the real issue is not about silence but about the requirement of confession. He argues that the “truth” of death has shifted from the “interrogation of the corpse to that of the dying patient” (p.651). Armstrong draws on Foucault’s critique of power as “...essentially something which forbids or negates or represses” (p.651), and suggests that power is productive rather than repressive, sometimes producing silence and sometimes demanding confession.

Grief, then, is sited at the meeting of two potentially opposing discursive imperatives: silence and confession. This points to the potential contradictory and fragmented processes through which grief has to be constructed. This paradox informs understandings of grief.

Williams (1989) found that the “awareness” of dying and “the demand for control [over] dying” (p.201) were not necessarily conjoined positions, and that “family sentiment” still influenced concealment, despite a trend favouring open awareness of a terminal illness in Britain and America. The hospice movement, with its technical skill in symptom control and its aim to facilitate open communication, was more successful, while in other settings many people were still unaware, and the communication was left up to the doctor. Lupton (1997) found that there was “collusion” between both doctor and patient to “reproduce medical dominance”

(p.98). Patients wanted to “invest their trust” in their doctor and the discipline of medicine (p.105). In New Zealand, the Christchurch Press (29.10.86) had already reported that medical practitioners supported the premise that “the terminally ill have the ‘right to know’”, indicating how the discursive imperatives of silencing and confession compete for pre-eminence. Arguments range from the belief that denial is a necessary part of hope, and that hope is a central and necessary feature of medical care (Beilin, 1981), to the belief that open awareness of one’s dying is a right that should be promoted.

Glaser and Strauss (1965) challenged the pretence of hope that families and health professionals often engage in, and suggested that people need to be emotionally accompanied in their dying. Seale (1998) has researched extensively in the area of death and dying and found that family members did indeed desire to emotionally accompany a dying parent. Kubler-Ross (1969), in her stage theory, is perhaps most famous for promoting the need for open awareness, in order to complete the journey to the stage of acceptance, the final stage before death. Frank (1994, 1995), in his analysis of his mother-in-law’s dying, and in his valorising of the place of the narrative in achieving an heroic death, also supports open awareness. He advocates listening “*for [the] story*” and suggests that “...death, if it is to be met on equal terms, must be named” (Frank, 1994, p.15-16). Timmermans (1994) critiques the assumption that open awareness *should* connote the ‘good death’. This view is supported by Seale (1998) who comments that his research indicates that, even within “the individualistic environments of late modern, anglophone countries, [open awareness is not] an option which all wish to take” (p.7). Meanwhile, Walter, Littlewood and Pickering (1995) suggest that the media is responsible for the “emotional invigilation” of the public regarding the appropriateness of expressions of grief. The idealisation of what constitutes a ‘good death’ or appropriate grieving behaviour is problematic, as we fail to take into account the reality that death is a process as much as an event. How one dies is influenced by

understandings about death, as well as age, ethnicity, social class and gender.

Other writers problematise death, and point to the impossibility of any universal understanding of death. Derrida (1993) critiques the various disciplinary constructions of death, particularly the assumption that we know what we are talking about when we name 'death' (p.25). He points to the absences in "anthropologico-historical" knowledge, and to the lack of discussion around the meaning of death: "What is death in general? or 'what is the experience of death?' and the question of knowing if death 'is' :- and *what* death 'is' – all these issues remain radically absent *as questions*". (p.25). Derrida recognises the need for specificity when speaking of death.

... every culture has its own funerary rites, its representations of the dying, its ways of mourning or burying, and its own evaluation of the price of existence, of collective as well as individual life....[and that this culture can be transformed] even within what we believe we can identify as a single culture. (p.24)

Not only does culture shape current understandings of death, but we can only conceptualise "my death" by experiencing the death of others. Baudrillard (1976/1993) categorises this current age as one of "symbolic exchange" and challenges the concept of biological death with "its objective and punctual character". He suggests this understanding is culture specific and attributable to the dominance of modern science.

Every other culture says that death begins before death, that life goes on after life, and that it is impossible to distinguish life from death...Death is not a due payment ...it is a nuance of life; or, life is a nuance of death....Neither life nor death can any longer be assigned a given end: there is therefore no punctuality nor any possible definition of death.

We are living entirely within evolutionist thought, which states that we go from life to death: this is the illusion of the subject that sustains both biology and metaphysics.....It is more real to say that whole parts of

'ourselves' of our bodies, our language fall from life to death, while the living are subjected to the work of mourning. (p.159)

Tierney (1997) suggests that "perhaps the most brilliant insight" to come out of Baudrillard's analysis of death is his recognition of the "biological idea of death as the cessation of life, and the role that this myth plays in the formation of modern identities" (p.65). Baudrillard (1976/1993) disrupts understandings of a distinction between life and death, thereby creating permeability, or more fluid understandings around the concept of death. He suggests that death has been taken out of symbolic circulation.

Strictly speaking, we no longer know what to do with them, since, today, it is not normal to be dead, and this is new. To be dead is an unthinkable anomaly; nothing else is as offensive as this. Death is a delinquency, and an incurable deviancy... ..Death is ultimately nothing more than the social line of demarcation separating the 'dead' from the 'living': therefore, it affects both equally. Against the senseless illusion of the living of willing the living to the exclusion of the dead, against the illusion that reduces life to an absolute surplus-value by subtracting death from it. (p.126-127)

Baudrillard points to the need to reintegrate our understandings of the symbolic over the semiotic, and to expand our understanding of death.

In summary, although Freud pointed to the importance of the unconscious and critiqued the essentialist view of self, it was feminist scholars who emphasised the importance of understanding and theorising the mother-daughter relationship. Some French feminists, whilst problematising notions of self and gender, have built on Freud's work. The feminine has been valorised through the use of psychoanalysis, and the incorporation of psychoanalytical insights into popular discourse on the mother-daughter relationship. Some American feminists have highlighted the issues of interdependence and connectedness as underpinning the mother-daughter relationship.

Within the context of understanding death and bereavement, postmodern theorists have challenged the dominant discourses on grief and death and focussed on the social processes surrounding death, as well as the avoidance of death talk. Foucault's work has acted, in a sense, as a case study that has pointed to the confluence of discourses that incorporate both silencing and confession. Since his writing, social theorists have attempted to contextualise and deconstruct, in a far greater way, understandings surrounding death. Previously established understandings of grief are now being examined in the light of different understandings surrounding language, and subjectivity.

The study, which will be presented in chapters four to twelve, is guided by a feminist poststructural framework and has been informed by the literatures discussed in this chapter.

CHAPTER FOUR

THE RESEARCH APPROACH

In this chapter I explicate the ontological and epistemological understandings informing my research approach to explain why I chose to work within the theoretical perspectives of feminist poststructuralism, and how I developed a method for undertaking discourse analysis in one particular area.

Informing the research: Epistemological and ontological understandings

The scientific method has come to be viewed by many as the methodology to both 'natural' and 'objective' knowledge. Within medicine and, I suggest, by default within nursing, it remains the 'right' or mandatory way to think. Although the scientific method has much to offer nursing, since the challenges of Kuhn and Feyerabend to the concept of objective 'science' or 'the scientific method' as the sole arbiter of truth, researchers in nursing, among other disciplines, have critiqued the notion of the scientific method as self correcting knowledge.

Nursing may benefit from using the scientific method to explore some topics but the whole of nursing practice cannot be contained within the one method (Reed, 1989). Litchfield (1997) suggests that different, or multiple paradigms, posited on a variety of ontological and

epistemological assumptions, are more appropriate to represent the full range of nursing practice and knowledge. Litchfield claims that:

...scholars of nursing have noted the discrepancy between the tenets of nursing practice and the predominant scientific paradigm, and stated the need for methodology that is consistent with the philosophical foundations of the discipline.

(p.35)

Newman, Sime & Corcoran-Perry (1991) have identified three research paradigms which have developed in sequence and are available for use today. They are the:

- *particulate-deterministic paradigm where health and illness are studied as objective entities with definable properties that are able to be assessed in order to find prescriptive practices.*
- *interactive-integrative paradigm where health and illness are studied contextually as lived experience.*
- *unitary-transformative paradigm where knowledge is personal, involves pattern recognition and is a function of both viewer and the phenomenon viewed. (p.4)*

Each of these paradigms, and the methodologies they generate, are of use to the study of nursing. In this research I situate myself in the third paradigm because I am interested in meaning patterned and constructed through language, and how meanings change in interactions between speaker and listener. This is particularly pertinent to a study of the experience of grief. My position draws heavily on a discourse analytic approach, which recognises that language is not a 'transparent' medium but changes and structures as it transmits meaning. In expression and in dialogue grief is given meaning. Nurses, as frequent witnesses to death and grief, are uniquely positioned to play a role in this meaning making.

This study explores women's discourses of grief and self within which they must work to make sense of the death of their mothers. I am situating the research process itself within a theoretical paradigm that views subjectivity or the concept of self as multiple and in process.

Poststructuralist theory posits the view that personhood is constituted discursively, meaning that our subjectivities are constituted across many discourses which can create multiple and often contradictory subject positions. The subject is therefore viewed as constantly in 'process' (Gavey, 1989; Butler, 1990; and Davies, 1991). Identity is viewed as being shaped by the different discourses that influence one's understanding of self and the world.¹⁰

This theoretical premise is fundamentally different from the humanist discourse which emphasises the centrality of the human person and in which the 'individual' is viewed as an autonomous, unified and rational. The major emphasis within this research project is to understand the ways in which women position themselves in their talk about grief and loss or, in other words, to explore the subject positions women take up in the various discourses of death and grief they articulate. At the beginning of this project my approach to grief and loss was essentialist in that I understood subjectivity as singular, and the experience of grief as universal and unitary. On the surface, therefore, my project initially appeared to be quite straight forward. However, personal experiences and empirical evidence from participants in this study increasingly could not be fitted into this framework. My engagement with feminist poststructuralism and poststructuralist revisions of psychoanalytic theories offered possible routes to a new comprehension. I now critique the very foundational concept I thought of as 'natural' and as a given, namely, the humanist concept of identity¹¹.

Therefore, this feminist postructuralist analysis of the grief experience of 'motherless daughters' is not posited on a single 'right' way to understand grief and to manage the grief process. Rather, I see the need

¹⁰ See Wittmann (1998, p.10-11) for a discussion on how different discourses impact on one's changing subject position and understanding of self.

¹¹ See Weedon (1987), where she defines the humanist discourse as presupposing an "essence at the heart of the individual which is unique, fixed and coherent and which makes her what she is.... [Whereas] poststructuralism proposes a subjectivity which is precarious, contradictory and in process, constantly being reconstituted in discourse each time we think or speak" (p.32-33).

to maintain a 'critical epistemology', to develop understanding of the social processes and discourses that influence and impact on the lives of the grieving 'subject'. As Grace (1988) summarises, a 'critical epistemology'

... does not postulate the existence of universal laws of human behaviour or social relations, and does not assume that events in the social world are fully determined; there is not, therefore, a singular scientific method that gives access to valid and reliable knowledge about that world. (p.115)

As poststructuralist feminism and psychoanalytic theory offer a different perspective from humanism¹² in considering the experience of grief, the focus of my analysis is not on the development of a 'grand theory', but rather on exploring the gaps, silences, contradictions, and implicit power relations in discourses (Foucault, 1972; Weedon, 1987; Sawicki, 1991; Cheek and Rudge 1994). I am seeking an understanding of how the death of the mother is made sense of by daughters, so the nature of the daughters' accounts of their experiences becomes very important, and points to the larger social, historical and cultural relations and processes that constrain and shape their experience. Thus, I am challenging the concept of unitary 'authenticity' of the experience of grief, because the grief experience is discursively produced.

I am choosing to explore only women's experiences of grief and loss. The experience of men is almost certainly different since, as Weedon (1987) states, under patriarchy, women have a "differential access to the discursive field which constitutes gender, gendered experience and gender relations of power in society" (p.167).

¹² See Weedon (1987) who writes that the liberal-humanist assumption is of subjectivity as the "coherent, authentic source of the interpretation of the meaning of 'reality'" (p.8). The postmodern perspective is that issues of gender and ethnicity shape the experience of dying. This viewpoint therefore forecloses on issues supporting the universalising of grief management.

Understanding discourse and discourse analysis

This study draws on Foucault's (1980) understanding of the significance of language and his articulation of a theory of discourse, in which he discusses how various 'truths' become normalised and legitimated through particular discourses. Foucault rejected the premise of a universality of truth and sought to make a distinction between discourse specific knowledges and universal claims. According to Hall (1997), Foucault saw discourse as involving the understanding of "the production of knowledge (rather than just meaning)" (p.42-43). Hall explains that understanding the function of language is as much about representation as communication. Weedon (1987) claims that discourses themselves comprise "ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and the relations between them" (p.108).

Burr (1995) refers to discourse as a "coherent set of images" (p.184), or metaphors, that construct an object in a certain way. Hollway's (1984) view of discourse assumes that our subjectivity is constituted through "the meanings and incorporated values" (p.227) which are linked to our experience of life and our position in relationship to others. She defines discourse as "an interrelated system of statements which cohere around common meanings and values....[that] are a product of social factors, of powers and practices rather than an individual's set of ideas" (p.231).

Foucault's work can be considered poststructuralist when he rejects the notion of a politics that is based on absolutes of knowledge and of truth, and is critical of Enlightenment Rationalism in its claim to have a hold on truth and rationality (Hekman, 1990). According to Watson (1995), both Foucault and Derrida explicate their understandings of how particular discourses create their own definition of truth, and both analyse the part that discourse plays in the structure of society. Their viewpoints inform the epistemological perspective of feminist poststructuralist theory, in which knowledge is viewed as being socially

produced and inherently partial. Feminist research places the “social construction” of gender as central to the research inquiry (Lather 1998, p.571). Lowe (1991) claims that

In postmodern analyses, the central themes are: that no aspect of social reality can be regarded as ‘natural’; that language mediates or constitutes reality; that authenticity can be questioned; and that the individual, as subject, is removed from the centre of the analysis. (p.583)

Foucault (1972) also points out the pervasive discursive strategies and impacts of silence and of silencing.

... in every society the production of discourse is at once controlled, selected, organised and redistributed according to a certain number of procedures.... In a society such as our own we all know the rules of exclusion. The most obvious and familiar of these concerns what is prohibited. We know perfectly well that we are not free to say just anything, that we cannot simply speak of anything. (p.216)

In this study attention is given to how the participants understand that grief should be both expressed and not expressed.

Feminist poststructural analysis shares Foucault’s critique of the humanist ontological assumption that people have an essential nature and biologically based definitions of femininity. Gender is viewed as being socially constructed within discourse. A feminist poststructuralist perspective, is a critical approach which focuses on identifying the institutions and interests that are served by a discourse, as well as the differentiated and gendered subject positions constructed through discourse (Fraser & Nicholson, 1990; Davies, 1991; Maynard, 1994). Stanley & Wise (1990) critique the categories of “woman” and “gender” ...suggesting that “woman ...is a socially and politically constructed category, the ontological basis of which lies in a set of experiences rooted in the material world” (p.21).

Feminist poststructuralist approaches seek to identify the linguistic and interpretative resources people draw on, and asks who benefits by their deployment. Fairclough (1992) clarifies this position by stating that

discourse is more than a “freeplay of ideas within people’s heads” (p.66). He writes of how discourses are “firmly rooted in and oriented to real, material, social structures” (p.66).

Discourse incorporates understanding of the various power structures and regimes of truth. Potter & Wetherell (1995) suggest that, as such, discourse analysis is heir to two traditions. One tradition involves consideration of discourse “practices”, the other discourse “resources” (p.81). The macro view considers how conversation is organised to sustain social practice, and this involves drawing on the understandings of social theorists and of ideology. The micro view considers the techniques by which discourse analysis works, and this involves understanding the social practices and content resources that are drawn upon, including “the devices, category systems, narrative characters and interpretative repertoires which provide a machinery for social life” (p.81) .

‘Subjectivity’ and ‘subject positions’

Within any discourse, subject positions are ascribed to both speaker and listener. The Foucauldian view is that in discourse, both ‘subjects’ and ‘objects’ are created, taken up and accepted as objectively real¹³. This echoes Althusser’s notion of ideology. Althusser (1968/1971) challenges the assumption that the individual is the author and guarantor of his or her meanings. We take up a position as a subject through recognising ourselves within discourse; we are in fact “hailed” into the discourse. For Althusser, our experience and understanding of the world are defined through ideology promulgated by ideological state apparatuses (for example, the institutions of the family, the church, and education). Althusser (1968/1971) states:

¹³ See Sawicki (1991) where she argues for Foucault’s utilisation of this concept in his analysis of discourse.

I shall talk of practices. And I shall point out that these practices are governed by the rituals in which these practices are inscribed, within the material existence of an ideological apparatus, be it only a small part of that apparatus: a small mass in a small church, a funeral, ...a school day, a political party meeting...

As a first formulation I shall say: all ideology hails or interpellates concrete individuals as concrete subjects, by the functioning of the category of the subject....The duplicate mirror-structure of ideology ensures simultaneously:

- 1. the interpellation of 'individuals' as subjects;*
- 2. their subjection to the Subject;*
- 3. the mutual recognition of subjects and Subject, the subjects' recognition of each other, and finally the subject's recognition of himself. (p.158-168)*

It is within ideology that individuals become constituted as subjects.

Belsey and Moore (1989) explain that

...the process of interpellation by ideology addresses individuals as unique subjects conferring on them an identity which appears 'obvious'....The result is that individuals accept their subject position in the social formation as 'freely chosen', and ideology therefore becomes the condition of our experience. (p.245-246)

Foucault and Sennett (1982) shift the analysis to "regimes of truth" now "concrete, historical and cultural beings ...are constituted by the discourses that create subjectivity" (p.9, cited in Hekman, 1990, p.69). Weedon (1987) says that Foucault elaborated the concept of a "discursive field", mediating the "relationship between language, social institutions, subjectivity and power" (p.35); arguing that social structures and processes are organised through institutions such as the church, medicine, and the family; and insisting each of these institutions is located in and structured by a particular discursive field. The discourses of grief are one such discursive field.

Not all discourses will carry equal weight or power within a discursive field. For example, Foucault (1972) states that

...doctrine links individuals to certain types of utterance while consequently barring them from all others.... Every educational system is a political means of maintaining or of modifying the appropriation of discourse, with the knowledge and the powers it carries with it. (p.226-7)

As already argued, the 20th century grief experience has been under the hegemonic sway of medicine, which has prescribed 'appropriate' subject positions for grief. This study explores the subordinated and potentially subversive subject positions that circulate within lay understanding as revealed in the discourses of women whose mothers have died. Discourses construct as much by omissions as commission. Silencing is a powerful discursive tool. How do individuals respond to the discursive power of silencing? This research is concerned with explaining the silencing of grief by the institutions of the family, the church, and the education system. I am interested in the silencings both explicitly enforced and those unspoken but 'read', and I also seek to identify the subject positions that daughters utilise in order to make sense of both the silencings and the evocations of grief and loss.

I draw on the writing of Sawicki (1991), a feminist researcher who has extensively studied and had dialogue with Foucault about his research. She suggests that Foucault's notion of discourse offers the possibility of transformation because his analysis of power rejects the view that power resides monolithically and unilaterally in the law and the state, and argues that power and knowledge are interconnected in the practices that comprise history. Hekman (1990) indicates that discourses partake of power and not knowledge alone, and suggests that Foucault's theoretical depiction of power/knowledge relations in discourse, therefore, opens the possibility of researching the power/knowledge nexus precisely through analysing discourse. For example, the discursive production of being a 'good mother' or a 'bad daughter' is linked to our modes of thought, to our individual subjectivity and to the social, economic and cultural circumstances of our lives. For Foucault

(1978), the concept of the power/knowledge nexus demands exploration at both the macro and micro-level of society. He maintains that

The analysis, made in terms of power, must not assume that the sovereignty of the state, the form of the law, or the over-all unity of a domination are given at the outset; rather, these are only the terminal forms power takes...Power must be understood in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organisation; as the process which, through ceaseless struggle and confrontations, transforms, strengthens, or reverses them.

(p.92)

Foucault rejects the concept of power as being only repressive. His interest is in disciplinary practices and the productive nature of power which, according to Sawicki (1991), Foucault views as being

...exercised on the body and soul of individuals. It increases the power of individuals at the same time as it renders them more docile.... Foucault also isolates techniques of individualization such as the dividing practices found in medicine, psychiatry.... Disciplinary practices create the divisions healthy/ill, sane/mad ...which by virtue of their authoritative status, can be used as an effective means of normalization and social control. (p.22)

Sawicki (1991) views Foucault's analysis of power as a major contribution to understanding. She argues that Foucault does not support the Marxist 'top down' concept of power, or agree that universal meanings associated with shifts in power relationships can be extrapolated from history. Power is described as diffuse, as having positive potential as well as repressive characteristics. This recognition of the creative or productive potential of power offers the possibility of transformation.

Sawicki suggests that feminist researchers "... need to analyse the politics of personal relations and everyday life, and [account] for our participation in reproducing systems of domination despite our conscious protests against specific forms of it" (p.10). According to Sawicki (1991), Foucault's contribution is in his explanation of how "power grips us at the point where our desires and our very sense of the possibilities for

self-definition are constituted” (p.10). These concepts are explicated in Foucault’s discussion on truth and power in the *Archaeology of Knowledge* (1972). If our subjectivity is socially constructed through the language and other signifying practices of discourses, then the silence is as important as the ‘knowledges’ that surround the subject of motherless daughters and of their experience of grief.

The questions that underpin my research are directed at understanding both these silences and knowledges. A number of specific questions suggest themselves:

What are the relations of power and knowledge that underpin the daughters’ experience and understandings of grief following the death of their mothers?

What is the influence of the valuing in western society, of independence and stoicism as appropriate qualities of good grieving?

Who determines if and when women handle grief badly?

What is silenced, what induced and what mandated in the contemporary knowledges of grieving?

How do women collude or become coopted in a denial of the death of the mother to ‘survive’ grief?

What is the impact of such denial on the quality of their continuing life?

How are women’s experiences of grief discursively constructed?

What are the contradictions that are thrust upon them or that they actively take up?

Davies (1990a) argues that the answers to such questions lie not in psychoanalysis but in understanding how discourses “trap us into the worlds we are trying to move beyond” (p.502).

Fundamental ...is an understanding of the person as in process, and of words coming not from an essential core of the person but from the discursive practices through which the person is constituting themselves and being constituted. (p.502)

An individual's subjectivity can be viewed as a site of struggle between different discourses for dominance; whatever we do involves compliance or resistance to the dominant discourses. Weedon (1987) claims that

...discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects which they seek to govern. Neither the body nor thoughts and feelings have meaning outside their discursive articulation, but the ways in which discourse constitutes the minds and bodies of individuals is always part of a wider network of power relations, often with institutional bases. (p.109)

Therefore, in our personhood, we take on as our own the very discursive practices through which we are constituted. It is through discursive practices that Davies (1990a) sees us as interpellated into the collective and become speaking subjects: "We take the words we speak to be our own at the same time that they speak us into existence" (p.503).

To analyse the discourses of women who have experienced the death of their mother is to hear and value their constructions of their experience. These feminist understandings inform my approach in their emphasis on subjectivity and collusion/co-option, and support my commitment to prioritising women's perspectives.

A politics of grief

According to Prior (1989), the Western world's understanding of death is as a self evident physical and biological event sited within the body, as "first and foremost ... a biophysical fact" (p. xi). This is played out as 'natural and common sense', as part of the discourse of everyday life, infusing our social politics, and carrying with it the expectation that the grief 'wound' will heal, that you 'get over it'. A poststructuralist approach looks at death rather as a discursively constructed phenomenon, not as

...set apart from and independent of discourse but ...realised only in and through ...discursive elements which ... are made visible and palpable

through the existence of discursive practices, and so disease or death are not referents about which there are discourses but objects constructed by discourse ...discourse on death is composed not merely of what people say and write about death...but [involves] the entire range of practices, activities and settings which embrace death... death, therefore, is constituted as much in the cemetery as it is in the pathologist's mortuary; ...as much in the medical certificate of cause of death as it is in the funeral service. (Prior, 1989, p.3)

My interest as a nurse is primarily on the individual experience in this exploration of how women make sense of grief and death, how daughters construct their knowledges and subjectivities surrounding death and grief. Whilst this necessarily involves analysing the grand public knowledges and discourses of death and grief, the major focus of this study involves consideration of the personal dimension of daughters' lives.

This research does critique the hegemony of science and medicine in understanding grief, but my intention is not to simply suggest a better way to manage or understand grief. Rather, I seek to explore some of the gaps and silences that surround this very significant life event. As Cheek and Rudge (1994) ask: What "permit[s] certain statements to be made; what rules order these statements; and what rules enable us to identify statements as true or false?" (p.584). In attempting to understand the nature of the daughters' discourse on grief, I have attempted to determine what rules the women see for understanding what constitutes healthy reactions or 'good grief', and unhealthy ones and 'complicated' or 'pathological' grief.

Foucault's (1977, 1978) analyses have frequently illuminated how the discourses of health professionals can 'psychologise' and control or shape people's understanding or experiences in relation to, for example, madness and sexuality. I argue that the same can be said in regard to grief. Foucault (1976) highlights the need to focus on 'subjugated knowledges', when he states:

I believe that by subjugated knowledges one should understand ... something which in a sense is altogether different, namely, a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of scientificity. I also believe that it is through the re-emergence of these low-ranking knowledges (such as that of the psychiatric patient, of the ill person...) parallel and marginal as they are to the knowledge of medicine -- ... involve what I would call a popular knowledge (le savoir des gens) though it is far from being a general commonsense knowledge, but is on the contrary a particular, local, regional knowledge.

(p.82)

I see this highlighting or privileging of the daughters' understandings in itself as a political act. My aim is not to explicate some new universal truth or linear sequence of the grief experience, but rather to focus on the specificity of the women's grief experiences, aiming to illuminate the dilemmas, ambiguities and flux that exist within this sphere of their experience.

In summary, this research takes the approach, and applies it to the grief process, that understandings of death and grief are discursively constructed, and subject to regimes of power; that there is the potential for transformation at the site of struggle, that it is possible to understand the macro forces that operate on women to constrain and shape their grieving - the silencings, the incitements and the sanctions; and that the discourses used by women will reveal how they understand themselves, their relationships with their mother and how they grieve and transform their grief. The discursive approach allows cognisance to be given not only to the larger forces shaping their experiences, but to their own agency and reflexivity, and to the discursive strategies, techniques and tools they draw on. I argue that nursing can benefit from such an approach to understanding grief, and can play a strategic

part in the process of helping make a daughter's grief move toward transformation rather than to oppression.

CHAPTER FIVE

THE RESEARCH PROCESS

This chapter outlines the actual processes used in this research. After restating the aims, there is a discussion of the ethics and values associated with the research. As well, I discuss the process of recruitment and gaining informed consent, and data collection. The chapter concludes with a description of the data analysis strategies used to generate the research outcome.

Research aims

The research aims are to analyse the narratives of women whose mothers have died to explore:

1. How grief is understood and articulated by these women;
2. What major discourses dominate and constitute the women's understandings of both grief and loss, and to understand what primacy is ascribed to the mother-daughter relationship within these discourses; and
3. The implications for nursing practice of this discursive approach to grief.

Ethics and values associated with this research

Approval for undertaking this research was given by the Massey University Human Ethics Committee and by the appropriate Regional Health Authorities in September 1996. This process took six months because it involved two separate sets of negotiation and application procedures, and was only achieved in this time frame because the Regional Health Ethics Committee finally agreed to process consent under fast track arrangements. The Massey University Human Ethics Committee initially insisted that audiotaping of interviews be optional. However, it was finally agreed that taping and the transcription were essential for discourse analysis. Therefore, consent included an agreement to taping (See Appendix B for consent form). Taping was not an issue for any participant at any time. The women clearly understood why I needed to tape the interviews and had no reservations about permitting this.

My methodological choice of indepth interviews was informed by my ethical commitments. I intended to privilege the women's information, rather than bring to bear my own perspective which had been gained over twenty-five years of nursing and teaching in the area of grief and loss. My commitment to doing this arises from two sources: nursing and feminism.

Nursing ethics

As a nurse, I have always highly valued the relationship between the nurse and the person receiving care. This is essentially a dialogical, reciprocal relationship based on careful listening by the nurse to the person 'in care'. The interactive process which occurs offers the possibility for transformation of either or both people. This special relationship is widely recognised by nursing theorists, although expressed differently by different writers (Christensen, 1990; Benner, 1991; Benner & Wrubel, 1989; Newman, 1994; Litchfield, 1997). For

instance, Christensen (1990) describes this encounter as a 'partnership'. All the writers agree that in order to be effective, the relationship should be viewed as an egalitarian and reciprocal relationship, although the person receiving care is clearly the focus of concern for both participants. This study is based on the same belief, and a determination that the interview experience for the women in the study should be a positive one. In short, my approach to the interviews incorporated the same ethic of care and responsibility as in my nursing practice. Throughout the interview process I wanted to engage with the women in such a way as to facilitate their exploration of the ways they understood grief. Whilst my intention was to draw out the participants' knowledges, every effort was made to enable participants to 'control' the interview process. Mischler (1986) captures the dynamics of 'good interviewing' in this mode when he suggests that

...an interview is a form of discourse...[it] is a joint production of what interviewees and interviewers talk about together and how they talk with each other.... research [should be] guided by the aim of empowering the respondents. (p. viix)

I used a deliberate strategy of reflexivity in order to lay aside any status as an authoritative grief 'expert'. It was my intention to focus on the women's construction of grief rather than endorse any perceived ascendancy of 'expert' over 'lay' understanding.

Very personal information pervades the transcripts, and this highlights the politics inherent within the experience of grief and loss. My responsibility as a nurse and as a researcher has been to both analyse and present the data with integrity, and in a way that protects the confidentiality and privacy of the women.

The intensely personal nature of any research on grief can bring to the surface issues that people may think they had previously dealt with. Some of the women were overcome with unanticipated emotion during the interview process. The dangers of this have been long recognised by researchers in the area of grief. Parkes (1995), Rosenblatt (1995), and

Cook (1995) all draw attention to the ethical issues in bereavement research. Parkes' (1995) research suggests that the research process should do more good than harm for any participant. Rosenblatt's (1995) research on the ethics of interviewing the bereaved also indicates that the process should be beneficial. In this research I was very aware that I had to take responsibility for any problems that might arise during the research process. I arranged for a counsellor who was well qualified in the area of grief management to be available should it be required, and I also was cognisant of other counsellors, and the resources available, in the geographical areas where the women were interviewed. However, I had previously taken 'grief' groups under the overall supervision of a clinical psychologist, and taken part in two live in 'grief' workshops conducted by Dr. Elisabeth Kübler-Ross (1975), and I believe my background is such that I would have been able to recognize if a person was getting too distressed and was in need of support. At all times, my role as a nurse researcher, meant that the needs of the interviewee would always take precedence over any research requirements.

Parkes (1995), based on his extensive background in grief research, suggests:

When a respondent becomes distressed, the interviewer will be guided by the respondent and by his or her own understanding in deciding whether to interrupt the interview. If tape recorders ... are used, the respondent will be reminded that they will be turned off on request... Apart from giving emotional support, the interviewer will confine him-or herself to the research the interviewer should be able to point the bereaved person to possible sources of impartial assessment and advice. (p.180)

In the event, although participants did express emotions, it was not necessary for any of the participants to seek out professional support as a result of the interview process.

Feminist ethics

Feminism, the second source of my commitment to egalitarian interviewing, has long debated the issue of the power relationship between the researcher and the researched. In utilising a postmodern feminist epistemology, I am particularly aware of reflexivity in interviewing and of the need to consider the relationship that exists between the researcher and the research participants. Feminist research highlights the importance of the relationship, stressing the need for quality communication between the researcher and participants. Oakley (1981) challenges many of the standard approaches to interviewing and observes that, for the traditional interviewer, “extracting information is more to be valued than yielding it” (p.58). She stresses that a feminist methodology requires more than the mythology of “hygienic” research with its accompanying mystification of the researcher and the researched as objective instruments of data production, and proposes that this be replaced by the recognition that “personal involvement is more than dangerous bias - it is the condition under which people come to know each other and to admit others into their lives” (p.58).

Ribbens (1989) distinguishes between the ‘public’ or ‘private’ types of information within stories and suggests that certain styles of interviewing can influence the way experiences are interpreted. I am very aware of that the women gave very private, and sometimes very painful, accounts of their experiences of a highly personal and sensitive life event. I had to continuously reflect on my responsibility to them during both data collection and data analysis. For example, I could try to maximise the power of the interviewee within the interviewing process, but exercise power as researcher during the analysis of the data. Ribbens (1989) states of all types of research:

... our research is itself a social process, occurring within particular sorts of social contexts and structures, ...it will have our own thumbprints all over it. (p.591)

Oakley (1981) and Ribbens (1989) also highlight power issues within the interview situation. My own stance is that the researcher has a duty to attempt to redress this power differential at every stage. This has, for instance, involved me respecting the wishes of a small number of the women not to include specific information in the research. Some women wanted to discuss a particular situation, but to have the information omitted from the study. In one instance, when I was forewarned, the tape was turned off but in the other two instances a note was made not to include the information. However, it is impossible to abolish completely the power differential between the researcher and the researched. At most one can be cognisant of its dangers and attempt to incorporate this recognition into every aspect of the research process.

How I, as the researcher, am situated within the research is also of importance. I come to the research as someone who has a personal and professional understanding of grief processes, but who has not yet had to experience the death of my mother. I believe my professional and personal background supports my understanding of issues pertinent to the research, while my position as an 'outsider' in relation to the experience itself supports my focus and dependence on the women's data.

Recruiting participants and gaining informed consent

The criteria for inclusion in the study

There were four criteria for inclusion in the study. Firstly, the study was open to any woman who had experienced the death of her mother, either her birth or adoptive mother, no less than six months before the interview. Whilst I do not support the view that time passed is an indicator of the 'place' or 'stage' in an individual's grief process, this decision was an effort to minimise any potential distress among participants and or members of their families. Indeed, no women

interviewed had experienced the death of their mother within the past twelve months.

A second criterion was that a potential participant should be excluded from the research if she was undertaking counselling and if, in discussion with her counsellor or doctor, *she* considered that participation might not be helpful. Some of the women did disclose that they were having counselling, however *none* considered that the interview process was an issue of concern for them. They controlled this aspect of the process. The third criterion was that participants would agree to the interview being audio-taped. This was discussed with each woman but it was not an issue with any. They were given the assurance that they could withdraw from the study at any time if they wished, and that they could ask for the taping to be turned off during discussion of a particular topic.

A fourth criterion related to the interviews was to recruit an aged based cross-section of women who had experienced the death of their mother when they were between the ages of five to twenty years; twenty to fifty years; and fifty plus years of age. While I recruited women from a range of social circumstances this was serendipitous as the women's social situation tended to emerge only during the interview process. The time period following the death of the mother for the daughters ranged from between one and thirty years.

The participants

The first fifteen women who formally agreed to participate in the study by completing consent forms make up the research group. Chapter Seven introduces the four participants who were children when their mother died, whilst Chapter Ten introduces the eleven women who were adults when their mother died. A small amount of information is drawn from the women's narratives in order to give the reader an understanding of the context of the women's lives.

Participation by the fifteen self-selected women occurred in several ways. Firstly, I was approached by a number of women who, on hearing about the research project through mutual networks, asked if they might be involved in it. I agreed to send information to them about the study, once ethical approval was received. Several other women I met fortuitously. For example, a woman who was providing a service for me at a local institution, asked what I was studying. Within a few moments she had stated that her mother had died some years ago. She spoke with some passion about how the experience had continued to impact on her life, and offered to be part of the study if I wanted people.

I also met with a local 'motherless daughters' support group, and spoke about the research project. Information sheets with my contact address were left behind for any of the women who might be interested in being part of the research. This support group comprised a small number of women who had answered advertisements placed by one of them at a local library and shop. The specific impetus which had led to the initiation of the group was Hope Edelman's (1994,1995) books on the experience of being a 'motherless daughter'. Some women from this group volunteered to be part of the study.

While I had been given ethical approval to advertise through a city book shop if I had difficulty recruiting, this was not required. I did not wish to advertise widely because of my concern about the number of people who might respond. This anxiety arose from the experience of Hope Edelman who was overwhelmed by the response to her book *Motherless daughters: The legacy of loss*, from women from throughout Australia and New Zealand who inundated her with correspondence. I also chose not to access participants through hospital or professional counselling groups. My intention was to interview women within the community and, if possible, outside of the gaze of health professionals. In order to protect confidentiality, and because one of the above mentioned groups is small, I do not intend to give a breakdown of numbers from each group.

I spoke with eighteen women about the research project and fifteen finally participated. The women who did not take part each had their own reasons. One woman, on receiving the information regarding the research, rang me back and said that she would have to regretfully decline the offer to be involved any further as she was now “only getting myself together”. She said “It feels just like a wound has started to heal”, and stated that she was “glad it’s behind me”. She spoke for some time about her mother, how her mother’s death had been a peaceful event, and how she was pleased to have had the opportunity to say farewell, but it was “painful”, and that “she was just starting to get her life in order”. She indicated that her husband had said “It’s six months”, implying she should be over it by now. She gave her permission for this conversation to be included.

One woman did not contact me back again regarding her involvement after receiving the information that was sent to her and I did not re-contact her. The other woman was keen to be involved in the research, however, because of the busyness of her life and her many commitments, this did not eventuate.

After seeing fifteen participants, I considered that I had an appropriate number of participants. At that time I was finding similar patterns occurring within the narratives, and I was getting to a point of saturation when several hundred pages of data had been transcribed. When other women rang to ask if they could be involved in the research, I respectfully declined their offers. It became very clear that the death of their mother is intensely felt by women. Even the other women who unsuccessfully sought involvement in my research gave me a brief outline of the events surrounding their mothers’ deaths. I realised then that my decision not to advertise widely was a wise one because most women appeared to want to talk about their mothers and the events surrounding their death, given an opportunity and an interested listener. I would have been overwhelmed.

The fifteen women are not a representative sample of the New Zealand population. They are all women of European descent, in the main well-educated and middle class. As such they can be expected to have been subject to the major discourses of educated, European oriented society in New Zealand. Whilst generalisations cannot be made from their talk in any positivist sense, they will make manifest in their talk the discursive patterns and tensions engendered by the forces that shape the discourses of larger society in New Zealand. As such, insights from their talk will be applicable to nursing practice in engagement with women like them.

Obtaining consent

When potential participants indicated interest in the research, a general information sheet regarding participation in the study was sent to them to reflect on at their leisure. In order that no one felt persuaded to agree to an interview that they would subsequently regret, I ensured that a period of time had elapsed before responding to each woman's request to discuss the research project.

After contact had been made with me, a time and place to meet to discuss the research was negotiated with each person, usually in their home. The purpose of the study was explained, the nature of the woman's involvement and any other matters that needed clarification, were discussed. An information sheet (see Appendix A) was given to the participant. The interviews were described as providing the opportunity for them to reflect on and talk about their experience following the death of their mother. The women then filled out the consent form (see Appendix B) which included an agreement that I tape the interviews. Each woman chose the name by which they wished to be known in the research.

Data Collection

Thirteen of the women arranged for me to visit them at their home, and the other two women chose to come to my home. I had intended to visit

the participants for about an hour at a time, over a number of visits. I found this to be quite impracticable. The women had a story to tell, and I soon realised that it was not appropriate for me to attempt to control the storytelling because it would have detracted from the sequencing and quality of the narrative. Consequently, a number of the interviews were three hours or more in duration. I have to state that, with a small break for a cup of tea, the time slipped away easily for both the interviewer and participants.

I realised that I was, on many occasions, being 'hailed' into the women's stories, and that the story was in part being recreated in those moments, within the interview. The interview commenced with an open question such as: Can you tell me about your relationship with your mother? and/or: Can you tell me about your experience of being a daughter? Thereafter, questions were determined primarily during the dialogue. The interview style was one of drawing out the participant and of valuing their experience. Whilst the participant controlled the actual interview process, I was able, either within the dialogue or at the end of the interview, to ensure that I had covered areas listed in the predetermined interview prompts (see Appendix C). I found I was very comfortable with the women's own sequencing of their stories. The interviews were taped not only in order to have a verbatim record of the 'data' for analysis, but also to enable reflection on the interview process itself including tone of voice, pauses, silences and issues such as an abrupt changing of the subject.

Although I attempted to create an open and interactive dialogue with the women in order that they would, as much as possible, 'control' the dialogical process, I am aware that this data reflects both the subjectivities of the fifteen women interviewed as well as my own, and that the interactions between the interviewees and myself were inevitably shaped by the 'talk' that we co-created, in response to the research questions. My focus centred around understanding what grief and loss to death meant to each participant.

Data analysis

All of the women used a narrative form, incorporating a 'storyline' with characters, subject positions, and a plot indicating personal development. The narrative in this sense was a powerful, practical imperative. It determined the shape of the research outcome in that all of the women determined to tell their story in their own way, and not in my time frame.

The narrative has been well recognised as a form of making sense of self and experience. This viewpoint is held by Mischler (1986), Ricoeur, (1986), Franks (1997), Stanley (1994) and Freedman & Combs (1996). Chapman (1978, p.19 cited in Smith, 1980) suggests that "structuralist theory argues that each narrative has two parts: a story (*histoire*) [that is,] the content...and a discourse (*discours*), that is, the expression, the means by which the content is communicated" (p.215). Hyden (1997) suggests the narrative's importance is its form because it is one of the main ways through which "we perceive, experience, and judge our actions and the course and value of our lives" (p.49).

MacIntyre (1981) asserts that "it is because we all live out narratives in our lives and because we understand our own lives in terms of the narratives we live out that the form of narratives is appropriate for understanding the actions of others. Stories are lived before they are told—except for the case of fiction" (p.197). Mattingly (1994) argues that narratives construct our understandings of the world, suggesting that there is always distortion in narratives "because of our temporal existence" (p.811).

It is through the analysis of the narratives constructed by the women in this study that I was able to identify and make sense of the various intersecting and interrelated discourses. Examination of the narratives showed how these discourses have impacted on the lives of this group of women.

Each narrative demonstrated a movement of “plot”, a change in their subject positions, as new discourses were taken up, arising from their changes in understandings and circumstances over time. The women use the narrative to constitute, create, and recreate their knowledge of the grief experience and the mother-daughter relationship. Ricoeur (1986) suggests that it is “*narrative identity*” which constitutes us.

I emphasize the expression “narrative identity,” because that which we call subjectivity is neither an incoherent succession of occurrences nor an immutable substance of becoming. It is exactly the kind of identity which the narrative composition alone, by means of its dynamism, can create.
(p.131)

The study of the narrative offers, according to Hyden (1997), understanding from a number of vantage points:

as a social and cultural construct, as a transformation and expression of ... suffering, and most of all as the suffering person’s attempt to construct ... her world, to find ... her own ... life context. (p.65)

The narratives of the fifteen women each represent their situatedness and context, and allow for an examination of the politics of power revealed within. Their subject positions are neither wholly heroine or wholly victim, but a tense and often conflicting interplay of both.

While each narrative is delivered in the present, it conveys evidence of a linear progression through time; there is a past, a present and a future. Ricoeur (1986, p.130), draws on St. Augustine’s treatise on time (Confessions Book XI) to suggest that memory is the “presence of the past”, awareness is “presence of the present” and expectations are the “presence of the future”.

During the analysis each narrative was examined for its discursive patterning at macro level, and for identification of the micro techniques through which discourse was utilised in the storied lives of these women.

The following three steps outline the process of data analysis.

Step one: Identifying general discursive parameters

I began the analysis by reading and re-reading of the transcripts. This process continued throughout the analysis. Initially, I read with a view to noting the participants' responses to my statement about the aims of this research and the interview prompts (see Appendix C). This first phase of reading generated new categories of information that are presented as Appendix D.

In the next phase I sought to understand the social world of the women as revealed within their talk and to identify the overall discursive patterns that existed within the corpus of the text. This served to give a sense of the shape of the general argument embodied within the women's talk. I do not argue that the outcome of this process of identifying patterns is generalisable to other women; rather it is an overview of the discursive phenomena that I was able to identify in the narratives of these particular women.

During the early stage of data analysis I began to identify two primary patterns, one associated with those who were children when their mother died, and the other with those who were adults. This began to shape the research outcome. The following summative descriptions of the two patterns indicate the general differences between the two groups and well as my beginning recognition of pattern within the narratives.

Pattern one: Those women were children when their mothers died.

The dominant theme is of the mothers' sickness and/or unavailability. The narrative is framed around either a physically or psychiatrically ill mother, who is not well known, or remembered by the daughter. Rather, the mother is remembered around certain significant events that happened, that influenced the daughters' lives. The daughters' talk is about grief that pervaded the whole of their lives, grief that began prior to the death of their mother and ever since. The story-line goes on to describe how the daughters tried to make sense of the little known and remembered events, or of how they attempt to find out the 'real' story surrounding these events. However, for some of the women their talk is about their still not knowing

and of the impact that silence has had upon their lives. Finally, their narrative is about how they have kept their mother's memory alive, and their ongoing search for details of their mothers' lives. The women speak of their understandings about death. For some, death is death, it is the end. Others discuss how they still feel connected and continue to make meaning around the events.

Pattern two: Those women who were adults when their mothers died.

The dominant theme for this group of women is that the emphasis is on the quality of relationship that the women had with their mothers. Their described subjectivity is viewed as relational, and appears not to be based on understandings of an autonomous self, rather of a self-in-relation. The sequence surrounds, firstly, talk about the mother and daughter in relationship. The daughters speak of the events leading up to the mothers' changed health status and death. Tensions exist here around information control, and their subjectivities surrounding these events. The women tell a story about their mother's death and the part they played in it. Finally, the women talk of how they are continuing to reconstruct their lives following their mothers' deaths. For a number of the women their talk is about how their mothers are still part of their world. They explain how their mothers continue to be a part of their lives, and of how they are an integral part of their being, and understanding of self. They discuss their understanding of continuing bonds.

Step two: Determining the discursive structure

The next step was to further deconstruct the discursive elements within the women's talk. I again read and re-read the data in each transcription and began to deconstruct the data word by word, phrase by phrase, person by person. I was searching for patternings that were common to all as well as ones that reflected the differing tensions, or subject positions of the women.

Whilst scanning the text I was looking for words and phrases that crystallised the emergent patterns and conveyed the fullest impact of what was being said. These were words and phrases that did or could go

beyond the immediacy or the idiosyncrasy of what was being said. Such words have, or carry within them, a discursive weight, in that they often capture a repetitive meaning, and can be analysed by grouping them into fields of meaning (Grace & Arnoux, 1994; Arnoux, 1995).

These key words and phrases served to highlight tensions within the text that, in some instances, I initially perceived of as being of less importance but, on further reflection, changed my mind following the recognition of beginning patterns. I analysed the text as a corpus and went beyond the idiosyncrasy of the women's talk. Once all of the major groups of words were identified into associated fields of meaning and grouped, I was able to identify three major discourses. I then wrote a metadiscourse to reflect *the essential components of the three discourses*.

Step three: Identifying the resources and techniques of discourse

Concentrated re-reading of transcripts began to attune me to the importance of subject position and how subject-position was put into context by the women in this study. Alerted by Foucault's understanding of discourse I became increasingly interested in how the women constructed 'roles' for themselves in a narrative of grieving. The most salient narrative resources were the subject-positions that were adopted. I began to see that subject positions were also narrative characters and that there were storylines which served as context for these subject positions.

I was able to identify four key storylines present in each narrative.

- A *death story* in which the mother's death is depicted as either a 'good', or 'chaotic death',
- A *self-in-relationship story* in which the women speak of the care that existed between mother and daughter for each other.
- A *politics of grief story* which incorporates sadness over the life of the mother, and/or the effects of silence,

- A *striving for connection story* in which the women seek metaphysical/psychical connection with their mothers.

I then looked at the “discursive practices” and “discursive resources” that were drawn on by the women. These terms are defined by Potter & Wetherell (1995), who describe discursive practices as “what people *do* with their talk”, and discursive resources as the “resources that people draw on in the course of those practices” (p.81). From examination of how the women use the narrative, and from attending to their descriptions of events, I was able to determine the subject positions that the women were drawing from (Althusser, 1968/1971; Davies & Harre, 1990). The term ‘subject position’ as used in this study derives from the belief that subjectivity is a linguistic construction. For example, in the following chapters the women will often be seen depicting themselves as morally caring, and as committed and responsible daughters.

Generating the outcome

The ongoing process of data analysis led to the identification of three distinct discourses: *Continuity*, *Discontinuity* and *Silencing*. Other discourses may exist within the narratives, but these three constitute those relevant to the research problematic. It is the patterning of these discourses, their interconnections and tensions, and their essential components that give form to the metadiscourse of grief which is the research outcome.

In the discussions on the three discourses in subsequent chapters they are separated out for the purposes of presentation. However, within the understandings of each woman they co-exist and interrelate. Each discourse is multidimensional, and has a number of identified characteristics. At different times and in different circumstances a particular discourse will have pre-eminence. In particular, continuity and discontinuity co-exist in tension with each other, with one having

primacy at any given time, and with silencing intersecting both discourses, but having a profound influence on discontinuity.

In summary, this study uses the processes of discourse analysis to examine the narratives of fifteen self-selected women. The outcome is the identification of three distinct discourses, namely continuity, discontinuity and silencing, which function in interrelationship to constitute the metadiscourse within which women construct their understandings and experience of grief. Analysis of the data revealed two different patterns within the metadiscourse primarily associated with the age of the daughter when her mother died. Each pattern has identifiable characteristics which are stated in general terms supported by examples selected from the data. However, each pattern is manifested differently when situated within the actual life circumstances of each woman.

In the next chapter the emergent metadiscourse of grief is discussed in more detail.

CHAPTER SIX

THE METADISCOURSE OF GRIEF: CONTINUITY, DISCONTINUITY AND SILENCING

This chapter, which begins the presentation of the research outcome, explores the metadiscourse of grief through discussion of the essential components of the three distinct discourses which emerged during the processes associated with discourse analysis: *Continuity*, *Discontinuity* and *Silencing*. These reflect and embody the social processes and discursive imperatives around the experiences of the daughters bereaved of their mothers, who participated in this study. In later chapters I will discuss how these discourses were characteristically presented as the women utilised the structure of the narrative to present and develop their understandings of the death of their mothers.

At this point it is important to reiterate that the narratives which form the corpus of the text, and are scrutinised by the gaze of the researcher, are all situated within the circumstances prevailing within a particular society at a particular point in time. Despite the idiosyncrasies of personal circumstance, which become evident as individual narratives are subjected to the processes of discourse analysis, the interview transcripts yield structures and reveal ideas reflecting shared social

processes and socially available understandings. Although there can be no claim to universality or generalisation, the discussion which follows may offer insights relevant to women of European decent who have experienced the death of their mothers.

Introducing the three discourses

The discourses of *Continuity*, *Discontinuity* and *Silencing* can all be identified at some time, and in some form, in the talk of the fifteen women in this study. Of course, not all aspects of each discourse are present in any one transcript because they emerged through an inductive process of discovery within the corpus of the text.

Before discussing the patterning of the three discourses within a metadiscourse of grief, the defining characteristics of each discourse will be introduced.

Continuity

Continuity is a discourse which places the daughter within an ongoing relationship with her mother. It can refer to the relationship existing when the mother was alive, and therefore physically present with the daughter, as well as the relationship regenerated at a psychical level by the daughter after the death of the mother. A selection of key words and phrases from the text depicting continuity are listed in Appendix E.

Continuity incorporates ideas of:

social connection (the self-in-relationship)

mutuality (intersubjectivity - "we" and "she and I")

psychical knowing and/or connectedness

spiritual connectedness

ideological beliefs surrounding connectedness

'bad' or inappropriately continuing grief

Continuity is a multidimensional discourse made up by four distinctive components. Each component will be introduced supported by selected exemplars from the text.

The first component can be seen in words and phrases that reflect a **positive relationship**:

We had an extremely close relationship.

I was very very loved to the point of distraction.

I was more my mother's friend.

She was more like a sister.

This discourse is characterised by talk of:

- Harmony
- Comfort
- Support
- Encouragement
- Affection
- Caring
- Love
- Closeness

The second set of key words and phrases can be seen in words that reflect **an intersubjectivity**:

We were so close really, we created our lives around each other.

We'd chat away for hours.

We were so much alike, so close really.

She was always there for me.

Continuity is also characterised by talk of:

- Connectedness
- Engagement
- Mutuality

- Reciprocity
- Togetherness
- Relatedness
- Incorporation
- Availability
- Being with

Within this discourse the women's language is inclusive, with references to "we" and "us" as well as "she and I" as they speak of the remembered intersubjectivity of daughter and mother.

The third set of key words and phrases can be seen in words that relate to **a sense of perceived and/or desired ongoingness:**

I still feel linked with her, she's just there.

I catch a glimpse of myself in the mirror and I see my mother.

She is with me forever.

I've become my mother.

[She is] watching over us benevolently.

Continuity is also characterised by talk of:

- Always
- Linked
- Connection
- Present with
- Continuing bonds
- Spiritual presence

There is a remembered connection when the mother was both physically and socially present, and in relation with the daughter. Later, on a psychical and spiritual level, the women create, incorporate and integrate into their present lives an ongoing mode of relationality with their absent mothers. Thus, the daughter-self is depicted in ongoing

relation with her mother. The mother-daughter relationship tends to be valorised and the daughter positioned as one who cared, who cares, and/or who wants to care. A *moral ethic of care for the other* characterises these narratives about heroic mothers and daughters.

The fourth set of key words and phrases subsumed within continuity reflect an **active process of reconstructing the events surrounding the mother's life and death:**

She [friend] has a lot of my memories. She's giving these back to me and it's fantastic.

They would talk about her, they didn't let her memory die.

I need to talk, to try to understand....It was important to me to tell the whole story.

It's important for me to find out about my mother's life.

There is clear evidence that the daughter recognises and processes unresolved issues associated with her mother. The reconnection between mother and daughter becomes incorporated into a new understanding. This view incorporates the deceased mother into the daughter's current understanding of life.

Continuity is also characterised by talk of:

- Reconnection
- Reintegration
- Reawakening
- Reconciling
- Regained continuity

Discontinuity

Discontinuity is a discourse which places the daughter outside of the relational sphere. This discourse refers to death as the end of the mother-daughter relationship, but this study reveals that this discourse is a consequence of other losses as well. The women describe a number of different terms that herald in what discontinuity means to them.

Discontinuity incorporates ideas of:

- the absence of the mother through illness and hospitalisation*
- the loss of the mother to illness and medical regimes*
- the death of the mother*
- the social loss of the mother through silence, through the absence of talk and the loss to memory over time*
- the need to get over it (the medical/psychodynamic discourse on ‘‘good grief’’)*
- the expectation of decathexis (a medical discourse)*
- the expectation of disengagement (a medical/psychodynamic discourse)*
- the hiding of death (a sociological discourse on the sequestration of death)*

Discontinuity is marked by two themes which are introduced together with selected examples from the text. A selection of key words and phrases from the text depicting continuity is listed in Appendix F.

The first set of key words and phrases refers to the recognition of a **disruption in the mother-daughter relationship**. Sometimes the women refer to events and circumstances surrounding the mother’s death as part of the disruption eg. Illness and hospitalisation.

- They found the tumour, it was too late.*
- She was mostly in hospital. She wanted to die at home. She hated it there.*
- She died. I was stunned with the shock. How dare she leave me I was so angry.*
- But after a week or two, they don’t really want to know.*
- All that they want to do is to get on with their lives.*

Discontinuity is characterised by talk of:

- Illness
- Separation
- Death
- Absence
- Change
- Alienation

The second group of key words and phrases relate to the daughter's **suffering over the death of her mother.**

...that feeling, walking out of there just knowing we wouldn't talk to her again.

Its like the worst has happened, It's a huge thing inside me.

The pain gets less, but it never really goes away. You never get over grief.

This discourse is also characterised by:

- Dislocation
- Disappointment
- Disconnection
- Separation
- Pain
- Loss
- Grief

Paradoxically, within this discourse there is a common expectation that the experience of loss and grief should be a temporary dislocation to life and work. One is expected to move on and create new relationships and relate to others as an autonomous and independent person. Themes of dissociation and self-control are common in the text.

I disassociated myself from it.

I just chopped off, I disassociated from it. I kept myself in control, I mean I control it.

It never got talked about.

Silencing

There are two elements within this discourse: silencing as the act of silencing others, and silence as absence. Appendix G outlines a selection of key words and phrases from the text depicting aspects of silencing.

Silencing incorporates ideas of:

using words like "it" in place of 'death'

a protectionist discourse

a lack of appropriate language to adequately represent death

that which cannot be spoken

Silencing and silence are powerful contributors to the primacy of the discourse of discontinuity.

They can't mention the word death, these things get turned into something abnormal.

We picked up messages that you weren't allowed to talk about it. We grew up in those days not asking about anything. We would have taboo subjects.

She [mother] said "I love you but I have to go now".

It was all very much "Let's not bring it up, because we will probably upset the poor thing".

You know, saying "Oh lets not talk about it", and, just sort of business as usual I guess.

Silencing is characterised by talk of:

- Denial
- Absence
- Protection
- Being over it

The metadiscourse of grief: Discourses of continuity, discontinuity and silencing

The three discourses of continuity, discontinuity and silencing are always in relationship and bring together and represent the key and common elements of the metadiscourse of grief. They highlight options available to grieving daughters.

Grace (1998) defines a metadiscourse as representing:

... a cohesive structure that goes beyond the individual and idiosyncratic patterns contained within the corpus of texts to reveal a singular discourse, or number of discourses that most of the narratives reflect at some point.

(p.261)

I am using Grace's concept of metadiscourse to explicate understanding of grief as it is constructed by the interplay of the discourses of continuity, discontinuity and silencing. Whilst continuity and discontinuity can be viewed as absolute binaries, in the same way that life can be viewed as the positive opposite of death, they do not appear that way in the narratives of the women in this study. The discourses are contradictory and offer the availability of quite different subject positions¹⁴ that can be taken up. The politics surrounding these discourses are important.

The discourse of continuity enables women to retain a construction of self-in-relation in making sense of the event of death, through continuing psychical bonds with their mothers. Discontinuity supports dislocation of the self from personal relationships and inserts the individual as a prop for the institutions of the family and the state. Within medical and management discourse, death prescribes a goal of 'getting over it' and accepting discontinuity as a part of life.

Discourses have both content and form. The content is outlined in the sections which follow and sets the scene for a more detailed exploration of their multi-dimensional forms in Chapters eight, nine, eleven and twelve.

The discourse of continuity

Continuity is the emergent discourse. It exists in tension with the discourse of discontinuity. The dominance of one is clearly at the cost of the other. Continuity is present everywhere in the talk of the women but it is countered and subjugated because it lacks the formal and institutionalised backing of the dominant medical and psychodynamic ideologies. In this sense it is a subversive discourse when surrounding

¹⁴ See Davies & Harre (1990) for a discussion on the concept of subject 'positioning', and how the self can be argued to be discursively produced. Consideration is given to the subject positions we identify with that constitute our understanding of self or identity. Our subjectivity is seen to be in constantly in process and reconstituting us on a daily basis.

illness, death, grief and loss. Both continuity and discontinuity, but primarily discontinuity, are rendered more powerful when reinforced by the third discourse that I have identified as silencing - an act - and silence - a consequence.

The following selected quotes show how the discourse of continuity connotes a mother-daughter relationship involving connectedness that incorporates a concept of reciprocity and mutuality. This was present in the talk of all the women in this study¹⁵.

We had an extremely close relationship. She was always there you see, she was always there for me. We were so close really, we created our lives around each other. She spent time with me, she'd sit down and talk, we'd chat away for hours. We were the greatest of friends, she would listen like no one else really. We were just so much alike, so close really.

The relationship is impacted upon either by a short term or chronic illness event, or by sudden death. There is now a strongly competing discourse of discontinuity which involves a rupture and change in the status of the relationship, but continuity remains.

I catch a glimpse of myself in the mirror, and I see my mother. I have a lot of her ideals, I talk to her, how often I think of her. I can see her in me, she's part of who I am, what I do and how I see life. I still feel linked with her she's just there somewhere. I know that she's around me, I think oh, she would have liked that. I have this sense of continuity, when she died it was like she was out. I have a sense that she's just there, that people who have died are watching over us.

They didn't let her memory die, they would talk about her.

The key elements that make up, structure and constitute the various facets of continuity within the mother-daughter relationship, can be seen through categorising the subjective pronouns and key words and phrases that describe the relationship through time. The discourse of continuity surrounds beliefs of 'knowing', of 'connection' or 'connectedness', that the women are able to speak about.

¹⁵ Words and phrases representing the discourse are presented in italics.

Identification with the mother was achieved through the utilisation of various modalities to achieve ongoing connection, such as: identification through the reiteration of past discursive practices, and the incorporation of past mother-daughter or family rituals. Other processes identified were:

The need/desire for a continuing relationship through invoking the mother and or utilising modalities of psychical incorporation and connection.

The iteration of various beliefs and ideologies to incorporate either secular or religious knowledges to their understanding of a spiritual connection with the mother. Particular storylines supported the daughters' understanding of self-in-relationship.

The discourse of discontinuity

The discourse of discontinuity is present in the narratives of all the women, but there is significant variation in the pattern and length of time that discontinuity is present. Discontinuity is presented by the majority of the women as a painful and difficult time in their lives. This discourse enables and supports subject positions of grief and rage, and is remembered as a time of separateness, and of feelings of alienation and aloneness.

For the women whose perceptions of their relationship with their mothers involved significant periods of emotional or physical separation which began in childhood, discontinuity is the predominant discourse. The mother's death is portrayed as both a physical and a *social* loss, compounded by a powerful silence. Their grief is as much over the social loss of their mother-child stories and hence their understanding of the events surrounding their mother's death. A number of these women have very little knowledge about their mothers' lives. The women grapple with understanding and making sense of the discontinuity and their desire for continuity and connection.

For the women who had a good relationship with their mothers and experienced the death of their mother in middle age, the experience of discontinuity is still evident and painful yet, over time, there is a fading with the gradual re-emergence of a powerfully felt discourse of continuity.

The beginning of discontinuity is reflected in these statements:

She had a fear of hospitals, she couldn't face going to hospital, she wanted to get back home, it was this terrible fear. They found the tumour, it was too late. She got secondaries, they were giving her chemotherapy. She was so sick, so ill. She was mostly in hospital. She had been dying for a long time. It really only gave me about ...years of knowing her, other than being ill. In the process of her illness I lost a lot of my memories.

.....

She died. It was like the greatest loss in my life, an enormous loss, a huge loss. The pain gets less, but it never goes away. I couldn't believe she had gone. It was just a huge thing inside me. It was raw, it was something I couldn't possibly put into words or anything. I thought I was going to go 'beside myself', I was in a terrible state. I was stunned with the shock. There was this great big hole, it's quite a scary thing. It's an overwhelming feeling that comes out of the blue. I cry quite a lot.

Discontinuity is variously depicted as an outcome, a requirement, and/or a chosen behaviour:

I just chopped off, I disassociated from it. I keep myself in control, I mean I control it. I cut off my feelings. You 'kid' yourself that you've coped. I don't go around with a long face. I never allowed myself to grieve, I was determined not to let any emotion show. I really wasn't able to talk about it.

She said "Well just get a grip of yourself", just get on with it. I went and did some grief work.

From the beginning, the fear of death triggers a discourse of discontinuity, intersecting and competing with an increasingly subjugated discourse of continuity, and invoked by the often ambivalent utilisation and adoption of a medical discourse. Both the mothers and

daughters become intimately involved with the medical regimen. The mother's body becomes objectified, and an object of medical and family scrutiny. All of the women utilise a medical terminology that focuses on signs and symptomatology. These descriptors surround the daughters' illness accounts. The women who did not utilise medical descriptors tended to be either children when their mothers died, or women whose mothers died suddenly.

This discourse primarily depicts what 'it' (illness) or 'it' (death) evokes in relationships. 'It' represents an undesirable take over of *the body*, by illness or by death. The body becomes objectified and separated out from the person. 'They', the health professionals, are depicted as supporting continued life and preventing death from taking over. 'They' offer the illusion of overcoming death on the one hand, and yet on the other hand 'they' are depicted as promoting the need to 'get over it'.

The possibility of discontinuity is heralded in, yet is denied by most of the daughters in a renewed focus on supporting the mother's "disciplining" of the body¹⁶, in a bid to give pre-eminence to their desire for continuity. Death is that which happens to others. The desire on the part of the mother and daughter to collaborate with "medicine" and to manage the illness begins. In the women's talk, the discourses of continuity and discontinuity compete: the women look to medicine for care and continuity, yet the encounter with medicine hails in the imperative of discontinuity. The hospital and the hospice are modern signifiers of discontinuity. The mother's illness is therefore experienced as highly conflictual, as the daughters' encounters with the institution of medicine are wanted, yet not wanted; trusted yet not quite trusted. A number of the women question what the treatment and hospitalisation experience is doing to their mothers and to themselves.

¹⁶ Frank (1995) refers to the disciplined body as a type of body self that "attempts to reassert predictability through therapeutic regimens" (p.41).

Medically, the expectation to 'get over it' is a form of disengagement which occurs through the process of decathexis. The tasks of grief are seen as relinquishing one's bond with the deceased, and "withdrawing emotional energy and reinvesting it in another relationship" (Worden, 1982, p.15). This medical/psychodynamic discourse is very powerful. When describing their grief experience, a number of the women intimate their adherence to the idea that there is a 'proper' way to grieve, and that they have not grieved properly. On the one hand, they suggest, that they 'should' be over it, in other words, that disengagement should have occurred. Medical metaphors, such as, "cutting it out" are utilised to depict the process of getting over "it". Yet on the other hand, the women challenge their own words with comments that suggest "you can never get over it". In these conflicted ways the competing discourses of continuity and discontinuity are played out.

Read this way, the women's talk also supports alternative understandings of how to grieve. There is no doubt that the women understand death as a cessation of physical life, but their talk clearly demonstrates a tolerance for ideas about death that are broader than the merely physical. They speak of their mothers as still forming part of their thinking and being, and talk of a ongoing psychical relationship despite physical death. For them this is not incompatible. Whilst the women indicate that the intensity of the loss diminishes over time, they indicate that the loss does not "go", it is simply reconstituted and experienced differently. The 'mother' is still a part of the women's psychical, and social self.

The discourse of discontinuity is the discourse that the daughters draw on to construct their understanding of loss. Discontinuity is the moment of rupture of the daughters' prior way of thinking and being in continuity with the mother. The onset of chronic illness, or cancer or sudden death is the event that is most often described as taking over the lives of both the mother and the daughter. These life events are the sites at which the competing discourses, continuity and discontinuity,

intersect. The perception is of movement from that which is known, to the unknown or different.

Five of the women depict their relationships with their mothers as not having the level of connection and mutuality that they desired. They describe their childhood experiences as different from others. They speak of being 'I' or 'other'¹⁷, but not 'we'; their stories are not about a 'she and I' or 'us'. The fathers of these women had either died or were unable to be their primary caregiver, thus increasing the experience of loss. For this group of women there is no strong sense of connection. Their grief is sited around the lost potential of the "ideal" mother-daughter relationship. They grieve for what they never had or were unable to experience for any length of time; their mothers were unavailable.

Discontinuity heralds the belief and expectation that people recognise that culture is subordinate to nature, and that, between culture and nature, death exists (Seale, 1998). Discontinuity involves a recognition and understanding of our embodied status, and a belief that death is the end. Continuing to maintain a psychical bond with the mother is viewed as either 'complicated or 'pathological' grief. Any failure to get over her mother's death is judged as a form of weakness in a daughter. Within medicine, discontinuity is a dominant discourse.

The discourse of silencing

This third discourse of silence, or silencing, is a complex and powerful discourse which may have been invoked as a protectionist strategy by those around daughters at the time of their mother's dying. However, the women do not equate the silencing with being protected. They explain silence as an absence of telling - "we were never told" - or as something that was intuitively known but forbidden - "we picked up

¹⁷ Other is defined in this instance as differentiated from, being in a state of abjection "cast off, away, or ...differentiated from" (Butler,1993 p.243).

messages...the subtle things that go on in families that aren't actually said". Silence is also learnt through family rules which were explicitly stated: "Oh let's not talk about it!"

The most powerful impression I gained from analysing the corpus of text was of the daughters' sadness over the loss of the quality of relationship. All of the women within this group acknowledge what I term a 'politics of grief' incorporating silencing that is entwined within their relationships. They demonstrate an understanding of their enmeshment with their particular family plots, and of their complicity with the politics and silences of family life. The roles the women played out were not of their choosing. This study does not reinforce the 'happy family' myth. Rather, the research indicates that the family can be as confining and conflictual as it is nurturing.

Death was often referred to as 'it', thus the word itself is avoided. It is not only the dying mothers who experience difficulty with articulating the concept of death. Death is defined in the Collins English Dictionary and Thesaurus (1993) as "the permanent end of all functions of life in an organism". This view is consistent within medicine's citing of death in the body (Foucault, 1963; Armstrong, 1987; Prior, 1989). It is possible that there is much about 'death' within its current usage which is unspoken.

Whilst most of the women did not talk openly with their mothers about death, it continues to assume a prominent place in their thinking. 'Death' was rarely named, and if it was, it was often in response to a question by me as the interviewer. It appears that 'death' is the signifier that least is said about. Inherent in the women's talk were the difficulties that the daughters experienced over the absence of talk about death. To name death is to signify the loss of the 'self', a loss and comprehension that is almost beyond words.

There are many accounts of silencing in the text. More questions are raised than answers are given. The women characterise silencing on the

one hand as something that happened to them, whilst on the other hand, silencing is also acknowledged by the women as something that they were both complicit with, and implicated in.

All women described family and institutional silencing as having occurred, or as still occurring. Three of the four women who experienced the death of their mothers as children describe their being made 'other', that is, separated through silence, either within their respective families or within their schools. Talk about their mothers was avoided. All were silent. These women experienced a social isolation in ways that the 'adult' women did not. This position appears to support a belief common at that time that 'children are to be seen and not heard'. Silence is used both to support and suppress talk or action surrounding the themes of continuity and discontinuity.

Family silencing

All of that was *completely unspoken*, if I had been told at the time. *It was never discussed never discussed*. She would *not speak to me* about it, *she would not talk TO ME*. *That word was never used*, she would *not admit to me*. She was dying *she didn't say to us*, but *she knew*¹⁸.

Institutional silencing

We picked up messages that you weren't allowed to talk about it. It was all very much *lets not bring it up*. **They** were rather equivocal *they didn't say too much* about what the outcome would be. *They can't mention the word death*, these things get turned into *something abnormal*. **They** wouldn't, **they** just *wouldn't let her go*, really we had no control in the end. *There was real dishonesty*.

I need to know, it's my right to know

[Women who were children when their mothers died]

¹⁸ Perreault, (1995) makes an interesting link between silence and language. She suggests that "if death is silence then life must be (in part at least) language, and giving the self in language, or to language is a death-defying act" (p.25). Was the mother's actual silence (excluding the symbolic) a part of becoming death. Or is it more?

I have unanswered questions, what happened at the time? I want to find out, to know about my mother's life it's important for me.

[Women who were adults when their mothers died]

I was furious that wasn't the answer at all. It was an incredibly jerky start which was pathetic. I mean their not telling.

[The daughter's complicity with silencing]

I have got nothing to piece these things together now because I haven't asked.

I wish I had been able to say, we mask it and then we become unconscious to it.

The concept of silencing raises a number of theoretical issues. Issues such as what silence or silencing achieves for different groups of people? Also, the extent to which silence aids in creating a sense of power or powerlessness. Consideration needs to be given to what silence both conceals and reveals.

The women who were children when their mothers died position themselves as being controlled by processes of silencing, and also as being agents in maintaining silence. The women who were adults when their mothers died describe a politics of denial. Silence is explained and understood as a 'discourse of protection'. The women describe events in which family members utilise control and silence in order to 'assist' them to disassociate or disengage from the past and its losses.

Some of the women who experienced the deaths of their mothers as adults also draw on a discourse of silencing to explain their lack of knowing about their mothers' illnesses or impending death. Their discourse raises the question of why this is so. Why do the women describe silencing as happening to them within the family and institutional context (see Appendix G), yet also indicate a complicity with the silencing? The women's desire to know the facts and to understand supports the liberal humanist discourse which advocates a right to know. Their narratives suggest that the denial of the dying process was actioned by medical and nursing staff in ways that are described as both intentional and unintentional.

The talk of the women who were children when their mothers died does not include accounts of their actual involvement in their mothers' dying. Three of the mothers were terminally ill, the fourth woman died unexpectedly in surgery. Whilst all four mothers died in institutional care, three of the daughters tell of their not being included in the talk and processes surrounding their mothers' dying, which indicates a possible denial of the dying process at an institutional level. The institutional silencing that this group of women describe comes from within the institutions of education and the church.

The questions surrounding the function or purposes of silence and silencing are complex. On the one hand, despite some of the daughters who were bereaved as adults making claims of mutuality, a number of their mothers are depicted as being unable to speak with their daughters about their dying. Of significance is the importance that daughters attach to the absence of the spoken word. It appears the act of 'telling' is valued more highly by the daughters than their already intuitively 'knowing' and reading of various symbolic acts that death is close. Why is this? The absence of speech is reported by a number of the women as a 'betrayal'. Yet it is interesting to note that most of these women do not use the word 'death' themselves.

Within current discourses, the silence that surrounds death appears to be linked to it's being the binary opposite of life, the problem is in part linked to the binaries that exist within our language. The silencing of 'death' talk may simply reflect a nihilism that has to be, and must be, silenced in order to 'get on' with, that is cope with, life. The actual dichotomy between life and death makes it difficult to depict this concept well.

What 'death' is, is what needs to be deconstructed. Death awareness and death talk appear to be deflected by the participants' focus on the 'body'. The event and impact of illness enables a focus on the control and management of the body, and on the many valid issues surrounding the

grief that is involved in the institutionalisation (the beginning experience of discontinuity) and sequestration of the dying. This silence, or 'absence', appears to be a strategy that is utilised by a number of the daughters and by health professionals. It links in with the medical ideology surrounding the need for "disengagement" and with death as discontinuity being sited within the body. The silence surrounding death talk may relate *not to* 'control over' others by the medical profession, but rather to the silence that surrounds death that is difficult to speak about.

There is the possibility that, in the expression of words of farewell, the act of speaking those words involves an acceptance of their finality. Perhaps, for the mothers, silence aided the possibility of hope, that is of denying 'death', at least in the interim. The mothers' silence could also be read as involving a recognition and acceptance of the dying process, thereby contradicting what I have just suggested. Silence may be linked to an acceptance of the inevitable, and indicate collaboration with the dying process which, in itself becomes the final silence. Currently available discourses may be inadequate to the task of meaningful dialogue and of explanation of the enormity of the upcoming change, a change that results in a letting go and cessation of the conscious self.

The complexities and issues that surround silencing - an act - and silence - a consequence are many. To suggest the mothers simply failed speak with their daughters is to simplify the whole issue of what silence means and might achieve. All that I can represent is that for a number of the daughters the absence of discussion was a sadness. As Armstrong (1987) suggests, "truth telling" now involves an expectation of the interrogation of the dying. Historically, the dying mother would have once been protected from the knowledge of her dying, with the family covertly complicit. Currently, there is a perceived requirement for the dying to grieve and to explain their dying, and to be heard to accept.

Schematic representation of the research outcome

The following schematic representations are an indicator of some of the patterns found within the analysis. The diagrams do not summarise all the points raised, neither are they intended as models. They do however give an indication of the narrative movement to be told within chapters eight, nine, eleven and twelve.

Schematic representation of how discourses are drawn on by women who were children when their mother died

Childhood

Hypothesised if not remembered continuity

Idealised subject position: **The self-in-relationship**

Discontinuity

The absent mother and childhood silencing are the dominant motifs

the loss of the mother through illness and/or hospitalisation

the loss of the mother to medical regimes - disciplining of the body, focus on illness

subjugation of knowledges - the imposition of silence and exclusion

the death of the mother as betrayal resulting in powerlessness, alienation and grieving

Available subject position: **The self-as-other**

Transition to adulthood

Discontinuity and silencing

Childhood silencing, unanswered questions and the search for the archetypal mother are the dominant motifs

the absent mother

the social loss of the mother through silencing

the expectation to "get over it"

the sequestration of death

self blame, shame, and powerlessness

Available subject position: **The self-as-other**

Adulthood

Recovered Continuity

Revivifying connection and making sense of the death of the mother is a dominant motif

reawakening bonds "psychical knowing", relatedness, and agency

the remaking of the self and relationship through dialogue - integration

spiritual connectedness

Available subject position: **The self-in-relationship.** At time of interview subject position in tension and movement between past discontinuity and future continuity.

Schematic representation of how discourses are drawn on by women who were adults when their mother died

Adulthood

Continuity

Mutuality is the dominant motif

connectedness and presence

mutuality and reciprocity

togetherness/relatedness

Available subject position: **The self-in-relationship**

Discontinuity

The motif is striving for continuity amidst discontinuity

the beginning of loss: illness and hospitalisation - powerlessness and grief

the social unavailability of the mother - loss of centrality within relationship

the death of the mother - absence, betrayal, rupture, grief and powerlessness

Available subject position: **Self-becoming-other - beginning loss of mutuality**

Silence/Silencing

The motif of powerlessness

the expectation to be "over it"- family and institutional silencing - victimhood, betrayal and complicity

the sequestration of death -silence

Available subject position: **Moving from victimhood and/or complicity to resistance**

Recovered Continuity

The motif of changing connections

the rejection of silence

experiencing or evoking the mother in dreams, metaphysical understandings, or spiritual beliefs

recreating the self-in-relationship

self as a living legacy

projecting the future toward recovered continuity

Available subject position: **The self-in-relationship**

In this chapter the overall research outcome, and the three emergent discourses, have been introduced. Chapters seven and ten introduce the women who took part in this study, and I expand the discussion and schematic representations in chapters eight, nine, eleven and twelve.

CHAPTER SEVEN

INTRODUCING THE PARTICIPANTS WHO WERE BEREAVED AS CHILDREN

This is the first of the two chapters that introduce the participants. I have drawn out some of the key points in the women's personal narratives. Information is stated in a way that preserves their anonymity. In several circumstances insignificant factual changes have been made to ensure anonymity or at the request of the women. This chapter introduces four of the fifteen participants who contributed their understandings about death and grief in their narratives. They speak as daughters who were children when their mothers died. Their narratives suggest a pattern of three identified discourses which is distinctive from the pattern of those women whose mothers died when they were adults.

Sarah

Sarah was the eldest of five children under eight when she was placed into care following the sudden collapse, and death, a short time later of her mother, from an undiagnosed brain tumour. Sarah tells her story thirty years after the death of her mother. She speaks of 'abandonment' by her parents at the age of seven, her mother because of her sudden death and her father because he placed them in a home. Sarah took on the role of being the surrogate mother, as she was instructed to do so by

her father. The metaphor Sarah speaks is of her “world turning upside down”. It literally did. She became a ‘little mother’ caring for her family at the home. I was struck by the image of a woman who as a child not only experienced the physical death of her mother, but also a ‘social death’ as a result of family and institutional silencing. Sarah’s stories about her mother and being a daughter were lost to her. It is in her adulthood that she has attempted to find out what she can about her mother, and to integrate the loss.

Sarah is single, she holds advanced tertiary qualifications and works in the area of grief counselling. Her particular interest is in working with ‘motherless’ daughters.

Holly

Holly was aged fourteen when her mother died as a result of a brain tumour that, according to family belief, was misdiagnosed. She tells her story twenty years after the death of her mother. She is one of three children, she has two brothers, and describes her childhood as

Mum just being really ill... she didn't have the support from Dad that she wanted... so I remember her being upset a lot of the time.

Holly’s dominant memory is of her young life immersed in illness and hospital visiting: “It seemed like for years”. The events surrounding her mother’s death were not discussed with her because she “wasn’t old enough to know”. Within her all male household “routines [were] juggled around... [it was] let’s just carry on life as if everything is the same”. Holly’s father died some years ago. She is still attempting to piece together her story and to find out more about her mother’s life.

Holly is a business woman who holds tertiary qualifications in the area of business management. At the time of the interviews Holly spoke of ending a current relationship, primarily because her partner could not cope with her getting upset over issues of abandonment and loss. The story of the events that surrounded the illness and death of Holly’s

mother now has a life of its own. Holly continues to live with her grief and to work at understanding and reframing her past. She supports other women in similar situations.

Kate

Kate explains her childhood as “sort of being shrouded in grey all those years”. She uses this metaphor on more than one occasion. The dominant focus of Kate’s narrative is the impact that her mother’s sickness, hospitalisation and subsequent death have had on her. Kate’s mother died when she was seventeen and she tells her story 23 years later. Her father died soon after her mother. Kate was one of three children; her brother was twelve years older, her sister nine years older. She depicts them as often being away from the home and doing their own thing. Indeed, she describes her relationship with her mother as like being that of an only child because of the age difference between her and her siblings.

Kate is now in her early 40’s, is a business woman who holds advanced tertiary qualifications, she lives with her partner, Heather. Kate’s escape from the greyness of her existence came through her educational achievements. She is a strong woman, whose life appears to be significantly shaped by her childhood experience of her mother’s, and her family’s, encounter with a chronic and life threatening illness. She is very health conscious, and lives life to the fullest. Kate considers life as ephemeral. Her perspective is that death is always around her, and this aspect of her life is not easy. Kate is highly aware of the fragility, and lack of permanence in life. She describes this as a legacy of her childhood. Kate’s perspective challenges some of the ‘conventional’ understandings surrounding grief and mourning.

Margaret

Margaret’s remembers a childhood without good memories. “I haven’t got any good memories, I scratch around trying to find a good memory,

and I can't find any". Her story is of the grief of living with a mother who was socially unavailable to her because "she was psychiatrically sick" and withdrawn. Margaret's father died suddenly and unexpectedly in her teenage years. Soon after, her mother was diagnosed with cancer and died. Margaret was seventeen and an only child. She tells her story 29 years after the death of her mother when she is in her early forties.

Margaret is married with a family and works as a consultant in the area of health promotion. Margaret justifies 'not dealing' with her grief earlier by speaking of her need to survive. Margaret 'survived' by utilising a discursive practice learnt from her parents at her childhood home, being silent. In her adulthood Margaret has sought to reconnect with her memories, and to integrate the grief into her understanding of life. Margaret found she had to acknowledge and do this because of the overwhelming sadness that she feels has pervaded her life.

The narratives of these four women shape and support the discussion in the next two chapters.

CHAPTER EIGHT

SILENCING DISCOURSE IN THE TALK OF WOMEN BEREAVED AS CHILDREN

It is not difference which
immobilizes us, but silence. And
there are so many silences to be
broken.

Audre Lorde - *Sister Outsider*.

This chapter is the first of two chapters analysing the lay discourse of the four women in this study who were bereaved while they were school children aged between 8-17 years. Silencing was the dominant preoccupation of their talk.

Their narratives contain a 'plot' in which they move from a childhood dominated by silence, either imposed upon them or into which they are co-opted, followed by a period in adulthood during which they struggle with this silencing, before finally reaching a stage where they actively reject the silencing that has dominated their lives. Their talk, preoccupations and narrative 'plot' contrast with the talk of those women who were adults when their mothers died. This can be seen when consideration is given to understanding the subject positions that the women view as having been thrust upon them as children and later as adults.

In their talk the women depict three separate identifiable 'moments' of silencing, wherein silencing was achieved by different social processes. These three 'moments' are those of childhood when talking about 'it' (death) was prohibited; of early adulthood when, urged to get 'over it' they were denied discussion; and contemporary adulthood when, at the time of interview, the thing that they want to do is know their story in order to understand, or to construct or continue some form of connection, when and if they are able to talk about it.

Childhood silencing: Questions unanswered and unasked

Three of the four women who were bereaved as children portray themselves in childhood as powerless, and the silencing as something that happened to them. The contextual circumstances of the death of the other woman's mother, namely more sudden and occurring during her teenage years, had a softening effect on her experience of silencing but her pattern had much in common with the other three women. Two ways of silencing permeated their childhood after their bereavement: questions that were never answered and those that were never asked.

I haven't quite got the words to describe it as I'm thinking about it now ... You know, if we had been told at the time... and I'd been able to express all the grief and be surrounded with people who didn't abandon us. (Sarah, p.13)

... we were never told. (Sarah, p.2)

... no one ever explained what she died of. (Sarah, p.9)

.....

And nobody spoke about it. (Holly, p.4)

... the main thing I do remember is hardly anything being talked about it. (Holly, p.44-45).

... but let's just carry on life as if everything is the same, and that's pretty much like it was really. I don't remember us ever talking from then on. (Holly, p.4).

.....

... illness was never discussed, never discussed. (Margaret, p.2)

Mental illness was something to be ashamed of. (Margaret, p.4)

.....

I don't know so many things about her life. (Kate, p.24)

The techniques of this silencing reflect the social context of each individual woman and, as a group, they describe a diverse politics of silencing. Margaret makes this point when speaking of her experience:

I think what happened was a combination of circumstances as always happens ... I mean it's never one thing. (Margaret, p.17)

In a multiplicity of ways this diverse politics of silencing enforced a particular subject position and power relationship upon these women. They depict themselves as having been silenced through both family politics and institutional politics.

Family politics of silencing

It is interesting that the desire to prevent any lasting interruption of the child's life after the death of the parent came into being just after the word "orphan" was dropped from common usage.

Silverman & Nickman, *Continuing bonds*.

In this first section I analyse the women's understanding of their silencing within the family in their childhood, a time when many questions can be left unanswered or remain unasked. Many of these questions relate to prohibitions that were either 'read' as existing within the child's family, or the wider social milieu. The strategies of silencing are both overt and covert.

Sarah's understanding turns on a theme of abandonment in childhood. Her mother died suddenly, at the age of 36, and the family was immediately broken up, with the five children being placed in a home. Sarah aged eight, the oldest child, was then effectively and profoundly silenced. She depicts this world of childhood as being surrounded in a silence instituted and sustained by her family.

Sarah views herself as having been constituted into a world of silence when discussion surrounding her mother's collapse and sudden death became prohibited. The practices she describes are associated with the protection of others, particularly her father. There is an actual absence of talk about her mother. She depicts herself as a child wanting to know the story surrounding her mother's sudden death. In recollecting her childhood memories, Sarah cried silently during the telling of her story, and she experienced difficulty with her breathing. She stated that her distress was related "to the circumstances surrounding her death and what happened afterwards, and us never being told anything" (p.2). Sarah states a number of times that discussion was prohibited: "We were never told what she died of" (p.2); "No one ever explained what she died of" (p.9). This prohibition was also supported by family friends. Sarah remembers being taken by "somebody else" to their place and "looking from this window and there being all this talk around" (p.4), talk that she was not involved in. She tells of how discussion was also proscribed by her father who "never talked about it" (p.10). The silencing for Sarah becomes another part of her grief.

Sarah became alienated from her family for a number of reasons. As a child she was required to become the primary carer. She had to be mother to the other children, comforter to the father and obedient to the religious sisters in the home. Some of her first messages from her father were that she should "make sure [that the] kids are good for the nuns, and make sure they keep out of trouble" (p.5). Consequently, Sarah's need to understand is seen as secondary to that of family responsibility. She describes how she "kind of felt responsible, knew that I was responsible for my family now" (p.5). Sarah, in describing her 'mothering' role, states of the nuns:

I don't know if they put it on me as well. But I was always to look after him (her young brother) and, you know, dressed him in the morning and changed his nappies and whatever had to be done.... And then, before I went to bed, you know

there would be a round of getting all the other, the littlies, up to go to the toilet before we went to bed. (Sarah, p.6)

Sarah also spoke of 'reading' her father and learning to be silent:

I remember my father was always crying, and ah yeah, it was always so, yes I think you learnt by avoiding that subject you would not upset him. (Sarah, p.24)

Sarah also depicts herself as having had to learn to 'read' the family dynamics. She alludes to this when talking about "the subtle things that go on in families that aren't actually said, but kids make up from what is not said" (p.24). Sarah believes that, even in childhood, she was aware that understanding is more than language alone, that understanding involves also symbolically 'reading' the other person. Whilst language constitutes part of the 'reading', so does silence. Sarah describes how, as a child, she sought to read the silencing process that she was unable to explicate. Forced to make sense of the silence, Sarah constructed the 'solution' of self blame: "I felt ashamed all my life that she was dead" (p.2). Sarah reads her culpability in the absence of talk; disapproval of her in the silence. "We were never told what she died of,...that's all the more reason for you to assume it was somehow because you were naughty" (p.2-3). The effects of this politics of silencing was occasionally reinforced by possible strictures. For instance, a cousin said to her: "Anyway, your mother died because you were naughty" (p.3). Sarah describes this as sending her "into this terrible, terrible grief stricken state" (p.3).

Shame can be explained as a consequence of discursive strategies to silence, and to keep in ignorance. Sarah states:

I realise now looking back ...I had really felt ashamed all my life that she was dead...it was because underneath I felt I was responsible. Because we were never told what she died of. (Sarah, p.2)

Not only does Sarah describe herself as having been made 'ashamed' by the silencing but also she was constituted as 'other'. In other words, she was dislocated from any essence of herself or her emotionality. "I think I cut off feelings" (p.5). Her "otherness" and alienation occurs not only

through her being different in not having a mother, and needing to be placed in an orphanage, but also, and just as importantly, through the silencing that was so much part of her childhood experience. For Sarah, the lack of explanation, and “it” never being talked about, one of the most powerful and significant aspects of her talk. In fact, within the narrative, she particularly highlights her account of the silencing that existed.

I think what affects the grief, how I've grieved more is how the people still living allow you to do that ... they just didn't do that ... and probably they didn't know how because there wasn't that information around. Um, so I don't think what I know of her life has affected it, it's more of what was around when she died that's affected it. (Sarah, p.31)

Sarah here suggests a lack of intent to silence, indicating the possibility of either a protectionist discourse, or simply a lack of belief in how important it is to constantly inform children throughout their ongoing development of the circumstances surrounding death and loss.

The psychoanalytical perspective can be challenged by considering the place of language as a performative. There is evidence in Sarah's narrative that subject positions surrounding grief can be explained through understanding the deployment of specific discourses, and through consideration of the family politics that surround issues of child instruction and control.

The politics of silencing was different for Margaret. Her early childhood was, in part, made up of trying to understand the experience and silence that surrounded her mother's “mental illness”. Mental illness appears very early on in Margaret's narrative and becomes the signifier that her mother is “other¹⁹”; that her mother is both dysfunctional and different from “normal” mothers. Margaret depicts mental illness as not being recognised within middle class families in New Zealand. It was a reason

¹⁹ Ussher (1991) researched how mental illness become the signifier that positions women “as the Other”(p.11). Ussher also discusses how mental illness in women in the nineteenth century was viewed as a disease of the affluent.

for silence and shame. Margaret is powerless not only because of her experience of the reality of her mother's illness, but also because of the silence in her childhood that surrounded her mother's mental health "problem".

It was never discussed, never discussed. But she was very sick, I mean, I'm pretty sure she had [names the illness], in fact I'd swear that she did. (Margaret, p.3)

I mean they never talked, sat down and had a civil conversation or anything... I think Dad probably was like many in the fifties, a mental illness was something to be ashamed of. (Margaret, p.4)

I had gone to my aunt's ... [in the third form] ... for Mum I think to have a mastectomy, though I wouldn't be sure... It was never really discussed. It was just to have an operation. (Margaret, p.11)

... mental illness wasn't recognized. Certainly not in um affluent middle class families ... it just wasn't acknowledged, it was something to be frowned on... I'm looking in hindsight and thinking you know historically that was so, it was something to be ashamed of. (Margaret, p.37)

Margaret suggests her mother ceased to exist within a 'normal' social milieu. The concept of "social death" is a term referred to by Glaser and Strauss (1965) in *Awareness of dying*. Margaret recognises the boundaries of her mother's life.

Mum just wasn't able to... follow through with any friendships, I think. Or didn't have the energy. (Margaret, p.3)

So Mum hardly ever used to go [to Church], so I suppose for her she didn't fit in... I mean ... I suppose Mum felt that she could never fit in... I don't know, I might be reading it incorrectly I'm not sure. (Margaret, p.8)

Small (1997) draws from Glaser and Strauss' (1965) and Sudnow's (1967) perceptions of "social death", suggesting that "it can be argued that people cease to exist socially before they are biologically dead" (p. 217). Margaret's subject position as a child is that she has no voice, she can only observe and experience as a child the silence and the failure to do anything about her mother's "illness" and state of being. She not only has to cope with an emotionally and verbally violent mother who "was never given any help" (p.3). But, on reflecting on her childhood through

the lens of her academic background in health promotion, she states that “she should have been” helped (p.3). Because her father never discussed the situation, Margaret is unsure about her mother. She only knows her either as a person enmeshed within a discourse of mental illness or, in her adolescence, as “sick” with cancer.

I don't really know what sort of person she was ... I've heard...that she was quite reserved, a lovely person but reserved ... I never knew that side of Mum at all.

(Margaret, p.2)

Holly, like Sarah, experienced significant silencing in her now all male family. She referred to Hope Edelman's book *Motherless daughters* and described her reality as being similar to some of the statements made in that book. She discussed how other “motherless daughters” spoke of their lives going on as if nothing had happened other than some changes in the family routines.

...the only things that would be any different is, your mother dies, a few of the household routines are juggled around, but let's just carry on life as if everything's the same. And that's pretty much what it was really. I don't remember us talking about her from then on. It was like ... even when Mum was ill I was now the person sort of running the money, ...you know cooking meals and ironing and doing all those sorts of things as well. (Holly, p.4)

Holly tells of how the silencing was reinforced by her brothers, of how they had knowledge of her mother's death and she does not, but they do not speak about the issues. “My older brothers would probably know... it's kind of nothing that's ever been discussed” (p.5). She states of family friends: “If they ever saw me it was all very much let's not bring it up because we probably will upset the poor thing or something” (p.4). Holly depicts herself as having been protected by family and friends but that, with the resultant silencing, she is unable to talk about her mother. Rather, she is expected to enact out the domestic aspect of her mother's role within the home.

In contrast to the other three participants in the group, Kate does not speak of any sense of overt silencing. Instead, there appears to be family

collusion and complicity in the lack of talk around the possibility of their mother's death. Her mother's fragile health status was known. Kate makes many references to her "sick" mother whose death was a sudden death resulting from a surgical emergency. Kate states: "I expected to see her the next day, or the day after" (p.4). Whilst there was a knowledge and understanding that her mother was very ill, there was also the expectation of cure because of the advances in medical technology and care. The family was able to be complicit in the avoidance of death talk. 'Sickness' can be juxtaposed against death within 'Western' culture because of the high emphasis that is placed on medical technologies, and anticipation that one more investigation or operation may just help. Kate acknowledges the possibility of death when she states:

... it was either the second or the third that she had since I was about twelve for valve replacements ... it gave her a bit of extra life, but I most of the time from me being twelve or thirteen to being seventeen she was mostly in hospital (Kate, p.3)
... So her death at seventeen was not like um, it was almost like she had been dying for a very long time. (Kate, p.4).

Kate's viewpoint reflects the societal repression that exists around 'death talk'. Foote, Valentish, & Gavel (1996) are all women who have experienced the death of their mothers. They challenge our lack of comfort in talking within families about death, and speak of the need to understand how this absence of talk impacts on the lives of daughters following the death of their mothers.

The effect of childhood silencing for Margaret, Sarah and Holly has involved an enforcing of particular subject positions and power relationships upon them. Margaret, through family and societal politics around the silencing of mental illness, depicts herself as shamed. Holly, like Sarah, in taking on a domestic role is expected to disengage from the experience of loss in order to carry on.

Institutional politics of silencing

Sarah recounts hearing of her mother's death from within the institution of the church. One of the religious sisters 'broke the news' to Sarah that her mother had died. Sarah was called out from breakfast with the rest of her family to the back porch.

...and she was busying herself with the flowers and she said "I've got something to [starts to cry] [to tell you²⁰] [30 second pause].

And she said "Your mother died last night" now Sister Hope will take you up to the chapel to pray.

[So you were taken straight to the chapel to pray?]

Well that's my memory of it, I don't know exactly I don't think anything else was said, because I think, because I think, she was really uncomfortable you could tell by the way she was busying herself with the flowers. [Sarah is quietly crying].
(p.7)

Sarah tells of how she clearly 'reads' in her religious superior, that the circumstances surrounding her mother's death were not for discussion.

Sarah depicts how she learned that prayer is how you respond: "So she took us up to the chapel to pray and I think that was all in a way strange" (p.7). Yet Sarah tells of her need to deal with the feelings that she had about her mother's death. She does not recall being given the opportunity to discuss her feelings or to ask questions of either of the religious sisters. Rather, she was to be alone and to converse with God through prayer. But, Sarah was unable to identify with the cultural mores of Catholicism. She had not been previously introduced to the symbolism of the Church, so the experience was foreign to her. As noted above, she depicts it as "all in a way strange" (p.7). She did not

²⁰ Through the process of analysis I became aware of how I was captured by 'the story'. The telling became a joint production. I found that in some situations I would finish the end of a sentence or add minimal encouragers. This was in part in an attempt to support the telling, but also as a result of the dynamics within narrative telling. I interpret the pauses in conversation as related to Sarah's grief and the difficulty of the telling. Sarah later discussed the value of having someone who is interested hear her story.

understand that she was in the process of being made subject to a religious discourse.

Sarah remembers her great difficulty in reconciling these disciplinary and adult behavioural responses to the loss of her mother. She tells of her sudden change of living circumstances from her family home to the institution – as a “home where religion ruled your day” (p.8). She describes all this as a “foreign experience”, stating that Sister Hope “probably tried to explain now that your mother’s in heaven with God and all that sort of business” (p.9). She indicates, by pointing to her head, that these rituals were head knowledge that “never did anything here [pointing to her heart]” (p.9). Within the church, as within the family, the ‘story’ surrounding her mother’s death was closed for Sarah.

Sarah goes on to use her adult experience to substantiate the profundity of the silence that she experienced as a child in the orphanage. She tells of how, years later, a nun told her that her mother had left the hospital and visited the orphanage on the hope of meeting with all of her family. Sarah was absent and was never told of the visit. In the interview Sarah said “that was the first time I knew she had been up there” (p.11). Not until she was well into her teens was she finally told by an ‘adopted aunt’, that the reason for her mother’s death was a brain tumour. “When I look back you know that was quite astounding” (p.12). As a child the whole mystery was kept absolute.

These experiences of institutional silencing were not unique to Sarah. Holly and Margaret also speak of a silencing within the institution of the school and the church. Holly tells of how she does not remember:

... anyone at school, you know any teacher or anyone ever...

[Breaking in: ... acknowledging it.]

Yeah not one. ... But surely that’s wrong, that even teachers you know should check. (Holly, p.42)

As with the politics of family silencing, the politics of institutional silencing often resulted in a sense of alienation, resulting in people being

constituted as 'other', and of living as 'other'. Holly recalls being inadvertently made 'other' by her best friend who does not talk about "it". She justifies this.

She was only fourteen as well, so she wasn't going to say, you know, how did you cope over the weekend. (Holly, p.43)

...probably the main thing I do remember is not, hardly anything being talked about it. (Holly, p.44)

I just sort of remember going to school feeling a little bit like everyone was staring at me. (Holly, p.44)

Holly reads the institutional silence, and knows she is different. She has been constituted as 'other'²¹.

By the time of her parent's death Margaret had already learned of the politics and the power of silence within her own home. Her parents "never talked" (p.4) and illness was "never discussed, never discussed" (p.2). Margaret recounts a similar experience of institutional silencing in relationship to her father's death. She states: "I don't think my school friends ever asked me, ever. 'Cause I was in Form 1 then, they wouldn't know how to" (p. 8). In indicating that "they wouldn't know how to" Margaret suggests that there may have been exonerating or extenuating circumstances, and that the silencing was not with malevolent intent. In effect, they had yet to learn how to respond to experiences of grief. Nevertheless, the experience was profound and confusing.

I was rather bemused because I didn't go to the funeral, I wasn't asked if I, I wasn't asked if I wanted to go. I mean it just wasn't an issue, I went to school on the day of the funeral and the class gave me this huge bouquet of flowers. I still remember it, I've got the card still.... I was totally bemused as to why I should be getting this... I was quite embarrassed. (Margaret, p.7)

²¹ Roudiez (1980), in introducing Kristeva's work *Desire in language*, states that "The 'other' has either commonplace or philosophical meaning (e.g., what exists as an opposite of, or excluded by, something else). When capitalized the "Other" refers to a hypothetical place or space, that of the pure signifier, rather than to a physical entity or moral category" p.17.

When she was given a bouquet of flowers by the teacher the gesture was mute, she was overwhelmed with confusion and unable to make sense of this action.

The rules had changed for Margaret when her mother died some years later. This time she was asked and attended her mother's funeral. By then she was a senior high school student. Margaret is very open about her feelings. She acknowledges her dislike of her "abusive" mother, and indicates that the emotion that surrounds grief is linked to the requirement of a loving relationship; that the grief experience is therefore more complex when there is not a perception of having been loved.

...it didn't really impact on me, I was just so determined not to let any emotion show or anything like that... I had no feelings for Mum at all, so it just seemed hypocritical to me, you know, when this person that I'd really hated until very recently and then felt pity for, you know, I should show emotion for. (Margaret, p.16)

Margaret described the events that surrounded the funerals of both of her parents. She describes her silencing, and her complicity in the silencing process. In doing this Margaret continues to deflect from her friends the reality of her home life.

... so I lived two lives really, the life at home that was dreadful, and I loved being with friends and um people outside home and they would not [emphasised] have known what was going on at home, would have had no idea. (Margaret, p.9)

Margaret's different interpretation of the events appear to be influenced not only by silencing but also by her different experience of relationship and mutuality with her parents. She speaks of what life was like after her father's funeral:

*Oh people would say to me "Oh Margaret, how are you doing"? ...
You know, "How's your mother doing?"
And that would be it, and I would say "Oh I'm fine thank you, Mum's fine"
[voice clipped and brisk] you know and that was it. It was never ever discussed*

which when I look back now I think it's absolutely shocking really...the only conversation I had with Mum about it was I said to her "Have we got enough money?"... the people of the church... [gave me] something in remembrance of Dad...I got a locket... So, but they never talked about it... So it wasn't that they didn't show concern they did. (Margaret, p.8-9)

Margaret's reflection on these events as an adult woman is that it was "absolutely shocking". She and her mother did not talk about the death of her father other than her need to ascertain that they were still financially secure. This action is consistent with her viewpoint that "there was just no relationship there basically" (p.11). In this situation Margaret is complicit within the silencing process. Margaret acknowledges that she felt support from "the church." She reads their concern, however it was also primarily unspoken support.

Margaret depicts herself as having been in an abusive and very unhappy relationship with her mother, but she felt loved by her father who died suddenly some years before. She states "I had that emotional link and I felt very loved by Dad. So it didn't need to be put in words in a way" (p.33). This understanding raises the whole issue of why, for example, death is often expected to be spoken, and yet other aspects of relationship are considered able to be 'read'.

Margaret speaks of her mother's funeral.

I did go to the funeral.

[What do you remember of that?]

Very little, I remember being amazed that so many people were there, friends of mine from my previous school (named) they were there... I just, I just found it so difficult. So I was definitely of the stiff upper lip variety and was not going to cry and didn't. Really hard, so I guess in a way I just let it wash over me....there was a measure of cutting off and my aunt was determined to keep things light and frivolous anyway, and so there was an air of sort of unreality about it I suppose ... I just chopped off which meant that, that there wasn't ever a grief process. I never went through a grief process, I never allowed myself to because I'd chopped it off...and I think in doing that I wasn't able to grieve for my dad either. (Margaret, p.16-17)

Margaret uses the metaphor of “cutting off” and “chopped it off” to describe her mechanism of “getting over it”. The first reference of “cutting off” refers to when Margaret was at her mother’s funeral. Margaret was determined to control her feelings, and was abetted in this by her aunt. Margaret justifies her control, by linking it to the fact that she had “no good memories” of her mother who, in Margaret’s memory, was always psychiatrically ill, and later died of cancer. She again reiterates that “it”, mental illness, “was never really discussed that I know of” (p.4).

However, in speaking of her father’s death, Margaret uses a very different metaphor to describe her father.

[He was] my anchor in the storm, sort of, gone, and I had a very close relationship with Dad. And it um, was never talked about, I mean Dad was dead and you didn’t discuss it. So I had nobody to sort of talk about the effects.

(Margaret, p.6)

Margaret understandably reiterates the behaviour of silencing learned from her parents. She attempts to “cut off” and disassociate from the grief and sadness of her life. She presents herself as ‘over it’ for a good part of her adult life until she recognises the need for her to make sense of it, to reconnect and talk about “it”. Margaret describes her grief and inability to talk about it.

It was dissipated as generalised sadness....overwhelming sense of sadness...It was just a real sadness. (Margaret, p.21,27)

Finally, Kate’s experience of childhood silencing comes from a subject position different from those women who depict silencing as having been imposed upon them. Rather, she portrays herself as having been complicit with a family silence about her mother’s illness and potentially limited life expectancy. Throughout the whole of the interview Kate depicted her mother as a very unwell woman.

My main memory is of her being sick. She died having an open heart operation.

(Kate, p.3)

Kate acknowledges indirectly that her mother was aware of the seriousness of her heart condition:

So I, we, left her and I just expected to see her the next day or the day after ... My Mother called [other daughter] and said ... "look after our Kate as though she sort of knew something". (Kate, p.4)

While Kate was involved in supporting her mother at home, she appears to have joined the rest of the family in refusing to ask questions about her mother's health status and the potential of her dying suddenly.

Adult silencing: The struggle with silence

As the children became adults they received the clear message that one should be 'over it'. However, the grief and the continuing silencing itself became a cause of further grief. Craib (1994) suggests that the well established rules for mourning in western society have increasingly lost their effectiveness. He utilises "the market place metaphor" to proposed that "goodbyes are said, [and] 'business' is finished...with the real horror, pain and mess of death" (p.15) being denied.

The powerlessness that comes from not knowing, and the continuing silencing, may persist as a result of well meaning family and friends assuming the need for a loved one to 'get over it'. This 'protectionist' discourse can be imposed on another, in an effort to help the individual avoid having to talk about a particular death.

Holly recalls how her aunt censured her for not "being over it":

...she got completely upset and annoyed with me and said, you know, "Well just get a grip of yourself, you know" she said, "God, I've got friends who are losing their mothers all the time" you know, "Why do you think you are so special and so different", and you know,[really] "God, you know, it's been twenty years, just get on with it!" ... And you know, and then she will say "I've lost my mother" Well, I mean she was in her seventies when she lost her mother.[starts to laugh]. (Holly, p.27)

Holly recounts how her ex-partner argued with her in the same manner.

[He] was actually the person that I brought this house with, and that's when I started the grief counselling and that's why we broke up. Because he used to say to me, "You know you're **making a big deal out of this, just get on with it**", you know "I know people who have lost people and they've - **just get over it**". And I felt that I can't have somebody that just doesn't understand me like that. (Holly, p.37)

Holly speaks of how she transgresses from 'the norm' that others want to foist upon her, when she wants to talk about, and find out about, the death of her mother. The awareness of the disapproval of her aunt and her ex-partner is apparent in the way she relates the story of her censure. Holly's emotional distress is treated by them as inappropriate behaviour, and in need of sanction and being 'brought into line'. Her behaviour as an adult is put under question. She is positioned as a non-coping, somewhat neurotic individual. Holly recounts how most of her life she has "got upset easily".

... and people have stopped me, you know, quick throw them into your arms [the grieving person] pat them, and then hope that they stop crying and hope that they change the subject, you know, and that's, I think that's a really bad thing. (Holly, p.40)

An example of this is given by Holly when she speaks of asking family friends to tell her about both of her deceased parents.

I got really upset when they started to talk about them, and it was then they stopped talking about it. (Holly, p.40)

Any demonstration of emotionality appears to make others want to position Holly as 'other' and as non coping, and to become silent.

The comments of Kate, Margaret and Sarah confirm that 'coping' is valued within their social milieu. Like Holly, any display of grief positioned these women as having a problem that needs redress. Silence suggests getting on with life, and having gotten over the 'wound' of bereavement, and the absence of talk about death may also be viewed positively as a sign of grief resolution. However, after a certain time, constant talking of death and of the person who died is viewed as

neurotic and non-coping behaviour. Despite the fact that talk and tears are often stereotypical representations of women in general²², the expectation is that neurotic behaviour has to be put right. Women are expected to 'get over it' and if that involves counselling, so be it.

Sarah encapsulates this perspective:

... you know, the only other opportunities that I've had to talk about it are in therapy. When you are sort of looked upon as, you having to go and finish with the unfinished business, or its you know, you've got a problem that you still haven't worked it through.

[Really, is that what you feel?]

Well, no, well I think that's how society looks at it. (Sarah, p.13)

Here, Sarah intimates that therapy was necessary for her. She suggests that the only opportunity within her milieu for being heard was through the modality of therapy, and takes issue with this, that it should be so. Just prior to this Sarah had said:

...just before I answer that, is that, I'm thinking more, gosh, somebody's interested in this. Yeah, I think that ah [becomes distressed] that its bringing, um, I don't know, nobody ever asks about it in that interested way. (Sarah, p.13)

Sarah's therapy can be viewed as part of the orbit of professional medicine, as medicine proposes that mourning is time limited. Sarah's expectation of professional counselling and psychotherapy is that it enables people to meet the expected performative of being 'over it'.

Kate also identifies 'the problem' as hers. She describes herself as 'paranoid' and worried about the possible deaths of the people she loves dearly (p.12). This is supported by her former partner:

... when I tried to talk about it with Peter he wouldn't have a bar of it. He basically, he didn't get annoyed by it, but he said "It's your own little problem, it's not my problem that you think...you'd better get and deal with it"... that's

²² Hockey (1997) discusses how images of women grieving in an unconstrained way are not only inappropriately gendered, but also fail to represent the British cultural imperative to grieve privately. She suggests that grief is expected to be a "competent" performance (p.90).

when I went for some counselling which was reasonably useful at the time that I had it .(Kate, p.21)

Kate positions herself quite differently from Sarah in relationship to counselling. Unlike Sarah, Kate does not take issue with counselling because she wants to get over her fear that “death” suddenly takes away the people she loves, which was her experience as a young adult. However, she does reposition herself by offering a different construction when she suggests that she is not that unusual: “I just don’t think that people talk about it”. Thus, by implication ‘the problem’ is bigger than her, it is a societal issue. She states that her former husband, and her current partner are “both sort of very gracious in my paranoia” (p.13). She accepts her former husband’s analysis of her “paranoia” as “related to my feelings [about death] that I don’t have control over them” and that her response is “child like” (p.13). When Kate talks of her response to death she uses the following terms:

*...the legacy the deaths have had on me...I’m absolutely paranoid about death
...have had quite a bit of counselling over it (p.12)...I’m always
worried...emotional response is very strong... It’s nothing that I’ve got rid of.
(Kate, p.19)*

Whilst Kate employs medical discourse and its categories of ‘mental illness’, she does this somewhat subversively:

*It got to the point with Peter where I would be paralytic with fear over him dying.
I mean a more healthy specimen of manhood you could not wish to come across.
(Kate, p.21)*

She laughs as she finishes this statement. Whilst Kate appears to accept her positioning as ‘neurotic’, she also powerfully questions and takes issue with the absence of talk around death, suggesting that “it’s healthier to have some cognisance of mortality” (p.23). Kate is far from death denying, she wants to talk about and integrate these understandings. Death is part of life. She states: “I always feel that everything is ephemeral...I never allow myself to feel safe” (p.20). For

Kate, pain and grief are not denied but rather enmeshed within her daily life experience.

Margaret's strategy for dealing with the family micro-politics following her father's death was to create a psychical space between herself and her abusive mother: "The distance between Mum and me got greater" (p.10). She creates her world amongst friends at school, whilst living as an alienated and abused child. Margaret states:

...she was very violent... [Was that physically violent?] Yes ...emotionally and verbally violentI haven't got any good memories, I scratch around trying to find a good memory and I can't find any... Which is rather sad to say the least but [sighs] so my memories are of being frightened and abused. (Margaret, p.2-4)

When I asked Margaret if there was anyone that she was able to talk to, she replied "No, and I wouldn't have wanted to" (p.10). Margaret separates this aspect of her life from others, while she challenges her mother: "I started to rebel ...I used to say to her she wasn't giving me the security I need" (p.9). Their relationship was one of conflict. Because of the trauma over her relationship with her mother, and her sadness over her father's death, Margaret's learned strategy for survival was to present as being 'over' it. Thus, she colludes with the expected 'norm', and replicates her parent's way of utilising silence as a strategy.

Margaret suggests that her faith has, in part, both acted as an agent of silencing in supporting her denial of her grief, and also as a support:

...there's been a comfort in my faith I think... I guess my faith has helped me avoid the issues that we've been talking about, you know for so long I didn't have to, um, address those issues because in fact [You mean dealing with your grief?] Yep, because, in a way, that relationship that I had with a loving God ... actually enabled me to survive emotionally. (Margaret, p.34)

The Christian discourse is a powerful ideology which Margaret characterises herself as having been immersed within, and by which she has been "helped". She depicts herself as having been incorporated into the understandings, conventions, teachings and the power/knowledge

associated with her religious beliefs²³. Margaret outlines this movement, along with her changing subject positions and the different dimensions within her analysis.

I'm imbued with a Christian philosophy, I suppose that, there is a hope in death and that's what I cling to now... . I have no problem with the basic tenants of the Christian faith at all, and I've found those an anchor. And because I've had a loving father the concept of God as a father has been helpful to me. (Margaret, p.35)

Margaret presented herself to the outside world as “over it”, both in the instance of her father’s death, and later following her mother’s death. Margaret says that she “disassociated from it”- from both integrating the experience of her mother’s “illness” and her parents’ deaths into her life. in order “to survive” (p.17). This ‘disassociation’ resulted in Margaret never allowing herself to integrate these losses into her life. But, over 20 years later Margaret recognised her silent grief and, like Holly and Sarah, she decided to undertake counselling. Through this dialogue she opened the “Pandora’s box” (p.16). Margaret acted on her silent grief following a professional conference on grief when she was “feeling so awful, and that made me aware that I had to deal with it”(p.17), she tells of how she opened “the box” and started reading and talking about her experiences.

Thus, all of these women have utilised counselling to deal with their ‘problem’. Yet, whilst they all began counselling to deal with aspects of the problem, they have used therapy not as much as a means of getting over it, but rather as a means of integration and connection.

²³ Althusser (1971) discusses how ideology is a “ ‘representation’ of the imaginary relationship of individuals to the real conditions of existence” (p.152), and how ideology functions in such a way that individuals are transformed “by that very precise operation which I have called *interpellation* or hailing” (p.163).

Adulthood: Rejecting the silencing and creating connection

If we had a keen vision and feeling of all ordinary human life, it would be like hearing the grass grow and the squirrel's heart beat, and we should die of that roar which lies on the other side of silence. George Eliot - *Middlemarch*.

In this section I discuss how the women, as adults, take up positions very different from those of their childhood, or their earlier adult life, where they were positioned as powerless and/or neurotic. This is not to say that the women do not move in and out of positions of different forms of agency²⁴. Despite this, the women hold to the view of themselves as now entitled to know the 'story' about their mother's death. They now 'want to know' and to be able to talk about what death means. Their need for continuing bonds is now asserted as legitimate and important. Holly positions herself as being ambivalent about her constant struggle for knowledge, as being exhausted by the struggle but ultimately unable to step aside. Being 'over it', and 'coping' are now false, a pretence.

...you get to the stage where you don't really know if you actually want to find out...just how much more can you actually take. (Holly, p.9)

...maybe, it was just easier to go on as if it hadn't happened and pretend that you coped. (Holly, p.17)

[you] ...kid yourself that you've coped until it just has to blow up in your face. (Holly, p.17)

Holly's experience of childhood powerlessness comes to the fore. "Part" of her wants to know more, but she is unsure how she will cope. Like Margaret's "Pandora's box", and Sarah's not knowing, Holly positions herself as fearful.

Part of me, sort of wants to find out more.

²⁴ See Davies & Harre (1990) for a discussion on how the "constitutive force" of discursive practices lies in the provision of certain subject positions. They indicate how "particular images, metaphors, story lines and concepts ... are made relevant within the particular discursive practice in which they are positioned" (p.46).

[About what?]

About what happened at the time...

[Well her medical records I, I would guess would be available.]

Right, right, and then part of me thinks well what say you find something really awful, but it's like how much more and what could be so bad. (Holly, p.19)

Holly's ambivalence relates in part to the oppressiveness and feelings that surrounded her childhood. Her desire to know is linked to her adult status in which she rejects being silenced, or positioned as powerless or neurotic²⁵. For Holly, the finding out of subjugated knowledges involves the pain of working through and integrating the feelings that make up both her childhood, and now her adulthood, constructions surrounding her mother's death. Like Margaret, her adult position involves reading and finding out from others. She states of the book *Motherless daughters* (Edleman, 1994): "It's not something that you'd pick up on a sunny Sunday afternoon to cheer yourself up" (p. 28). The adult Holly refers to her solitary journey and what it means to not have her mother alive. I say this because, for all of the women, their mother is physically but not socially dead. The women have not denied connection with their mothers, the connection is ongoing. Holly tells of what societal silencing means:

...I think it's more reflecting back on how it's affected all my life through, and especially through the time that I didn't even realise it did. Um, I think if may be if you could somehow make people more aware of that, I think maybe, it wouldn't have been like that. (Holly, p.33)

Some information about her mother means that Holly begins to renegotiate her understanding of her and link her with as an adult. Meaning is being reconstructed through dialogue.

Well I've made some really neat contacts with my mother over the last year... [Holly meets a woman at a dance class, whose aunty she finds out was her mother's best friend]. ... So I got the names of all my Mum's best friends, and I've

since met with one of them...sat till one in the morning talking, and that was a case of her obviously dying to share all her stories with me. (Holly, p.45)

Holly asserts the transformative, and potential power, of the narrative through the example of story telling by a woman who was prepared to talk with her, and to provide narratives about her family history.

I don't remember getting upset...she was as much involved...on the verge of being tearful. I left there absolutely buzzing...I had this totally different picture of my mother... I always had this fairly grey picture from my aunty...and had this totally different picture. (Holly, p.46)

The issue of importance here is that Holly is able to establish other perspectives on her mother's life. She wants to know the stories, plural, so that she can frame and understand what is known about her mother's life. This is now Holly's positioning as a mature adult.

These points are also reiterated in the lives of Margaret, Kate and Sarah. Margaret now asserts her 'need to know', and to talk about her mother's life after her 20 years of silence. She now sees as essential the need to grieve the loss of her parents in her early life. She states: "I mean you can't grieve until you've processed why you can't grieve" (p.17). Margaret now creates her own agency. She refuses to collude with the silencing, or to present as being 'over it'. Margaret acknowledges that her need to know and to understand involves integrating her parents' deaths and the "abuse" as part of her life story. The need to do this results from "a combination of circumstances" (p.17). Margaret's experience was of the events not being talked about, and of disassociating herself from the abuse because of her bitterness toward her mother. Margaret depicts herself now as making a mature and

²⁵ Ussher (1991) draws a comparison with the labelled Victorian mad woman who she suggests some depict as "the immediate fore-mother of the modern-day woman diagnosed as neurotic, phobic, anxious, depressed or schizophrenic ...the list is endless" (p.64).

considered decision to “deal with this” (p.27), a viewpoint that is very much part of modernist thinking²⁶.

I think there are two levels aren't there, there is a place where you can formally, there's a time when you can formally think, yeah I would like to deal with this.
(Margaret, p.27)

However, Margaret's positioning is “not to get over it” but rather to “integrate the past with the present” (p.30). She now asserts a “need to do it for me” (p.27).

This same pattern exists for Sarah, Holly and Kate. Their need to know is now linked to establishing an ongoing sense of self. The concept of ‘identity’ appears to be less problematised for Sarah and Kate, however, both Margaret and Holly indicate above some ambivalence about trying to understand the complexity of ‘self’, and confronting the silences that exist within and surrounding their lives. Yet their adult subject positioning now refuses the silence, and they move in the direction of confronting the family and societal mores that surround their knowing the stories. The patterning within their talk is identifiable.

Margaret:

I have to go through it,... one of the dynamics that's missing for me is a sense of identity... in the past its been equated with who I am... [it's really] the knowledge of who you are... as opposed to what you can do... the knowledge of who I am is very minimal. (Margaret, p.28-29)

Sarah:

I want to find out about my mother's life... I feel stupid at my age... in case they think jeez what's wrong with this woman. There will be something wrong with me for wanting to know this... its important for me to want to know all these things. I just feel a bit stupid doing it, knowing that I will probably end up crying. (p.14) These things of what you know of your mother's life... I mean they are important things to find out, and that's part of the healing process, isn't it... healing is finding out the story... building up a sense of the person... To be interested

²⁶ Craib (1994) argues that in late modernity there are expectations of people that “they should be

in... what was your mother like? ...so it's all of those things...If you grew up in a family thereafter, that talked about these things normally, you'd be able to ask all those questions and have them answered. Do you know what I mean? (Sarah, p.31-34)

Kate also indicates that she wants to know the stories from her elder sister who had not lived at home for much of Kate's childhood. She states: "I didn't ask Jenny this time to tell me any stories, and actually I want to know some of those stories" (p.24). Kate appears to know many of her stories, and was involved in the process surrounding the care of her mother before she died. She indicates her different perspective:

... she [sister] has a different idea of what that time was like... and I say, it was like, "that this is my experience and don't deny my experience"... she was quite surprised to hear some of the stories. (Kate, p.24)

...she has got quite a different idea about our mother. (Kate, p.28)

What is important here is that the 'stories' are sought out, and that understanding is being reconstructed over time, as well as difference points of view being understood.

In summary, in this chapter I have illustrated the way the women have constructed a narrative around the motif of silencing. This experience was identified as one of the most salient for this group of women following the death of their mothers. Identified within their narratives are three distinct phases in which silencing occurred. By identifying the particular 'moments' in their lives and explicating the politics around 'their stories', in effect, these women identify the 'sites' around which the politics of silencing is based.

For Margaret, Holly and Sarah, their childhood experience involved the subjugation of knowledges around the experience of illness and death. Their stories were not made available to them, and this resulted in a sense of powerlessness. The prohibitions around this silencing, from the

doing" something to get over functional impairment (p.25).

perspective of the daughters, had the effect of engendering a sense of guilt and self blame, which resulted in their being positioned as shamed.

In referring to their early adulthood, all of the women not only characterise the process of silencing as pervasive, but indicate that, in their seeking to know more, they became depicted as 'other', as neurotic and non coping because they should have been 'over it' by now. Their desire to talk about and to know more about their mothers, and to integrate thoughts about death, therefore became invalidated, and even more so if they demonstrated any ongoing signs of distress such as crying.

Even within the contemporary adulthood of the women the process of silencing continues to be seen as pervasive. They recognise that aspects of this process of silencing are entwined throughout their whole life experience. The change taking place for the women in their adulthood is that, while they 'read' that their culture suggests continuing silence, they refuse this. Instead, they work toward actively understanding their life events. While they do want to "be over" aspects of the pain of grief, even more, they want to reconstruct events and to create new forms of connection, of continuity. The women seek to do this by recreating and discussing the events initially through counselling and later with people who are open to dialogue. As was demonstrated within the interview process, their understandings surrounding some events were reinterpreted through dialogue.

In the next chapter I continue the discussion about the group of women who were children when their mothers died with elaboration of the interplay of the discourses of discontinuity and continuity in their narratives.

CHAPTER NINE

DISCONTINUITY AND CONTINUITY DISCOURSES IN THE TALK OF WOMEN BEREAVED AS CHILDREN

This is the second chapter which analyses the discourse of women who were bereaved as children. These women all articulate a discourse in which both loss and longing dominate childhood, while adulthood is characterised as a determination to make connection or to construct answers and to make sense. The movement from childhood to adulthood is a narrative of a gradual change from childhood powerlessness and alienation to a quest for integration in adulthood.

Childhood discontinuity: The absent mothers

The women who were bereaved in childhood provided narratives premised on a sense of loss that predated the death of their mothers. They focused on a mother who, while central in their lives, was 'captured' by 'illness' and 'hospitalisation' - in short, by medicine. Medicine and medical care pervade the stories of these women right from the beginning of their accounts of the death of their mothers. All medicalised their narratives and gave chronological accounts of their mothers' physical or mental decline. The more detailed accounts, understandably, were given by the women who were older children at

the time of their mothers' deaths, and thus were more informed about the medical details of events.

The dominant pattern was of a childhood enmeshed within a world of illness; they spoke at length of how 'illness' took over their mothers' lives and their own. These women describe a mother who was predominantly unavailable to them in life; who was either 'socially' or 'psychically' lost to them because of illness and involvement in the 'world of medicine'. Kate, Sarah, Margaret and Holly all tell of how their relationships with their mothers became re-positioned and made 'other' in order to accommodate their mothers' immersion in the experience of illness.

It had been all my life basically... just being around sickness. (Kate, p.19)

... my main memory was of her being slightly withdrawn all the time. (Sarah, p.1)

... Oh, Mum was sick, sick she was psychiatrically sick. (Margaret p.2)

... She had cancer, so she wasn't well as well. (Margaret, p.11)

... she died when I was fourteen, but was diagnosed when I was about ten, so it only really gave me about ten years of knowing her, other than being really ill.

(Holly, p.1).

This loss of their mothers to illness, even before physical death, was canvassed extensively and immediately by the women, dominating each interview within the first five minutes. Although I asked them to tell me a little of her mother's early life and of their relationship, each daughter chose to speak about the impact of her mother's illness and death rather than to speak of the mother-daughter relationship. Their narratives of childhood relationships with their mothers were not sited around their childhood or family experiences as I expected. Rather, their talk encompassed medicine as a priority 'field'.

Systematic deconstruction of the narratives substantiates the dominance of the motif of loss. Certain words that supported the concept of the absence of the mother in some form were more frequently used than any other set of signs. The key words, phrases, and associated fields of meaning within the first five minutes of interview talk dealt with illness and or medicine. I then identified all of the other key words and phrases

within the narratives. Through analysing their comments, I recognised that beyond the women's talk on the actual experience of the death of the mother, there was a background discourse of how the experience of grief for this group of women turned on the loss of the relationship with their mother while she was still alive rather than on her physical death as such. This loss was without connotations of blame, but rather imbued with sadness and disappointment, except for Margaret who does acknowledge anger over her mother's behaviour, and the abuse which she attributes to her mother's illness.

I mean I have a sense of um anger that I have to go through it at all, you know, I really resent that fact that I've had to go through it now. And if I hadn't had a mother who abused me, I wouldn't be going through it. (Margaret, p.28)

... the fact [is] that she was psychiatrically sick. I think that's made it more difficult in a way....How can you deal with someone who's been sick and abused you....Because I felt sorry for her....And I mean that's been part of the grieving thing, I mean I felt tremendous compassion for her, despite the fact that she did me harm. (Margaret, p.36)

Kate made twenty-one references related to her mother's illness within the first five minutes of the interview. Typically, she spoke of her mother who "was very sick all my life" (p.1). In comparison, she made seven references to being a loved child, three to information lack, six to family history. On three occasions Kate spoke of her belief that her mother was 'quite old' when she gave birth to Kate. The importance of these figures is not in their absolute values, but in their comparison; the dominant motif is the loss of the mother to sickness.

Kate describes the discontinuity of her early years through utilising the metaphor of greyness. A main memory for Kate is of the social impact of illness on their lives, and of her mother "being sick, always being sick" (p.2).

I can remember it sort of being shrouded in grey all those years. I can remember going to school and doing feverishly well at school, because that was the kind of main point of the reality I had.coming home at night and my father and I going down to the hospital. And it seemed to go on for years, that we would just

go to the hospital night after night, and then one time, one time that she came back from the hospital, she had a huge haemorrhage when she was in bed, and it was really unpleasant and they rushed her back in, and I don't know any of the clinical details and that kind of thing, accept that it wasn't a very nice experience.

(Kate, p.3-4)

In this account, illness dominates life. Even when her mother returns home her remembrance is of her mother being “rushed back into hospital” following what she describes as a post operative emergency. Kate refers to her mother’s hospitalisation as “it” and to illness as being endemic to them “a very common sight, you know” (p.4). While her childhood is “punctuated with memories of fun holidays” and memories of “being very loved” p.3), Kate overwhelmingly remembers an experience that was “shrouded in grey” (p.3).

This same pattern of childhood discontinuity revolving around illness is recounted by Holly. Both women depict their early lives as times when, as young and powerless daughters, they were drawn as passive observers into the world of illness and medicalised institutional care that was unending. They were separated from a ‘normal’ family life which does not confront the inevitability of death, and drawn into a world which heralds the beginning disintegration of the social fabric of the family.

... we used to go every night, ...it seemed like for years. My father and I would have a routine of, I'd come home from school, wait for him to come home from work and we would both go up to the hospital every night. (Holly, p.7)

Holly is less sure of the exact period of time that was consumed by her mother’s illness but, like Kate, she states: “It seemed like for years, I don’t have [a] concept of time” (p.7). Although Holly was fourteen when her mother died, she argues that her relationship with her mother changed at the age of ten, the time at which her mother was diagnosed with cancer.

...she died when I was fourteen but was diagnosed when I was about ten, so it only really gave me about ten years of knowing her, other than being ill really.
(Holly, p.1)

Holly suggests here that illness and medicine took over her capacity to 'know' her mother in the same way. Holly's perspective is that her mother's 'illness' was the essential feature of her childhood. This was marked by physical relocation as the family moved to "a flasher house", her father responding to her mother's "dream I guess" to be "in a nicer home". But for Holly the memory of that home is of "Mum just being ill really" (p.6), in the same way that Kate had described her world as "just being around sickness" (p.19). Both locate their mothers as sick and unavailable. Their mothers are redefined as 'other'; as belonging to a world of 'sickness'; and as not being able to do the things that 'normal' mothers do.

Holly's mother is diagnosed initially as having "a lot of ear problems" (p.2), then as having "a mental breakdown ... which the family really [believed] was just really wrongly diagnosed" (p.3), because, after her mother "numbing out... it was obviously looked at more seriously and they found the brain tumour" (p.3). Holly made ten references within the first five minutes of the interview to her mother's sickness, and eleven references to her not knowing 'the story' surrounding her mother's illness and death.

Like Holly, Kate's discourse about childhood revolves around hospital visiting to a mother enmeshed within the world of medical technology.

She would just be hooked up to machines and drips and ... So her death, at seventeen was not like, um it was almost like she had been dying for a very long time ... the whole period leading up to her death was tortuous. (Kate, p.4)

For Holly, the actual meaning of her mother's death could well have been described as a death denied in the sense that it was hidden,

removed, masked by the routines of hospital²⁷. In this context, the events surrounding the last visit to her mother becomes an 'epiphanal'²⁸ event in Holly's discourse. Not only was it the last time Holly saw her mother alive, but also, in retrospect, she represents the night as one when neither mother or daughter were available to each other.

Research undertaken by Silverman, Nickman, & Worden (1992) and Silverman & Nickman (1996) on the child's reconstruction of a dead parent suggests that "bereaved children, regardless of their age seem aware of the meaning of death" (Silverman & Nickman, 1996, p.497). After interviewing children between the ages of six and seventeen, the authors challenge the viewpoint that inner representations are "unmodified and inaccessible" or "buried" in the unconscious (p.479). Holly does not speak of being aware that her mother was close to death and tells of how she played outside of her mother's room with a girlfriend.

And we we're just being really stupid, and pushing each other around in wheelchairs and things like that. And I think I've always felt really guilty, about that I guess if I could have done anything it would be that to be old, to be older at the time...so that you could be more support. (Holly, p.7)

As an adult, Holly's moral ethic of care²⁹, leads her to long to have supported her mother. A significant component of her present grief is related to her not having been involved in the processes surrounding her mother's dying, and the concomitant talk and ritual. Even within the hospital situation, the understanding of her mother's dying was sequestered from her experience of knowing. Holly represents this grief as ongoing, and herself as so sensitised to the medicalisation and experience of her mother's death that she "still can't even drive past [name] Hospital because that is where Mum died" (p.8).

²⁷ Walter (1991) discusses how 20th Century death is hidden from view and from open discussion.

²⁸ The origin of this word is derived from the Greek meaning to manifest, or to make known. I am utilising the word in the sense of the 'event' having high significance.

²⁹ See Gilligan (1982, 1986, 1987) for a discussion on a moral ethic of care and gendered differences.

Like Holly and Kate, Margaret's narrative deals with the loss of her mother to the effects of illness, but primarily a 'psychiatrically ill' mother, who was lost to mental illness and unavailable long before developing terminal cancer. The motif of psychiatric illness dominated Margaret's discourse as she made seventeen references within the first five minutes to her mother's state of health. Her descriptions reflect a childhood of alienation and of being 'other'. In fact, her relationship with her mother is one of loss almost from the beginning. Margaret describes her mother as "withdrawn" and "unbalanced" (p.2), a mother to whom, when she was 12 years of age, she would say: "You should be in a psychiatric hospital!" (p.3). This mental illness, whilst not life threatening, set the pattern. Her mother was never what a mother should be, in Margaret's account. Prior to the period before her mother was diagnosed with a terminal illness, Margaret described her mother as:

... violent and abusive (Margaret, p.11)

... there was just nothing except for abuse. (Margaret, p.33)

... Oh, Mum was sick, sick, she was psychiatrically sick. (Margaret, p.2)

*... Mum was sick, I mean by this time she had cancer so she wasn't well.
(Margaret, p.11)*

When her mother developed cancer, Margaret went to live with a family friend because her father had died some years earlier.

I went back in the August prior to her death... just during the holidays as I normally would and Mum was very sick. I mean she was vomiting and you know, she really was very sick. ... I got the doctor and he told me she didn't have long to live. This is a sixth former if you please. (Margaret, p.13)

Although Margaret had previously lived with the trauma of her mother's mental "illness" and her father's death, she was excluded from the processes of medicalisation that envelop terminal care. Her mother, in effect, disappears from her life just when "pity", something positive, begins to creep in.

So although I heard the words, what that meant was not quite clear to me I don't think. Although I knew this was pretty serious and I felt real pity for Mum at this stage.... I felt real pity for her, and then after I left [the family home] and went back to [family friend] I think Mum, Oh it's very sketchy what happened, but I think she was admitted to hospital and she died in hospital. But, I wouldn't really know. (Margaret, p.14)

Margaret was geographically separated and physically excluded from her mother's dying just at the time when she was beginning to recognise and understand her mother in relationship to her 'illness' experience. She is denied the possibility of a beginning understanding of her family social life.

Like Margaret, Sarah's discourse also turns on the theme of her mother's unavailability. Sarah tells three scaled-down stories about her mother-daughter experiences before developing the narrative about her mother's death. These stories are about small but very significant events in Sarah's life as a child. All encapsulate an element of discontinuity, which is reflected as abandonment or isolation. The first story is of her mother's care of Sarah after an accident. It turns on the theme of distancing.

...she'd come and stand at the bedroom door and show them in, but she'd never come in kind of and be that close to me. I don't mean physically, I mean sort of emotionally. (Sarah, p.1)

The second story reiterates this theme of an emotional non response.

I used to write 'I love [named]', we used to write out who we loved all in pages and I stuck it in the pot cupboard wanting her to notice it, and be interested I suppose but she just ignored it... I know looking back I wanted her to notice. (Sarah, p.1)

The third story was the most frightening - it is of potential loss.

...probably the other clearer incident is, when, you know she had five kids... and may be things were getting on top of her once, and she just said "Right I'm leaving" ...put her coat on and left. And I was just screaming at the top of my head, ...I don't think it was that long before she came back. And I was saying "I will be good, I will be good, I will be good". Although she had never said I wasn't good. (Sarah, p.2)

These stories function like a parable, representing the mother - daughter relationship as in some sense 'lacking', a lack which in hindsight may be linked to illness. Sarah's mother suddenly collapses and dies, and it is then evident she had been suffering from an undiagnosed brain tumour. This sudden death leaves the adult Sarah with a memory of a promised but never fulfilled bonding with her mother.

I don't know if it was my first night at brownies or what, but I remember waving goodbye to her [starts to cry] and going, and that was the last time that I saw her.... I don't know what happened after brownies, somebody else took me to their place (p.4)... So I remember, you know it was quite good that she did come out on the pavement and waved me goodbye, now that I think about it (yes) because it was the last time I saw her because she got moved [to hospital].
(Sarah, p.5)

Sarah's words "she did come out", represent the promise of the potential relationship and of her mother's presence being available to her. Sarah spoke of her mother being "36 when she died, suddenly one day" (p.3). This is factually inaccurate, but correct for Sarah because her mother died for her that day. Sarah never saw her mother again after she came outside to wave goodbye. Her mother was 'removed', hospitalised, and thereby placed in the hands of health professionals, while Sarah was placed in a children's home. Sarah's description of this event is brief, poignant and powerful, as she displaces talking about her own grief at being institutionalised to feelings of despair for her baby brother.

The day we went to ... [city] I remember him [her father], Oh yeah, we must have stayed a night with my Aunty [starts to cry] and I think we took my youngest brother up to the home that night. And then I think that my father came up the next day and then he took us up to the home.... but what broke my heart about that was going to the home to see my little brother, he had been there from the day before. ...and he was crying his heart out in a high chair and there was hundreds of other little kids around and just feeling you know heart broken for him really. (Sarah, p.10)

Although Sarah's discourse depicts a childhood of physical and emotional distancing and then removal, as an adult she seeks to

construct a psychical understanding and connection. In telling her narrative of childhood the adult Sarah re-positions herself. She reconstructs the connection with her mother - "it was quite good ... now that I think about it" - and sees the evidence for this in her mother's effort to "wave me goodbye".

Nevertheless, Sarah's discourse of loss relates to more than her mother's tragic death a short time after her collapse. Sarah positions her mother as mysteriously lost to her from an early age. She chooses to speak of her mother being responsible for the care of five children under seven and tells of a mother who was unwell.

...she had been having terrible headaches for a long time...she would have her ears syringed out to see if that would help.....they sent her away for a holiday up to these friends at [place] to see if... giving her a break would help. But it didn't.

(Sarah, p.9)

In the discourses of these four women, the unavailability of the mother and their own childhood lack of understanding of events, created a feeling of powerlessness and alienation, a sense of remoteness, rupture or separation for themselves as children. They become constituted into these subject positions, which create for them an abject state of being which further adds to their loss. They are 'Other'. Margaret becomes 'orphaned' and Kate, Sarah and Holly 'motherless'. They are outside of what constitutes a 'normal' family, and their longing is for the archetypal or good mother.

Transition to adulthood: The desire for the 'good' or 'archetypal' mother

A focus of this research is to explore the primacy attached to the mother-daughter relationship by bereaved daughters, and to consider in what way the mother-daughter relationship is constructed as a component of the grief process. For these bereaved children, the unavailability of mothers through illness is accompanied by a grief as adults for a mythical, or a 'archetypal' good mother. The women's grief is not only

over the loss through death of their actual mothers, it is also for the mother they never had - their 'ideal' mother. The women imply a loss of a 'normal' childhood relationship with their mothers.

Kate acknowledges that her memory of her actual mother is "hazy" (p.2). She identifies her child 'self', that is her childhood identity, as being entwined within her perception of her mother's identity. Chodorow (1978) also indicates this perspective in *The reproduction of mothering* when she suggests:

...from the retention of preoedipal attachments to their mother, growing girls come to define and experience themselves as continuous with others; their experience of self contains more flexible or permeable ego boundaries.... The basic feminine sense of self is connected to the world, the basic masculine sense of self is separate. (p.169)

Kate's words support Chodorow's perspective:

I have very hazy memories of her actually, even though I was seventeen when she died. It's like I've never really established what she was like as a person... because I hadn't kind of established myself as a person, so I wasn't able to sort of see her separately. (Kate, p.2)

But the issue was not just that her mother was unknown. In her reflections on the death of her mother Kate differentiates between the actual loss of her mother and the concept of having a mother. She acknowledges that her experience and loss incorporate, in part, her dream of the 'archetypal' or 'mythical' mother.

I've felt the loss of a mother, but actually I think I felt the loss of a mother that I never had anyway. I was terribly jealous of everybody else's, my friends' mothers ...I wanted a mother who was younger. I wanted a mother that I didn't have basically. I wanted a mother that was young, I wanted a mother that wasn't sick, I wanted a mother that was clever, and I wanted a mother that was like my friends' mothers. ...Yes so, so my grief was for feeling as though I'd missed out a bit, but I wasn't sure what I'd missed out on, some mythical mother figure I think. (Kate, p.7-8)

Kate presents this longing for the archetypal mother as an active quest in her young adulthood. When going out with boyfriends, she sought out, in their mothers, a mother that reflected her construction and understanding of her own mother: "I always, I always remember hoping that their mothers were going to be like my mother" (p.8). This search was ongoing. When Kate tells of her immigration with her husband to New Zealand, she speaks of her desire to meet a certain type of mother, "I was longing for his mother to be what I wanted a mother to be like and she wasn't like that at all". (p.8)

Sarah's discourse echoes Kate's longing. The unavailability of her mother meant the loss of a potential relationship, the loss of a role that mothers 'ought' to perform.

... it means not having that person that fulfils that role that mothers do for people. I've got lots of friends who still have mothers, and visit them, and do things with them, have a relationship with them. You know, all those things that a mother does, I don't have. So there's, you don't have that. (Sarah, p.30)

Chodorow (1978) also supports Sarah's viewpoint.

Most theoretical accounts agree that women as wives and mothers reproduce people—physically in their housework and child care, psychologically in their emotional support of husbands and their maternal relation to sons and daughters. (p.36)

Placed in an institution, Sarah represents her role as being a little "mother" to the other siblings in her family, whereas her desire is for a mother of her own. She longs for the nurturative and communicative relationship "that mothers do for people", not unlike the perspective of the archetypal mother.

Throughout the interview, Margaret positioned herself as being alienated from a very early period in her life. It is therefore not surprising that the converse longing for a 'good' mother was a major focus of her grief. Margaret spoke of how she "...wrote a couple of poems and put it all down" to acknowledge her father's death, but that "...with Mum it's not been like that at all ... so it's like dealing with grief

in a null and void state” (p.19). Asked if she had written or drawn anything about her mother, Margaret produced a poem which she explained as an effort to understand the concept of the term “mother” since “what Mum, or mother is, is just a foreign concept to me” (p.19). The key descriptors within the poem surround the concept of defining the word mother, and the poem highlights her mother’s unavailability.

*Mum it lingers on the tongue like a foreign word,
it's difficult to pronounce, it sounds unfamiliar, Mum.*

*My mother, my, mine, pertaining to, belong to,
of and to me, my mother.*

*My mother rolls of the tongue more easily than Mum
but it's not in a familiar sense there is something elusive
and strange about it.*

*Mother embodies fact, an hereditary factor a biological relationship
a factor of genes and chromosomes of which by implication I become a part.*

*Mother, a state of biology and bearing. A symbolic consternation of concepts that
are inside my experience as a mother but outside of my experience having not
been mothered.*

*My mother, Mum the words sound distant,
words I can't quite catch as my mouth forms that shape they spell out in absence
and absence of ownership, an absence of relationship. (Margaret, p.19-20)*

In this poem, Margaret differentiates between having a mother, and being mothered. She clearly defines her subject position as a griever, but not in the usual sense of the meaning. She suggests that her grief over her mother’s death is “...an absent grief, ...how can you grieve for someone who’s abused you” (p.22). Her grief is over the loss of the ‘archetypal’ mother, the term ‘mother’ is clearly the ‘signifier’.

...it's only the absence of what you didn't have that you grieve for.

[That's the grief?]

Yea, that's the grief, but it's not for the actual person. (Margaret, p.22)

Margaret defines what she means by the ‘good’ mother.

... the mother that's been there for their kids regardless... loved them through thick and thin, ...accepted them and been emotionally there for them without being intrusive...I have not had a pattern of mother or mothering³⁰. (Margaret, p,23-24)

Margaret's summary of the 'ideal' mother implies a moral order.

The right to be loved by a mother is a basic human right, it's foundational really, and that whole element wasn't present for me probably from birth I would think.
(Margaret, p.32)

She says her own children can assume the right to be loved: "I will be there for them, they know that, they know they're loved" (p.31).

Holly's discourse speaks of desire for her mother, and she positions herself in childhood as a quiet griever over her mother's unavailability. Like Sarah, she recalls a sense of "feeling left out" even as a child, and of being upset at her mother's leaving home. She suggests that "maybe, without blaming, maybe there needed to be some sort of reassurance there that she was coming back" (p.32). This was compounded with her mother's death. Holly tells of how, once her mother died, "she felt extremely on the outside" (p.32).

Like the other three women, Holly's desire is to have had a long term experience of a mother-daughter relationship. Her depiction of the 'ideal mother' is of a mother who is physically present and available to her. Holly espouses a belief in the significance and importance of the mother-daughter relationship, and asserts there is "no ending to it" (p.33), the grief is over all of the times and events for which the mothers' presence is desired. She cites the book *Motherless daughters*, highlighting how "...having a child or your first child ... can be extremely emotional because you're going through the, you know, the same act" (p.33). Holly tells of how having and raising a child herself will involve similar experiences and practices to those her mother went through. She

³⁰ Badinter (1980) attributes to Jean-Jacques Rousseau the crystallization of the ideas that launched "the modern family - the family founded on mother love" (p.30). Badinter indicates that prior to this the bond with the mother was understood differently, it was not 'maternal', the child was not central within and to family life.

implies that it is through the reiteration of these experiences and practices that further memories are created, and the loss further compounded. Holly's story about loss continues to be recreated as she experiences life. The desire for her mother is always present.

...there is no ending to it ...it will go on because then when my daughter is fourteen I will be thinking the same as you know, as what they are [other motherless daughters]. Saying that well, this is the age that I was when my mother left and you know it just must go on and on. (Holly, p.34)

She compares her own situation with that of her friends.

...they always have, their mothers are always the one's that are there for them, you know. All my friends that have got kids, it's always their mother who, who's the supporting person. Yea, and so I think, just thinking ahead you know, ...there is no ending to it. (Holly, p.33)

Holly's understanding of 'mother' is linked also to her understanding of home. With the death of her mother she states, "suddenly you don't have a home anymore, your home is where you live" (p.37). Home is constructed not just as a physical place, but also a symbolic link to her mother's physical and psychical presence. For all these women, their loss is also a grief over 'the loss' of what might have been.

Adulthood: Making connection

Another distinctive pattern within the women's narratives included the need to make meaning of the events and to create understanding and connection around the death of the mother as adult daughters.

While, as children, they were powerless, alienated and less comprehending, as adults they speak of using ways and rituals for establishing connection. They spoke of seeking out friends and counsellors to discuss, and in effect to reconstruct, their understandings of the loss of their mothers to illness, and to discuss and grieve the actual loss of their mothers. The women assert that, as adults, they have integrated their mothers into their lives, and that they are able to maintain "continuing bonds" at a psychical level. Holly and Sarah spoke

of how they feel connected both through the reiteration of specific practices that they identify with their mothers, and through the efforts to reconstruct knowledges about their mothers. Both of these women are more pantheistic, than Kate and Margaret who depict different modalities of connection.

Holly has difficulty in stating how she currently 'locates'³¹ her deceased mother. Her understanding is constrained by a conviction that death is located in the body. She says: "When I went down to the crematorium... I guess I go down and imagine that they're there, I don't ever think about them as being around somewhere else" (p.28). This suggests a physical and finite death but, alongside this, she juxtaposes a supernatural discourse.

How do I understand death? I don't know if I do really.... I don't have any concept of life after all, I don't know. Mm, so I guess I find death quite scary and quite final, it's really final.

[How does that fit with your [previously mentioned] thinking about past lives?]

Well it doesn't really. [bursts into laughter, both of us are laughing] I guess, I don't know, I tend to think of past lives as in previous but I don't think about them as in later.... I've never looked at, it just seems to be helpful to explain some things for myself, just to think that maybe that came from previous lives, but I never actually think about that for my parents. (Holly, p.28)

On the one hand, Holly locates her dead parents at the crematorium when she views death as final; on the other hand, she draws on supernatural explanations as a resource to understanding her own life.

I actually joined a meditation group as well, and that particular meditation group believes in past lives, and I think that can put another aspect on death if you can believe in something like that.... I tend to think of past lives as in previous but I don't think about them as in later. (Holly, p.28-9)

³¹ Silverman Nickman and Worden (1992) suggest five strategies of connection that children use but do not specifically look at how discourse constructs understanding, or of how actual rituals and behaviours are reiterated by the children.

Holly also sees herself as reiterating many of her mother's rituals. She portrays her mother as a very organised person, and represents herself in the same way.

She wouldn't just go to town and think now what am I here for? ...she would have a complete list written down. And that's exactly what I'm like. (Holly, p.24)

She describes her mother as a good saver.

She had a tin system...the Oxo tin system.... And I took that on,and now I do it with bank accounts. (Holly, p.25).

As an adult, Sarah links 'healing' to connectedness, to "finding out the story ...and building up a sense of the person" (p.31). She wants to know what her mother was like, "what she wore, ...what she looked like,...liked doing, ...was good at, all those sorts of things you know" (Sarah, p.32).

Sarah argues that her sense of 'identity' is linked to her need to construct her history. Unlike Kate and Margaret, she has no sense of her mother's 'presence' in her life, she has no supernatural explanation. Like Holly, she sees death as final and establishes her connection and understandings of 'self' and identity through constructing her past and present history. Sarah wants to know what her mother was told before she died, to find out if she knew she was dying, and why she converted to Catholicism before she died. Sarah does not speak of spiritual connectedness, and despite her Catholic upbringing, Sarah's views are mostly pantheistic. She conceives of death as being "part of life" (p.29), and linked to "the seasons, in nature and everything" (p.29). For her death is the end. "Its the end of living, its the end of breathing" (p.29). She has an agnostic's room for movement.

...apart from that I don't know what it is... I've never had any experiences of people appearing to me, or my mother appearing to me at the end of the bed saying "I'm in heaven!" [laughs] ...God knows what happens after you die if anything. (Sarah, p.29)

Kate views both parents as part of her internalised and 'psychical' self. They are constructed as part of her identity and being, using statements like: "I think I've got her personality"(p.9).

My mother was this quite lively person I understand, ...and this is the strongest link I think...the two of them vie in me for supremacy over my personality...and its anyone's guess who's going to come out at any one time...it's actually my mother and father and I haven't got control over them, you know they have got control over me in a way... and I do feel that, I actually feel that it's my father you know, I can feel his presence, so Oh, watch out here. [Kate starts laughing and quotes her father in a very pronounced accent]. (Kate, p.9)

Kate identifies her mother as influencing the stronger and more "outrageous" aspects of her life. As she spoke of her mother her voice became more animated, and stronger. She incorporates her parents' identities within her, through depicting their internalised presence as one of the strongest links she has with them. Kate also argues that her parents might be spiritually present. However, there are contradictions.

...and other links in some kind of odd spiritual way which I don't really want to admit to I'd like to think that she's been watching over me. But my atheist side won't allow that through. But sort of, I was brought up as a strong Catholic so it's hard not to be bitten in some way by all of that stuff. ... So I'd like to think there's been some sort of guidance there ...I, I think about both of them quite a lot, I mean I don't think that they're ever very far from my thoughts. You know, I don't think, ugh, that was a funny time of my life, and those people gave birth to me but really they don't have anything to do with me now. I, they still feel very much part of who I am and what I do, and the decisions I make, and how I see life. (Kate, p.9)

Kate incorporates these paradoxical and partial understandings successfully into her life. Her understanding of, and reinterpretation of, past experiences, in part constitute her current identity. She also represents herself as having, and enjoying, a strong physical likeness to her mother.

There is contradiction and ambivalence in Margaret's discourse. In life, meaningful connection was problematic because both parents

maintained a silence around the issues of abuse, and her mother's mental health. Nonetheless, Margaret intimates her sense of connectedness surprised her. At the time of her mother's death, Margaret was living 'up north' and attending a new school. While she had been told that her mother was terminally ill, she did not know that she was dying.

I suddenly had this overwhelming sense of sadness, and I started to cry which was most [emphasised] unusual for me. I just sat snivelling my way through geography and, um, I didn't know what it was... but it worked out that, in fact, that was about the time of Mum's dying. (Margaret, p.15)

Despite her description of dislocation within their relationship, and of anger toward her mother, Margaret's interpretation of this event in her early adulthood is of a connectedness with her mother at a psychological level. Margaret says that over the years prior to the interview she came to the point of recognising that, in order to survive the experience in "one piece" she needed "to integrate the past with the present, ... that's certainly not what I've done, I disassociated, so I've got to feel" (p.30).

More than 20 years after her mother's death, Margaret now argues she has chosen to work at establishing her own identity.

...one of the dynamics that's missing for me is a sense of identity. You know who I really am, not what I can do. Because I can do a lot of things ... I'm not sure whether, if I'd had a functional relationship with Mum, if it hadn't been as it was, abusive, whether I would have had that sense of identity even though they had died early. (Margaret, p.28)

Margaret refers to Bowlby's psycho-dynamic attachment theory as a possible explanation:

...I mean Bowlby writes after thirty years of experience in looking at this...you know mine was not attached. [Starts to laugh]. I was not attached and, um, that would be seen to be a, a crucial requirement of an identity, a solid identity ...the knowledge of who I am is very minimal. (Margaret, p.28-9)

Margaret's desire to create connection is linked to her concept of identity. She depicts a constant core component to her understanding of identity,

which she wants to better understand. Through counselling and establishing connection, Margaret attempts to “integrate the past with the present” (p.30). Her concept of identity is defined in essentialist terms as involving an essence.

...I'm talking about the very essence of your being that to me despite what I've read, and I've read a lot on identity, and people have different theories on it. For me, I believe there is a crucial part of you that remains constant... But that's not to say that all of that is shown all the time... But there's a certain knowledge of who you are, I mean that's my thinking.

(Margaret, p.29)

Margaret achieves connection through a number of modalities: creating a dialogical relationship with ‘particular’ family members; a period of counselling; writing poetry; and practising her faith. In doing this Margaret argues that this allows her to remember, and to reformulate her understandings in the light of other ‘input’ and dialogue. Margaret speaks of having an internalised construction of her mother that is in her mind now. “She’s just there somewhere, and I’m quite aware of that” (p.30). When I asked her about this awareness, she said “...it’s just a sense” (p.30). Margaret’s construction of her relationship with her mother, who is on “the margins” of her mind, is outlined in one of her poems. It also gives an insight into her subjectivities surrounding death.

*It's an **image** transcending time,
A figure framed by ebony hair and ivory skin
ethereal surrounded by particles of light,
standing silhouette on the **margins** of my mind.
She's wearing an **apron**. (Margaret, p.30)*

In this poem Margaret constructs a visual representation again of the archetypal mother, with an apron symbolising the private sphere of women’s work. Margaret wrote this poem because of what she called an awareness of her mother’s presence. “Mum is standing in the eaves, if you know what I mean” (p.30). There is time past present and future in her descriptions. She states: “I believe death is the beginning of a different life, it’s the continuation of life in a different form” (p.35).

In summary, these women use narratives to make meaning of their childhood bereavements. They ascribe meaning to their pasts by reconfiguring the dislocations and discontinuity that have ruptured their relationships with their mothers. As adult women at the time of the interview, they present themselves as having survived childhood alienation, and the loss of their mothers to illness. Their losses involve a complex range of factors that become interwoven within the narrative form. For example, they include the impact of medical discourses and practices, sites of conflict, interpretations and differing constructions of what constitutes reality.

The women reiterate their longing for an archetypal 'good' mother who would 'be there for them', as they negotiate their life experience. By the time of interview, and on occasions within the interview, these women construct their current experience of their grief process as a 'healing' one, where they are seeking to make connections, and to revivify and reintegrate their mothers into their lives. In other words, they are resuscitating the past and reconfiguring it to integrate a reflected upon mother with whom they construct an ongoing relationship.

CHAPTER TEN

INTRODUCING THE PARTICIPANTS WHO WERE BEREAVED AS ADULTS

This is the second chapter that introduces the participants. Minor changes or omissions have been made to ensure anonymity, or at the request of the participants. This chapter introduces eleven of the fifteen participants, who speak as daughters who were adults when their mothers died. The emergent pattern suggests that the majority of these women employed the identified discourse of connection in a greater way than the women whose mothers died when they were children. However, two of the women describe and draw on the discourse of discontinuity as a more prevalent discourse. Disconnectedness with their mothers is depicted as their dominant experience throughout their lives.

The women are briefly introduced in this chapter in order of the number of years since their mother's death. The reason for organising the stories according to the time since the death of the mother, relates to my interest in examining a prevailing medical view that decathexis should occur, that the women should be 'over it' within a one to three year period.

Em

Em is married with a grown up family. She was fifty-one when her mother died of cancer and tells her story approximately two years later.

Em's description of her relationship with her mother is of a mutually supportive relationship.

... we were just so much alike, I always felt very protective towards her. Even as a child I can remember feeling very protective of her. She was a good mother, she really was. She ... just made sure that I was on the top of everything.

Both Em and her mother were very musical. They created a culture of reciprocity around each other, "we were the greatest of friends". Their relationship was based on mutual love, their Christian faith, and a shared passion for music. Em's sadness is over her knowledge, and experience, of her mother's struggle within an unsatisfying marriage. She describes her mother as having an "unhappy" life, and as being reliant on her for support. However, Em acknowledges that this support was always returned. Her mother was always a strong advocate for her.

Em describes the experience of her mother's illness and death in great detail. Her narrative encapsulates stories of chaos, and of restitution, in her striving to keep her mother alive and with her. Whilst Em's faith is important to her, the death of her mother is a great grief and trauma. She depicts her mother as having been her hero - both as an astute and capable woman in business matters, and in her devotion to her children. Em's grief is expressed as "an emptiness and a terrible loneliness that nothing can ever fill at times" over her mother who was "always there for me".

Ann

Ann is single, and a registered nurse who holds advanced nursing qualifications. Ann was fifty-four when her mother died at the age of eighty-six and tells her story close to two years later. Ann's mother lived locally, but Ann felt estranged from her and she had not been able to

visit her mother for over a year because of unresolved grief issues from her childhood. It was not that Ann did not care about her mother's welfare. She did. Rather, it was the difficulty she experienced when spending time with her mother, due to her childhood memories.

Ann's story of her mother's death is told within the context of trying to make sense of her own life. Her talk is of personal struggle. The story strongly reveals points of crisis as she speaks of an absence of positive parental connection and of her sense of alienation. She powerfully describes physical and social isolation as the context of her family life. Whilst cultural notions of the need for women to be independent of their mother's are prevalent, Ann's grief is primarily over her lack of attachment and connectedness with her mother.

Following her mother's death, Ann attempts to make meaning around her abandonment and her mother's death. She describes her relief that the relational struggle between herself and her mother is now over. She accepts that the negative legacy of the past cannot be changed, and acknowledges her changing understandings of events through time. Ann describes a sense of metaphysical connection with her mother, a connection which is not easily defined. After her mother's death Ann attempts to find partial resolution.

Jane

Jane is married with a grown up family. She was fifty-seven when her mother died from the complications of a severe stroke. Jane is from a large family, and tells her story close to three years later. Jane still misses her mother terribly. She wrote a poem entitled "If I could only have you for one day". In the poem she outlines her desire to be with her mother again, one more time. Her narrative stresses a secular discourse of metaphysical continuity and a desire for more. A desire that is wanting, but cannot be met.

As the oldest daughter of a large and reconstituted family, Jane describes her relationship with her mother as very close. Her mother is not depicted as demonstrative, but rather, as the archetypal mother who is always there for her children.

...there was nothing that she wanted out of life, except for her children to all be happy and that was really real for her.

She refers to herself often as being a “substitute” mother in the family, owing to her being the eldest child, and describes her relationship with her mother as being like that of a sister.

Jane depicts her mother primarily as an heroic mother. She suggests that her mother’s decision to leave her husband for “the love of her life” was something over which she had no choice, despite the trauma to the family. Her narrative primarily focuses on their relationship, and of their joint mutual responsibility for the family.

Megan

Megan is single, and was in her mid forties when her mother died at the age of sixty-nine following being acutely admitted to hospital. She tells her story close to three years following the death of her mother.

Megan, the oldest of four children, poignantly describes herself as always being made ‘other’ to her mother’s involvement with the demands of family life. She grieves the lifelong emotional unavailability of her mother to her.

I never had any real connection with her....Because when I looked at the photos of her as a young woman she seemed vivacious and happy and I thought I’ve never known that woman. And [she was] very, very attractive, and Jenny whom I spoke to said she was just like that. And I said I couldn’t find out what happened that somehow changed that.

Megan’s sadness relates to her not ‘knowing’ her mother in the way that she wanted to. She spoke of how her mother had little support from her husband with managing the family, despite his being a good provider.

As the oldest child Megan was expected to provide 'psychical' support for her mother. Megan found this difficult because she had no sense of reciprocity.

Megan is a teacher who holds advanced tertiary qualifications. Megan vacillates between her disappointment and grieving for the archetypal mother, and remembering the many positive dimensions of her mother's life and caring. Megan's grief surrounds her desire for connectedness, and the loss of that potentiality in her mother's death.

Val

Val is a registered nurse in her early fifties. Her narrative strongly reflects the impact that her mother's longstanding illness and death have had on her life. Val clearly acknowledges two of her 'selves'. She spoke of her/'self' as her mother's daughter, and her/'self' as a nurse.

Val's mother experienced a severe stroke in her fifties and died some years later. Val openly acknowledges her rage and anger over the effects of the chronic illness that her mother experienced. She utilises metaphor to describe this:

... it was like the lights went out really ... I remember actually feeling, I mean, just kind of grief stricken ... I felt really angry, and I felt a rage really that this should have happened..

She describes the pain of powerlessness, and of her anger about processes surrounding health professionals' understandings of death and dying. At the time of her mother's dying, Val believed that, because of her experience as a nurse caring for dying people, and her personal experience of grief and loss, her mother's death could be different. The actual experience of her mother's dying left Val feeling both angry and disappointed. Val's perception is that issues of power, and of ownership and control, impacted on what was to have been a 'good' dying process for her mother. Val's experience of what she perceives are 'good' deaths in her nursing career, resulted in her suggesting that a lack of

emotionality and caring by some health professionals occurred in her experience of her mother's dying.

I think that the knowledge of nursing actually is in conflict with [their] knowing as human beings. When nursing actually values knowledge and knowing, and uses them, kind of in [a] complementary [way], then it actually shifts. I see the knowledge, sabotaging what they know as human beings.

Throughout the interview, Val raises questions about how knowledges around death are constructed. She critiques the regulation and control of dying within institutional structures, identifying also the power of silence. Whilst her desire was to emotionally accompany her mother throughout her dying process, her narrative is about her mother's 'chaotic' rather than 'good' death. She describes the politics surrounding institutional dying, and depicts her relationship with her mother as having been one of mutuality, and now of ongoing connection.

Julie

Julie was fifty-five when her mother died at the age of eighty-one following a sudden 'flu' like illness. Julie tells her story seven years after the death of her mother. Julie is married with a grown up family. She holds postgraduate tertiary qualifications and works as a consultant. The dominant discourse Julie utilises to explain her mother's death surrounds her belief in continuity. She speaks strongly of her love for her mother, despite the many ups and downs of their lives.

Julie viewed her parents' marriage as a "troubled" relationship. A theme of her mother's was: "You only get ten years for murder, but you get life for marriage!". Julie considered her childhood was "always kind of managed." Her early life was full of unanswered questions; questions about her parents, their relationship, herself. Julie has experienced powerful emotions associated with the rage and anger of grief and loss during her life, and following her mother's death.

Julie depicts herself as having the capacity to understand and also to forgive much in her parents' lives. She has learned to live with, and to

be comfortable with, the fragmented knowledge of her past. Her world view embraces change. She has lived in other cultures and learned to value different and contradictory experience. She has learnt also to live with what her mother believed were necessary secrets and lies, secrets that surrounded her first thirty years of life. Her mother continued to deny Julie's adoptive status until Julie was finally able to confront her mother about it.

Julie came to realise that her mother had to "live the myth," because the culture in New Zealand surrounding adoption at that time supported the mother's silence. Julie saw that her mother needed to play out the role of birth mother. She gives insight into her feelings that both surround the deaths of her mother, and her birth mother.

Julie learned of her birth mother's identity after her death. Julie's spiritual beliefs enable her to continue to include both her mother and birth mother strongly within her life view.

Cathy

Cathy is married with a grown up family. She was thirty-five, when her mother died at the age of seventy-six 'from' cancer, and tells her story eight years later. Cathy's account of her close relationship with her mother is linked to the history of her family's immigration to New Zealand. Cathy implies that the loss of her mother was much harder because of the fact that they had immigrated, and she was without the support of their extended family. Her grief was also linked to previous losses she/they had experienced in leaving the home of her birth. Because of leaving behind many of her friends, Cathy considers that she established an even closer relationship with her mother than she would normally have.

Cathy describes her mother as an "older" mother. She describes her childhood as a happy one and her mother as her hero, using terms such as: "She was my best friend"; "She was the most wonderful person"; "She

became a very clever person”; “She was such a rock”. On her mother’s death, Cathy’s describes her grief as beyond that which she experienced when she left her birth country and friends.

... it was the greatest loss of my life. I mean if you are trying to piece together people’s lives then the fact that I lost all my friends at [states age] and then went to [country] and lost them, and came to a different country...I guess I clung to my mother. It was an enormous loss.

Much of Cathy’s talk was invested in the hope that she and her family placed on medical intervention, and on an initial hope of cure. Her grief as an adult is over the silence that surrounded the loss of the most formative relationship in her life - with her mother.

Alice

Alice was forty-two when her mother aged sixty-four died suddenly following her sustaining a ‘flu’ like illness. Alice is a health professional, with a grown up family. Prior to her mother’s death Alice also experienced the sudden death of her husband. Alice tells her story nine years following the death of her mother.

Alice, like Cathy, places emphasis on the family connectedness resulting from their immigration to New Zealand. Alice has some ambivalence about aspects of the protectiveness of her family and her need as a young woman to be independent. Alice’s grief over the death of her mother is linked to the loss of a friend who was always there.

I always knew I could go to my mother. There was a great big hole, a great big hole and um (sighs) the things that you only talk about with another woman.... she could sort of see things, you see. She could see things that perhaps might eventuate....I thought, who is going to be there, you know, that I can share that with. ...And so it was definitely a different sort of a loss.

Elizabeth

Elizabeth was in her late twenties when her mother died suddenly ‘from’ heart disease at the age of fifty-five, and tells her story seventeen years

later. Elizabeth is married with a family. She is a teacher who holds advanced tertiary qualifications.

Elizabeth describes her mother as having experienced great personal and social deprivation in her childhood.

... she had a hard early life ... I felt sorry for her, it was almost as if I was the adult in some ways. I would look on what it must have been like for her as a child, and feel really bad about it ... my mother was brought up really in great poverty.

She describes her mother's marriage as unsatisfying for her mother. Concomitantly, her mother's life revolved around her children, and her love for Elizabeth. Early on in Elizabeth's telling of her story, she describes herself as having been "Mum's girl".

And I think I was always, you know how you have children who are Mum's girl's or Dad's girls and so on. I was always Mum's girl ... I certainly felt growing up almost alienated from Dad because of the feeling that I was Mum's girl.

Although Elizabeth had some ambivalence about her relationship with her mother in her adolescent years, as an adult she speaks of missing the relationship that she had with her. Her current concern is getting past the age that her mother died.

Catherine

Catherine was thirty-eight when her mother died 'from' cancer at the age of sixty-five and tells her story twenty-two years later. Catherine is one of three female children. She is a teacher who holds advanced tertiary qualifications.

Catherine describes her mother, who was a registered nurse, as a caring and giving person. Her sadness is over her mother's diagnosis of cancer after having given many years of her life to supporting her older and unwell husband. Catherine's grief relates to a sadness over her mother's quality of life because she wanted her mother to have time for herself, and she didn't.

Jean

Jean's narrative intersects with both groups of women, as her beginning understanding of her mother having cancer occurs when she was aged fourteen. Jean was in her early twenties when her mother died 'from' cancer. She is one of two children. Jean views her mother as different from other mothers.

[she was]... someone that people were hugely attracted to... she wasn't the archetypal mother and that was a bit of a problem ... she was ... slightly eccentric, but the sort of person that everyone envied.

Jean married before her mother's death. She depicts her marriage as "a need for security ...I married him because Mum was dying". Jean divorced several years later and now lives with her partner, Jessie. She states of her grief:

Ah its twenty-seven years, which is ah remarkable ... when you actually focus on it, [the grief] is still so raw. And it's not as though I haven't done some grieving, but there is a sense in which I suspect that grief is always there.

There is a huge pride as Jean recounts the many achievements of her mother's life, as well, there is anger and rage at her parents. The anger is primarily over the silence that surrounded her mother's ongoing cancer treatment and the turmoil the family went through because of the politics that surrounded her mother's dying. Jean is a manager within a large business corporation. She considers herself in many ways as being like her mother. Importantly, she speaks of the challenge when she reaches the same age as her mother when she died: "It's as though there isn't a map after (age)". Jean still finds it too painful to paint, as this was something that both she and her mother once enjoyed.

These eleven women's narratives shape and support the discussion in the next two chapters.

CHAPTER ELEVEN

CONTINUITY AND DISCONTINUITY DISCOURSES IN THE TALK OF WOMEN BEREAVED AS ADULTS

For a woman, the call of the mother is not only a call from beyond time, or beyond the socio-political battle. With family and history at an impasse, this call troubles incapable of staving off the irruption of this conflict, of this love which had bound the little girl to her mother, and then, like black lava, had lain in wait for her all along the path of her desperate attempts to identify with the symbolic paternal order.

Kristeva, About Chinese women.

This is the first chapter which analyses the discourse of women who were adults when their mothers died. For this group of women the experience of the death of the mother is incorporated within a narrative moving through three major discursive phases: continuity, discontinuity and changing connections.

These phases are held together through the use of narrative. The narrative format was pursued despite intrusions or interruption by interview prompts; the women adhered to their story. Each woman focused on the significance of her mother-daughter relationship throughout the whole of her life, and on what her mother's death meant

to her within that context. The social context of the mother-daughter relationship was the 'site' from which the daughters understood and made meaning of the grief experience.

Within the narrative format, each woman depicts herself as both subject and hero in the 'story' of her mother's death. They display what I term 'feminist heroism', which is explicated within the narrative form within the context of an ethic of mutual care. These women position themselves morally as heroes³², motivated by commitment to relationship rather than mere filial duty. Within the context of self-in-relationship, the plot, which involves themes of death, loss and betrayal, presents the tragedy as heroic. The resolution in the narrative comes in the women's reassertion of themselves as in relationship. In doing this the women draw on either secular spiritual understandings or religious discourse.

Nine of this group of women provide narratives that are premised on an ethic of mutual care³³. The narratives of the other two women more closely follow the 'plot' of women bereaved as children. Like that group, their mothers were unavailable to them in childhood, primarily because of illness, and they therefore experienced the social unavailability of their mothers. Their narratives assert them as preoccupied with continuity as a quest rather than as an achievement.

All of the women can be seen to have a strong attachment to their mothers. As time has moved on, the women demonstrate within their talk their ability to reflect on, and understand more, the culture and context of their mothers' lives. They express empathy and sadness over the grief of their mothers' lives, including, in some cases, sadness over their mothers' unsatisfying marriages. This understanding was also held by the two women who experienced their mothers as unavailable to

³² Seale's (1996) research describes how dying is "imbued" with meaning and identified the desire for and script of an "heroic death".

³³ See Gilligan's (1987) discussion on the need to understand how women's responsibility and ethic of care is played out differently. The male perspective, she argues is not the 'norm' rather only one category of knowledge.

them. The years following the death of the mother for this group of adult women range from between two and twenty six years.

There are three sections in this chapter. The first explores the discourse of continuity, of connection or social bonding between mother and daughter. In this the speakers' talk is characterised by comments that create an understanding of the '*self in relationship*'³⁴, typified by reference to "she and I" and "we".

The second section explores the discourse of discontinuity encompassing how illness and death sever the '*self in relationship*'³⁵. The separation from the mother due to illness, hospitalisation, and death is known or recognised as discontinuity.

The third section outlines how continuity is re-established in discourse and in practice in order to recreate and maintain psychical connection between daughters and mothers, despite recognition of the fact of death. The women speak of a belief in continuity using spiritual talk as much as they use terms deriving from more organised religious form.

³⁴ The research of Miller (1991) and Gilligan (1982; 1986; 1987) theorise that women's development and sense of self and identity is organised around and linked to a view of a relational 'self'.

³⁵ I do not suggest that the self in relation to the mother is the only relationship of this type. Rather Surrey (1997) indicates that this first relationship can create an "empathy" between mother and daughter which she describes as a "complex cognitive and affective process," a process which needs to be understood in order to comprehend the concept of "separateness within connection" (p.80).

Continuity: The motif of mutuality, self in relationship³⁶

In woman there is always, more or less, something of "the mother" repairing and feeding, resisting separation, a force that does not let itself be cut off.

Cixous, *Sorties*, in *The newly born woman*.

...as we talked, our voices became one voice, and we were in complete union in every other way. What peace came over me then, for I could not see where she left off and I began, or where I left off and she began.

Jamaica Kincaid, *My Mother*.

For the majority of the women, their talk surrounding the death event is linked to the signifier of the archetypal, or "good mother", that is, the "good mother" who is physically and psychically available to her children. In this interpretation the discourse of continuity unashamedly valorises the importance of the mother in more than the reproductive role, and is couched in an ethic of concern regarding the daughters' relationships with their mothers³⁷. This is evident in the narratives of nine of the eleven women in this group.

She was good, she was always there for me. (Em, p.61)

I would see her or contact her every day, I mean it was mutual. (Em, p.11)

.....

...Mum and I were always laughing with each other... I just always felt that the feeling was really that she felt more like a sister. (Jane, p.4)

... she wasn't that much older and ... we could always talk. I never hid anything from her, you know. We could always yak away about anything. (Jane, p.4)

³⁶ The term 'self-in-relationship' is taken from the research of Surrey (1991).

³⁷ Freud in his later work recognised that the relationship between the mother and daughter was not well understood. Surrey (1991) suggests that Chodorow's (1978) theories represent a beginning understanding of the importance of recognising how "girls [have an] ongoing interest in and emotional desire to be connected to her mother" (p.55), and the self development of daughter's involves learning empathy and reciprocity within the mother-daughter relationship.

.....

... *she was a person who was very much loved.* (Val, p.1)

... *I wanted to be with Mum.* (Val, p.1)

.....

Well I just have this memory as a child of loving her very much. Loving, loving, loving her. (Julie, p.6)

She really always affirmed me, and she was always there and she always meant well, in spite of all these things that I might mention. She always meant well... we were there for each other. (Julie, p.10)

.....

... *we had an extremely close relationship... she was a wonderful, wonderful mother. She didn't care so much about housework, she'd sit down and talk.* (Cathy, p.7)

She was my closest friend. She would have done anything for me, she was a very nurturing person, and her loss was the biggest in my life so far. (Cathy, p.27)

.....

... *she was always there you see, she was always there.* (Alice, p.3)

I was sort of more my mother's friend. (Alice, p.24)

.....

I remember her as very yeah nurturing. (Catherine, p.3)

I knew her as the nurse in the family and as the mother, and she was ... sort of a rock person, ... a sturdy sort of person. (Catherine, p.6)

.....

I was very aware of the loving of me. (Jean, p.2)

He [father] would ... watch Mum and I across the room, and watch us talking and relating and connecting in a way that he longed for. (Jean, p.7)

.....

I ... felt growing up almost alienated from Dad because of the feeling that I was Mum's girl. (Elizabeth, p.5)

I miss being able to share the children with her. (Elizabeth, p.5)

The mother-daughter relationship is seen as being based on a perception of a mutual concern for each other - the concept of 'self' is viewed as inter-relational, as both an independent and interdependent self. The women present themselves strongly as concerned for the 'other'. Frank (1995) writes of the "dyadic" relationship where "this other has to do with me, as I with it" (p.35). Whilst it is beyond the scope of this research to critique the concept of 'the-relational-self', it does, however, need to be acknowledged that, for this group of women, their beliefs about self-in-relationship form part of the ontological assumptions that they hold about the nature of their social world, and of how that world is known. These assumptions impact on how the daughters experience grief.

The mother's presence, her availability, and the quality of mother-daughter talk, is focused on by most of the daughters who claim a close relationship with their mothers. Cathy explains that their talk is part of their culture and belongs to the Irish tradition, and nostalgically speaks of this as "the happiest time" (p.9).

...she was a wonderful, wonderful mother. She didn't care so much about housework, she'd sit down and talk. ...And I would come and I would say "lets have a cup of tea" and we would sit there for two hours. And I would tell her what had happened at school, and we would chat about this and that. And she was just happy not to do the housework, um she would much rather just sit and talk. Which Irish people do. ... They have the gift of the gab.

[So you think it was a cultural thing?]

Yeah, I think so. It was a cultural thing. She would much rather of sat and talked to me than do housework. (Cathy, p.7)

Throughout the interview, Cathy emphasises that "she would rather sit down and talk, ...we'd chat away for hours" (p.4), and again, "she was prepared to sit down and talk to me for hours" (p.27).

This same notion of mutuality is suggested by Elizabeth as she speaks of her mother seventeen years after her death.

I still forget on occasions for a brief second that she is dead. And I find myself thinking, Oh I must ring Mum...and now I can't.

[Now its seventeen years?]

Yes, yes there are still things that I would like to share with her, and talk about to her, because I enjoyed talking to her. (Elizabeth, p.21)

Em's talk is also centred around shared activities, and their availability to each other.

I've always got on well with her. We were the greatest of friends, we both played the piano ... we went to every concert pianist together and we always went to the films together. We really created our lives around each other. (Em, p.7)

During one of her mother's hospital stays Em attempts to convince her mother of her need to stay with her to support her overnight. Em had previously stated that her mother was afraid of hospitals.

I said "Well you had such a bad night Mum I'm going to stay with you. I want to be with you". And she said "No you're not, I want you to go home, I'm going to be fine, I will be here in the morning. You are to go home". (Em, p.39)

Both recognise the other's fears and both express mutual concern. Em recounts hearing from medical staff that nothing more could be done for her mother. She attempts to maintain the possibility of their continuance. "We" becomes the signifier of joint action. She states "I thought, we've got to try something, we've just got to do something" (p.22). Em discusses with her mother the possibility of a trip overseas to visit an internationally recognised cancer clinic.

I said to Mum "Well how about going, we haven't gone to England and how about going?" ...and mother thought it was a good idea. And Dad said "well it seems a lot of money".

[...did you talk [with the hospital staff] about going to this clinic in [place]]

Yes I did, I told them we were going to go³⁸. (Em, p.22)

³⁸ Em indicated in the interview process how she and her mother complied with the 'experts' regarding her mother's treatment. Her narrative became chaotic with repeated hospitalisations and different messages regarding her progress. At this point in the narrative Em became the rational actor and unashamedly set out to keep her mother alive. She decided there must be a new regime of treatment. Lupton (1997) discusses how these actions are supportive of the reproduction of medical dominance.

Em and her mother did go to the overseas clinic where the care received was within the medical paradigm, but both recognised a need to discipline the body³⁹. The 'problem' was not viewed as the mother's problem alone. The desire for continuity became a joint challenge for both mother and daughter.

We were given the medication ... we came away feeling quite excited. She had a diet, and she had a tonic, and had various other tablets to take. (Em, p.24-25)

Julie depicts her relationship with her mother as having moments of significant stress, especially around the time she found out that she was adopted. However, her dominant memory is of them both being there for each other.

I just have a memory as a child of loving her very much...loving, loving, loving her. And then somewhere in adolescence I knew I couldn't actually have a rational conversation...And if I'd be right about something I couldn't sort of work it through or she would be in tears and then there would be troubles. (Julie, p.6)

... And yet I have to say that I still loved her you know. (Julie, p.9)

...she was jealous of my father's affections, and all of this, um she did one extraordinary valuable important thing and that is she always, always, um, valued me, you know. She never put me down you know...she made me think I was great.

[She affirmed you right through life?]

Yes she really always affirmed me, and she was always there, and she always meant well...she was lonely in her own way, and kind of we were there for each other. (Julie, p.10)

Julie utilises similar descriptors to those she uses to describe her mother's relationship with her grandmother. She states "she deeply, deeply loved her mother" (p.1), and, in describing her own relationship with her mother, she speaks of "loving, loving, loving her" (p.6). Her words imply a depth of relationship and a reiteration of family scripts. A similar sentiment is depicted by Jean who states that "My mother's

³⁹ Frank (1995) outlines in detail how self-regimentation and "the disciplining" of the body occur as a way of coping and of desiring to have control over the illness process.

loving was the finest quality of loving I've ever known" (p.32), and speaks of how she felt "affirmed myself by Mum" (p.36). Whilst Jean is very angry with her mother for not talking with her about her dying, she is proud of their relationship. "We certainly did journey in a lot of ways" (p.33).

Alice and Catherine also valued their mothers for always 'being there'. They refer to their mothers as being available and supportive. Alice saw her mother as her greatest supporter. "Even if she was in the other side of the world she was there you see, somewhere she was there for me...you know, I just knew that" (p.48). Catherine saw her mother as "family orientated" (p.1) and remembers her mother as "welcoming and warm" (p.2) and "as very, yeah, nurturing" (p.3). A similar discourse surrounding the concept of the 'good mother' is articulated by Jane when she says "... there was nothing that she wanted out of life except for her children to all be happy" (p.1). However, this is qualified when Jane gives an account of the family suffering when her mother left her husband on meeting again "the love of her life" (p.2). Jane, the eldest of several children, saw herself as being the "closer to her, I think" (p.10). Jane spent a lot of time with her mother, and cites an example of their "relational selves" when she states "She loved my garden. She loved pink and mauve and purple, and I was always buying things in those colours, just to please her, to put in the garden" (p.23). Jane's flower garden was created as 'theirs', as a place her mother was able to visit and enjoy most days in the later years of her life.

Val describes her mother as a "wonderful storyteller" (p.12). In the early stages following her mother's stroke, Val tells of how together they would be "just talking and talking and talking" about what had happened to her (p.7). She tells of how the only other option available to her mother at that time would have been to see a psychiatrist in order to cope with her grief. She discussed how the impact of such an event was simply "crazy making stuffy really, you know" (p.7). Because of this, and their

relationship, Val chose to spend time with her mother in listening to and validating her grief.

In these various ways, rather than in any one way, the 'self-in-relation' is asserted. However, two of the women describe their mothers as socially unavailable to them in life, and assert themselves as being in quest for a self-in-relationship. Neither Ann nor Megan perceive themselves as being central within their mothers' lives. They were always made as 'other'. This grief is greater than the deaths of their mothers.

I felt that I didn't have a connection with her...an emotional connection in my relationship with my mother. And when I looked into her eyes I feel I didn't, I couldn't see her...I don't feel that my mother ever saw or understood me, as my father hadn't either, um as the person I am. (Megan, p.2)

.....

I guess my relationship with my mother has always been very difficult, it was difficult when I was a child and it continued to be difficult up until the time she died. (Ann, p.3)

...it was as if she was not there as a mother for me. (Ann, p.5)

Butler (1997) suggests that dependency and attachment are vital to existence:

The one who holds out the promise of continued existence plays to the desire to survive. "I would rather exist in subordination than not exist" ... Let us consider that a subject is not only formed in subordination, but that this subordination provides the subject's continuing condition of possibility. A child's love is prior to judgment and decision; a child nourished in a "good enough" way will love, and only later stand a chance of discriminating among those ...she loves..., but...if the child is to persist in a psychic and social sense, there must be dependency and the formation of attachment. (p.7-8)

In this sense, Butler argues that subjection relates to, and is "produced through the workings of power" (p.6). However, Megan's explanation for

an absence of 'connection' with her mother suggests that she believes her mother was socially unavailable because of other family commitments.

...I never had um any real connection with her. (Megan, p.1)

I didn't have, um, a connection with her. ... there wasn't really, ah, an emotional reaction, an emotional connection, in my relationship with my mother... She was so busy bringing up the other children that there wasn't room for any other interests ... she ... had a lot of illness and was quite physically frail. (Megan, p.2)

...I didn't have the emotional connection with her. (Megan, p.4)

... when it came to emotional things I think the support wasn't there. (Megan, p.5)

Despite acknowledgment that the family was well provided for, Megan wanted her own archetypal 'good' mother.

I always hoped that my mother would be a mother in the way that I'd envisaged.
(p.48)

She draws on the absence of psychical connection to explain the impact that this lack has had on her own identity formation.⁴⁰ According to Megan, she became a "non person" (p.10) because of the various vicissitudes of her mother's life. The ethic of mutual care that should exist between mother and daughter was not there for her in her relationship with her mother, and also with her father.

A cousin told me ... how like my mother's mother I was...And, um, several years later, when she saw me again, she said I had been utterly squashed. (Megan, p.5)

... my dominant state of being, has been one of anger and I have been angry all the way through I think until quite recently. And every now and then, I still am.

... But that's the way I assert my selfhood.

[When you talk about selfhood what does that mean to you?]

... it's my sense of me and who I am (Megan, p.6)

When I looked at the photos of [my mother] as a young woman she seemed very vivacious and happy and I thought that I've never known that woman. (Megan, p.7)

⁴⁰ This argument is similar to that of Margaret in Chapter Nine.

Megan indicates that, in many ways, she felt as if she did not have a mother, and suggests this had its roots in her mother's early married life.

... she never stood up to any of these things. I think what she did was to put up barriers to protect herself and that's why she seemed so distant. (Megan, p. 8)

Megan's perception of the 'good' mother includes emotional connectedness, and she remembers an incident where her mother did connect with her because "it was unusual" (p.10).

And mother was so thrilled for me, and I was quite tickled by that because she was genuinely pleased. (Megan, p.9)

Ann's 'story' also reveals her desire to have experienced the continuity which was apparent within the stories of the other nine women who were adults when their mothers died. Instead, like Megan, her story is one of discontinuity before her mother's physical death.

Ann depicts herself in the foreground of her drawing, reproduced below, which she entitles "Alienation". She considered herself to be alienated from her mother because she was unable to be what her mother wanted for her, and the result was life long grief.

She was determined that I would stay at home and take her place ... she didn't want me to do anything outside the home ... it was to be my role to take her place and to help her. I didn't ever fulfill that role very well, I don't think she ever forgave me for it... she experienced it as a desertion of her ... I wasn't actually supported in anything. We had, um, I would describe it as a very difficult relationship. (Ann, p.1-2)

Ann also grieves the family politics that surrounded her claims of incest and physical abuse. Her talk indicates that this impacted upon the family dynamics, and robbed her of the possibility of an appropriate mother-daughter relationship.

She [younger sister] had virtually taken on the role that I would have taken on as the older daughter if it hadn't been for the things that had gone on in our family... I mean I had virtually lost my position, if I ever had one, as the oldest, elder daughter. (Ann, p.14)

Following her mother's death Ann felt she had already "done most of [her] grieving".

... it was as if she was not there as a mother for me, um I had grieved a lot about how things were in our relationship. (Ann, p.20)

... I mean she had been dead to me as a mother for years. (Ann, p.28)



Figure 1 Alienation

Despite her childhood experience, Ann defends a view of herself as morally wanting the best for her mother, and as committed to an ethic of care. She worried that her mother might not have good nursing care,

and wanted her enabled in such a way that she would experience a good death⁴¹.

I had found myself wondering, well I wonder if I can sort of give some, if they would perhaps allow me to stay over night if perhaps she was needing some night care. Although I don't how I would have actually got on trying to give it if you know what I mean. (Ann, p.13)

Ann is relieved that her mother died so suddenly.

...it wasn't that I couldn't believe it, I did believe it. And part of me, I actually felt relieved that, that it had happened that way because the rest home that she was in was really quite posh looking, but I don't think people got very good care. ...And I was quite worried about what was going to happen, um, as Mum got sicker. (Ann, p12)

Ann's inability to achieve relational connectedness with her mother is expressed by her as shame.

... there was shame attached to my relationship with my mother, but I also felt very ashamed about how bad it was, because it seemed to be such a terrible thing to have such a bad relationship with your mother. (Ann, p.22)

Ann justifies her mother's behaviour. "I mean mothers do their best, really no matter what they do, they do their best" (p.16) As a result of this interview she provided a note from her diary that she wrote following her mother's death.

... sorry I didn't do better ... sorry you had to go through all the pain about of the incest ... sorry I haven't been able to resolve my feeling towards you, to be the daughter you wanted.

⁴¹ Seale 1995 indicates the importance of scrutinising text for indications of "moral character" (p.603). Ann, like all of the other women, presents herself as wanting to emotionally accompany and support her dying mother despite her feelings of alienation.

Discontinuity: The challenge to continuity by the mother's illness and death

I would like to see research that asks questions about rage and anger, about the forbidden feelings, the unacceptable responses to death and bereavement.....I want to question the many guilt-making theories that surround bereavement and the so-called 'working through' of it.....my own instinctive feeling is that you do not work through bereavement. It works through you.

Virginia Ironside *You'll get over it: The rage of bereavement.*

Within the interviews the adult women employ the narrative to explain death, loss and betrayal as the tragedy that impacts on their lives. Discontinuity assumes primacy but continuity is never totally lost, as the daughter depicts herself as still in relationship.

Three different repertoires emerged that were utilised to explain the mother's move into the illness/death trajectory. The first involved the daughters' recognition of how the focus on illness, the disease process and the hospitalisation experience involve a 'take over' of 'the body' with the concomitant subjugation of social experience and discourse. The social dimension of 'the self' becomes secondary to the disciplinary regimes of "the body"⁴², and creates a beginning understanding of loss. This results in the daughters portraying their mothers in an heroic light in their coping with their dying, and in portraying themselves as heroic in their care for their mother. The daughters' beginning awareness of discontinuity and change, is signified in their use of medical terminology⁴³. The second repertoire surrounds disappointment over the

⁴² See Foucault (1978); Frank (1995); Kleinman and Kleinman (1994).

⁴³ Although I give a lengthy example of this in Cathy's account of her mother's dying later in this section, I have chosen not to focus on the medical discourse, but rather to give pre-eminence to the daughter's use of the narrative about the mother-daughter relationship and the grief experience.

death of the mother where shock and disbelief exist. This incorporates explanations of the women's physiological and psychological responses to loss, the focus of the medical paradigm. Within this repertoire is the utilisation of a motif of betrayal that mothers are not meant to die. The final repertoire utilised is the perspective that the physical death of the mother, marked by "the body", brings the loss of an irreplaceable social relationship.

The beginning of loss: Illness and hospitalisation

The interpretive repertoire used by Jean indicates that the terms 'cancer' and 'hospital' are equated with death. For Jean, these terms connote discontinuity and change.

...I was absolutely staggered because in those days cancer meant, you know, death. (Jean, p.9)

...that was the cancer unit. And it was sort of as a kid you used to look at it and think oh that's where people die... We used to stare across at the bay and just see it as just sort of a death thing. ...it was all to do with death. It had no, no small c, and I was panic stricken... I took a train out to see her at this death place. It was very hard going into that place because it was just unbelievable that mum could be there. (Jean, p.10-12)

Elizabeth experienced the isolation of waiting whilst an emergency team attempted to resuscitate her 55 year old mother. Her desire is to be with her mother. However, while the medical and nursing team attempt to save her mother's life, her mother dies.

... it must have been obvious she was dying. We should have been allowed in. But what happened instead was we sat outside ...they worked in the room behind the closed door. And would come out and say things like um "She's rallied, you can come in, in ten minutes". ...they would go back and leave the door shut, and then they would come back and say "She's had another one, you will have to wait". And in the end she died before we got in. ...it was the most dreadful feeling of utter hopelessness, because I could see what was happening ...we were shell shocked sitting there in a long line like birds on a telegraph wire. ...And we all just sat there in this terrible silence, it was just macabre. ...it was probably about

two hours ...How come we can go in now when she's dead but we couldn't go in before, when it might have been some comfort to her? (Elizabeth, p.12-14)

Elizabeth's discourse is a counter to the save/cure goals of the medical and nursing profession, which may compete with, and contradict, the social goals that surround the concept of 'dying with dignity', and certainly block the daughter's desire to be with her mother as she dies.

Val's grief was the loss of her mother to illness and disability. During "the process of her twenty-five years of illness, um, and particularly the last five years, I actually lost a lot of my memories about her" (p.1). Val's narrative is not unlike the women whose mothers died when they were young. She is very clear that dying is part of the life process, and that "we muddle sadness and badness ...we tend to think of dying [as] something that's really bad" (p.1). Illness and disability took over her mother, and their lives. She tells of how she had forgotten about her mother as "our caregiver" (p.1) because "our roles had been reversed" (p.1). The metaphor Val utilises to describe this process is that "the lights went out really" (p.7).

Catherine's sadness is that her mother had "been tied to him", her sick husband, for years, and had now developed cancer, just when "it was time for her to have a bit of fun" (p.10). The ethic of care, that is inherent in the protectiveness and silence of her mother is indicated early on. "It was probably going on before my father died, she didn't tell us [for] quite a few months" (p.10). Her mother's first comment to the surgeon was: "Is it hereditary, will the girls get it?" (p.10). Catherine's understanding strongly incorporates medical discourse. Her mother had an "oedematous leg ... due to the secondaries in the liver" (p.13). Whilst she views 'medicine' as enabling her mother to have a certain quality of life, her sadness is that cancer gets her before she has the opportunity to have time for herself, because "she had worked so hard" (p.10).

... she lost out by not having some time when she didn't have to nurse my father ... there is a sadness for what I would have liked her to have had. (Catherine, p.28).

Jean recounts the times of her mother's illness as distressing, primarily because of the conspiracy of silence that existed around her mother's illness. Some years following her mother's mastectomy Jean tells of how she "just slipped straight back into ...feeling scared"(p.15), following the visit from a doctor who diagnosed further cancer.

I don't know how long it took her to die but it was fairly horrendous ... she was hooked up with bottles and stuff. (Jean, p.16).

There are a number of contradictory statements. Jean identifies this herself in the use of the term "double speak" in regard to silence. There was some ambivalence about her mother's care when she was dying at home. On the one hand, her mother had "really deteriorated really ... Dad's nursing of her was hugely, hugely tender" (p.23), while on the other hand she states that "the one good thing, if it was good, being isolated from friends and everything, was that she was at home" (p.23-24). While silence/silencing is an issue, Jean's abhorrence is over her mother having cancer. Jean illustrates that the word cancer for her is a term that is categorised and marked as connoting 'death'. And death is the problematised binary to life.

Cathy uses the analogy of herself as mother with child to explain her own protectiveness toward her mother when she was admitted into institutional care. The role reversal she describes indicates a mutuality and reciprocity in caring with similar themes to those of Val.

I felt very protective, I felt very, very protective when she went into hospital. Anybody that came near her I watched every thing they did. ... Um, I watched what procedures were like. I felt really protective. Almost like a mother with her child. You know, I scrutinised them as to whether they showered her properly (slight laugh) and that type of thing. (Cathy, p.12)

Cathy's feelings about her mother's institutional care are important in that, although she was a health professional, she experienced a significant lack of control. She was unable to assume a professional voice; her narrative is one of powerlessness. It is important to recognise

the power that the institutions of medicine and nursing wield⁴⁴. Cathy is also influenced by her father, a doctor brother, and her mother's doctor, all of whom made a significant number of the decisions. In order to understand something of the powerlessness she expressed, I asked:

[Can you tell me a little about the difficulty you felt when talking to the doctors and nurses. Was it because you were a nurse? ... How did you feel?]

I felt stunned ... Because you go through the grief process even before people die⁴⁵. I mean I was grieving because I was losing my mother.⁴⁶ Um, I felt embarrassed I suppose, because I was a nurse also. But I also felt terribly protective towards her and I knew she didn't like it there. (Cathy, p.15)

Cathy's talk is of either a 'medical' or a 'religious' influence being exerted upon her father to admit his wife into hospice care.

And I'm not sure if it was the doctor or whether it was one of the ... nuns they kept badgering him to put her into the hospice for a break.

[Right]

And Dad put her into the hospice and its the only time I ever heard her complain in my whole life ... and it shocked me to the core because she was a real martyr.

(Cathy, p.13)

An issue here is of who manages or has control over the 'sick person. Cathy does not mention any involvement in the decision making by her mother, other than to comment that "she didn't like it there" (p.15). Rather, there is a sense of a loss of unilateral control, of inequity, within the medical encounter.

Cathy tells of visiting her mother at the hospice.

...and I said something to her about how are you, and she said "They washed my hair in the shower and it's gone all flat". And you see she wasn't used to that, because she would go to the hairdresser and have a shampoo and set and she always looked nice... it went horrible and flat and that upset her...

⁴⁴ See May (1992a, 1992b); Zola (1972); and Waitzkin (1994).

⁴⁵ See Kübler-Ross 1969 for a discussion on anticipatory grieving.

⁴⁶ Justus (1993) describes how she needed, and was given permission, to be both nurse and daughter. In Cathy's situation the dilemma is that she was aware of her mother's unhappiness at being institutionalized but was stunned, and felt powerless to act.

And she said, "they left me alone in this bedroom and I was cold and I was lonely". And that was the only time I have ever heard my mother complain and she hated it. She was a home body and she couldn't wait to get back home, and home was where she wanted to die. ...I'm very much aware now that not everybody wants to go into a hospice.

[Mm, Mm.]

And she hated it. She wanted to die at home and that was her aim...

And um I know that she was begging Dad to take her home. And she finally came home, and she waited to die till she got home and she died either a day or two later. (Cathy, p 13-15)

Cathy's mother uses what Kübler-Ross (1969) calls symbolic language. The concept of going "flat" is also imagery that is used by nurses to connote that stage before death, or as a metaphor for death. In the context of the interview it is also important to explain that previous to her reference to this statement of her mother Cathy had been talking about the physical deterioration in her mother's health. Now Cathy is also speaking about loss of control over bodily changes, and over the 'little' things that are important such as washing one's own hair, or of being well enough to get one's hair attended to professionally. Cathy recalls her mother saying that "they left me alone in *this* bedroom, and I was cold, and I was lonely" (p.13). This comment suggests change, isolation and death. There is a metaphor of impending death. The 'story' speaks not only of Cathy's mother not wanting to be at the hospice but, just as importantly, of her wanting to stay with her family in her home and to die there.

Cathy appears to have been unable to exercise any influence at the hospice, and she later describes herself as "stunned". She is too enveloped in her own grief to be able to 'act' as a nurse advocate for her mother within the powerful institutions of family and medicine because within the family situation, she had been interpellated into the role of being the "baby daughter".

In analysing Cathy's talk about her mother's diagnosis and admission I noted how she describes aspects of her mother's care by health professionals using a range of terms that reflect either medical or social discourse.

Medical Discourse

*she had a mastectomy
she had radiotherapy
on tamoxifen and things like
that
she got secondaries
hip "mets"
common site for it to re-occur
she got metastases
went in for all sorts of tests
injured the brachial nerve or
some... either that or
radiotherapy
massive radiotherapy
like having a stroke but she
hadn't
it was medically induced*

*only time I ever heard her
complain
was when she went into the
hospice*

*and they gave her chemotherapy
really the chemotherapy
killed her
more than anything
it was the chemotherapy*

Social Discourse

twelve more good years

it showed up as hip pain

quite a lot of suffering

*one arm became useless
that was a loss to her
she felt a little bitter
never ever complained*

and she started to get thinner

she couldn't eat

*she was so sick
she was just so nauseated
that she couldn't eat.*

There is ambivalence about much of her mother's later medical care. Grief and disappointment for both her mother and Cathy surround the incremental losses her mother sustained. However, Cathy acknowledges that early intervention gave her mother "twelve good years" (p.10). Cathy's description of what happened to her mother implies that both the disease process and the treatment had a largely negative impact upon her mother. As previously mentioned, the majority of this group of

women utilised medical discourse to emphasise both the physical and the social loss that was impacting upon the mother-daughter relationship.

Whilst the daughters accept the inevitability of death, at a psychological level their ethic of care requires that it be a 'good death'. This *desire* of the women for their mothers to have experienced a *good death*, cannot be underestimated. I suggest that the failure to achieve this ideal for five of this group of eleven women was a major factor in shaping their grief.

A moral ethic of care was present in all of the women interviewed. Most of the women also spoke of their desire to have been with their mothers when they died, although not all were able to achieve this. Seale (1998) defines this moral positioning as "emotional accompaniment". Cathy, despite her misgivings about her mother's institutionalisation, *now* tells a story of her mother having a humane death following her return home. This is an ending that Cathy wanted to help create, and it was an ending that she could live with. Her mother's death was now imbued with a different meaning and some appropriateness was now attached to the loss.

...he handled her medication. And she died in a very humane way.

[Right, how lovely.]

Because she just went to sleep and she died in her sleep. And she was so weak that she had to be helped up to the commode. And she was skeletal, but she had no bedsores⁴⁷. And she literally just went to sleep and died in her sleep. Partly from heart failure, but just dying in her sleep.⁴⁸ And really that is a wonderful way to go. (Cathy, p.19)

Julie describes her 81 year old mother as having been sick with a flu like illness for about ten days. "She was in that age group really...she had sort of run out of steam by the time she died" (p.12). Her mother's death she describes as "the most beautiful death ...you know, no pain, no

⁴⁷ An understood mark of excellence in nursing care.

⁴⁸ Note the contrast in language when Cathy uses both medical and lay discourse.

suffering ... It's magnificent" (p.12). Similarly, Catherine says that her mother "was very supported by local people ... she died at home, and that worked quite well" (p.15). She counts herself as fortunate, because "the people close to me that have died haven't had terrible deaths" (p.34).

Alice recalls how her 64 year old mother had "had the flu" (p.29). She had shrugged off the possibility of anything untoward, until she received a phone call from her aunt. Alice's response on hearing of her mother's sudden death is of shock and denial.

I said "She's fine, she's just had this flu", but I said, "She's getting better ... And she said "Don't you know?" And I said "Know what?" And she said "Your mother's dead". And I was standing there [points to place in home] and I just threw the phone away... ..I just sunk onto the floor, and I, you know, I reverted right back to the infantile and the only word I could think of was Mumma and I haven't thought of that word for years [voice breaking] ... thirty-three years, forty years probably(Alice, p.31-32)

However, on hearing the details of her mother's death, she describes it as a 'good' death.

...and she said "I don't feel well and I'm going to have a shower and go to bed" ...so, um, my sister went in and here was Mum dead. ...here she was in bed. And it was just lovely. (Alice, p.30)

Megan describes being with her mother in her dying, and says that viewing her body in death provided comfort.

I could see her face just changing ...the sort of fear that had taken over ...it was a sort of fearful timid look on her face and it had all gone, and you know and she looked very beautiful. (Megan, p.29)

The 'how' of a loved one's dying is very important. As spoken, it reflects something of the daughter's desire to maintain a quality of being, and of care, for the mother until death.

Ann, like Alice, viewed her mother's sudden death as having something positive about it.

There was also a sense of relief that she hadn't got sicker and sicker ... they couldn't care for her and I think I would have been the only family member that would have even realised. (Ann, p.27)

When this is not achieved there is remorse, rage, anger and soul searching. This is present in the narratives of Val, Em, Jane, Elizabeth and Jean.

Val utilises a metaphor of darkness to describe the experience of her mother's dying. She speaks of how "the nightmare started" (p.14); and again, with emphasis, "it was like a nightmare for me" (p.15). Val also uses a metaphor of a "journey" that her mother and she were planning to go on. Despite her knowledge and skill as a nurse, she is shocked to find her perception as different and 'other' to the attitudes of the medical and nursing staff at the hospital. Following her mother's death, Val tells of how she needed to speak "about the rage that I had felt and not pretend that it hadn't happened, you know" (p.16). Val had wanted to draw on her own experience of working with dying people, and on her ability with as a team worker to create "the good death" for her mother. She critiques the silence in the management of her mother.

I mean here's a hospital of old people and they just don't know how to deal with dying, you know. (Val, p.19)

Megan discusses how she had an opposing view from the management concerning her mother's hospitalisation. She speaks of the "they", that is, some of her family and the health professionals who would not stop active treatment.

They actually treated her for the heart attack, because they obviously couldn't do [procedure] until that had righted itself ... She was in hospital for three weeks before she died, and they upped the dose and kept on treating her ... they were still treating her until a day or two before she died. (Megan, p.22)

She describes her family as drawing from the cultural scripts of medicine.

Everybody talks as though there's hope, we'll follow this treatment, or that treatment ... and there just seemed to be a big gap between my reality and the

other reality. No, I just thought she had come to the end of her strength. (Megan, p.20)

Megan also speaks of the “good death” her mother experienced in the last few days of her life.

I don't quite know the right word, precious sounds a bit precious ...there was something beautiful about it, and I think that, um you know, people in a sense choose when they are going to die. ...after, you know, she was unconscious her presence was very much still in the room. (Megan, p.22)

When Jane speaks of her acutely ill mother, she uses the collective “we”. Jane comes from a large family, but clearly distinguishes her own ‘self’ when describing her relationship with her mother. However, when her mother is hospitalised, she calls into play terms relating to a collective self:

... they said it was pretty bad ... it was quite serious ... she wasn't able to speak to us, but her eyes were following us you know. And we were all scared. (Jane, p.7-8)

It was really a very bad, hard time of course for all of us. We set up a roster because after three days we were all in such a state, we were all tired and we decided to get together and set up a roster, so that we could have our sleep as well. (Jane, p.16)

Jane describes family conflict over the decision to not ‘actively’ treat her mother following her severe “stroke”. Jane, as the oldest member of the family, was asked by the medical staff to agree to support their decision for no treatment. This created conflict, both for herself and within the family. Jane discusses the micropolitics around her mother’s dying, including how she attempts to advocate for her mother and obtain morphine for her in order to deal with her pain and make her death better.

I went to one Sister and she said “Well, we’re just not allowed”. “But” I said, “my mother’s going to linger” ...I would have liked her to be slowly helped. ...so I went to another one the next day, and she was a nicer person. And I said “Could you not give her something? I know she’s got something worrying her”, and she said “I’ll give her an injection of morphine”. ...now Mum slept much

more peacefully. ...we felt cruel ...when someone's in pain and you can't do anything about it ...and wanting her to be out of the misery of it all. (Jane, p.18-19).

The loss of the mother to illness, hospitalisation or sudden death is described often within a context of power and control, that includes, for a number of the daughters, their willing, and at times ambivalent collusion, with medical treatment. There is a tension between wanting and resenting any care given. The process of deterioration and movement from life (and relationship), toward death is described at length by the daughters. The mothers appear to become categorised by and become their illness while the daughters desire intervention and restitution. It is as if, by focusing on the instrumental tasks of survival, the need to focus on or contemplate one's mortality is lessened. Life, relationship, and activity are valorised, whilst death is differentiated from that which is normal - life.

The betrayal: Mothers don't die

A number of this group of women also articulate a discourse that turns on the concept of betrayal. The women indicate that their mothers should not have left them in such a vulnerable state.

I felt Mum's death was sort of like a betrayal. Like, how dare she go and leave me alone, when I still needed her! ...How dare she do this to me personally! ...you get so self centred.... I felt very betrayed with my mother, she let me down, Oh yes, she left me and, um, you know, I hadn't given her permission...I felt bereft, very lonely. And, um, quite shaky I think for quite a long time. Quite shaky. It shook my confidence in the world quite a lot.

[When you talk about quite a long time, what are you thinking?]

I mean about five or six years. (Alice, p.36-37)

.....

I don't know that it was all right for people to die, and I think there was a sense in which, um, with Mum it was almost as though she was letting us down, she wasn't doing her bit. (Jean, p.22)

.....

...I feel cheated, very cheated. (Em, p.5)

.....

It was something that I couldn't possibly put into words or anything. It was just a huge thing inside me...a great heaviness all of the time. (Elizabeth, p.23)

For Cathy it is like there are two selves operating. On the one hand, she acknowledges that her mother is dying, yet on the other hand, she denies it. She links into Kubler-Ross's stage theory to explain herself through using one of the most common medical/nursing discourses on grief. At one level, Cathy is saying she knows her mother is dying but she justifies why she is not allowed to leave, and tells of her desire for her mother to remain with her.

I can see the stages I went through, I mean I felt angry. How dare she leave me! She was my best friend, and she needed to be here to see my children grow up. And I wanted, and how dare she leave me, and I was so angry at some stage. (Cathy, p.21)

The sense of betrayal may in part be explained in the psychological denial thesis, that the western world is a death denying society (Kubler-Ross, 1969), that death is a taboo subject (Walter 1991, Cline, 1995), that "the dead cease to exist" (Baudrillard, 1976/1993, p.126). I expected to hear a number of comments that suggested an "acceptance" of the mother's death and of the daughter's desire to move on; comments that might reflect an ideology of individualism, that is, of an autonomous and individuated self. However, on the contrary, the women expressed a great deal of sadness and grief over the loss of the relationship, or of the potential for a relationship.

For example, I asked Em what her mother's death meant to her.

*It's a tremendous loss in my life. It was something that **nothing**, no matter what anyone did or said could ever fill that gap. It is something that is totally gone. (Em, p.62)*

*... ..I think for me **my comfort's gone**...And I used to get angry with her, ... she would come and she would say to me "Oh look at your hands, I've told you not to work that hard" ...and I miss that and it annoyed me at the time.*

[So, she was the one that pampered you?]

Oh yes, she did, but that's what I miss, someone caring (voice breaking) ...just being there. (Em, p.63)

[...What does grief mean to you now that you have had this experience?]

*Um, an emptiness and a **terrible loneliness that nothing can ever fill at times.***

[Do you get over it?]

No, I don't know ...that I ever will. (Em, p.67)

Cathy acknowledges her denial.

*Even though I was a nurse I **never believed my mother would die.** To me she was **immortal**, and other people die, but your mother doesn't die...I never believed, despite the fact that I was a health professional, that my mother would die. I mean she was sick but I **never believed she would leave me.** (p.18)*

*She was prepared to sit down and talk to me for hours. **She was my closest friend.** **She would have done anything for me,** she was a very nurturing person and her loss was the biggest in my life so far. (Cathy, p.27)*

Alice depicts her grief over the loss of the relationship.

*There was such an agony about grief that you would think, I cannot actually live for the next hour...the first days after you have lost someone you have loved **desperately**... there is almost a nauseous feeling, this is, you know, I cannot live with this desperation, I suppose. Of course time gets you through it...the agony goes, I don't know if you get over it but the agony goes... You stop being that nauseous feeling. (Alice, p.47)*

Alice makes a comment about how her grief for her mother differed from what she had previously experienced on the sudden death of her husband who died tragically following an accident. Interestingly, she utilises the metaphor of the heart for her husband, a romantic discourse, and of breath, for her mother, a natural signifier of life.

*...with Phil I know my body changed. It changed to a different rhythm...I could **feel my heart**, my blood running around in my body, in a different way... But with my mother, it was **more the anxiety, it was the breathing** and that's why I think I*

talk about my safeness, you know my safety in the world was absolutely threatened. (Alice, p.48)

I thought I had this grief thing worked out but it was entirely different. The grief I felt for my mother was entirely different from the grief I felt for Phil. Um, it was entire 'cause I had always known my mother, my mother had always been there. (Alice, p.36)

Val tells of her grief over the loss of a special relationship.

...when I used to sit by her, she used to just kind of rub my cheek...I can't actually think of the word but kind of the, I suppose it's almost bereft, I suppose, as kind of not ever again having, you know, experiencing that. (Val, p.22)

Jane speaks of the loss of a presence always there:

...its a very big piece of me, it's a very big gap. Um

[What do you mean by that?]

Well Mum was always there. (Jane, p.21)

The physical loss: The body in death

The moment of viewing the mother's 'body' at the time of, or after death is a point of tension that can, according to different understandings, connote either discontinuity and continuity. This experience of viewing the body is a transition experience between continuity and discontinuity, that can facilitate the beginning of recovered continuity. One viewpoint within medicine is that viewing the body is beneficial as it helps to make real the loss, and thereby facilitate the process of disengagement, but this viewpoint was not however appreciated by all of the women. Given that death is understood within medicine as located within the body (Foucault, 1973), this viewpoint has support. Baudrillard (1976/1993) critiques current understandings that "this death, everywhere in life, must be conjured up and localised in a precise point of time and a precise place: the body" (p.159). However, the most common viewpoint portrayed by the women was of their desire to be present with their mothers at her time of death, rather than a need to view 'the body', although this was important for some of the women. This perspective is

'evidence' of an ethic of care, and supports the view that death represents as much a social process as a physical process. Em, Jane and Megan all "wanted to be there".

*...they said "You know that the end is nearly here?" And I said "Yes, I do recognise that" ...I mean she had been through hell. And the doctor said "Well we can just barely hear her heart beat, it's just there and that's it" ...we were standing in the corridor and I was talking to one of the nurses and [husband] came out and said "She's gone, she's just gone," and I just broke down totally. I'm not normally a noisy person but I was just, **that was the last straw**. And I said "**I wasn't even with her**. I just can't, and [daughter] came out and she said to me, "It's all right, Mum, she's breathing again". But it was the shock, because I don't go to pieces, I keep myself in control. (Em, p.51-52).*

....

I wanted to be there, oh I cried, I wanted to be. I had spent at one stage about sixty hours there, and we, we didn't know when it was going to happen.... I'd been there until oh two or three hours before she died.

[Mm]

I came home and went to bed, and had a sleep and then the phone rang and it was [sister's] husband and he said "Get up here as soon as you can" ...we walked up the corridor and the family were in the corridor crying and I said "No" [voice raised, speaks "no" as it was said at the time]. And I cried and rushed in and said "I wanted to be there, I wanted to be there, I wanted to be there".

[Mm.]

Yeah I know, but I mean, you know she had family around her so that was all right. (Jane, p.21)

.....

...the nurse came to sponge her earlier on in that morning, ...I helped, I wanted to do that ...It was all part of her care and I wanted to be involved in it. (Megan, p.29)

I wanted to be there when she died, and I would have been terribly upset if I hadn't been, ...it was as though she waited for us all to be there. ...I'm sure that she would have wanted us all to be there. (Megan, p.30-31)

Alice, like Elizabeth, experienced the sudden death of her mother. She saw it as important to view 'the body'. Alice supports the medical view

that it is helpful to view the body, especially when there has not been an opportunity to be with the dying person, or prepare oneself for it.

Cathy, of her own volition, brings up her concern regarding the viewing of her mother's body. Whilst a number of the women spoke of the value of viewing their mother's body, or of having their mother's body at home, Cathy's understanding of this experience is different. The doctor suggested that Cathy view her mother's body and Cathy does what she is told, because of the authority of the doctor.

[Did you feel you had to go over to view your mother?]

Well, I did what I was told. Because that was the doctor and doctor's know best.

[Right]

And I was stunned you see. I was absolutely stunned and I was grieving. And I just did as I was told. But now I know better.And you know the theory spouting out. And he said "Um, it's very good to view the body it makes it more real for people", which is out of the text books you see. So I went around there after organising my little children ... and I had seen people when I was nursing that had been dead for three or four hours.

[Mm].

I had never seen anybody that had been dead that long and that wasn't my mother. (Cathy, p. 20-21)

Cathy is aware of the medical discourse of objectification of the body. However, in her explanation, she speaks of "people", and doesn't utilise the term "body" or "corpse" for herself. For Cathy, her mother represented the social. "That wasn't my mother. ...My mother was warm and she was funny and she was loving" (p.20).

When Cathy goes in to see her mother she expects her mother's body to in some way still reflect her previous being as a 'communicative body'. She is still expecting connectedness in some form. Using Frank's (1995) description of the 'communicative body,' I suggest that Cathy was expecting to see some indication of her mother's embodied presence, for example, a sense of something that might be called 'soul' or as Cathy states a "warm(th)". The experience of death is not new to Cathy. She

had cared for many dying people, and cared for their 'bodies' after death. However, she conceptualises viewing her dead mother's body differently.

And the person lying there was cold and her blood had all drained away and she was white and she was like marble ... And it was the worst thing I have ever done in my whole life. And she was lying in her bed, in her double bed and I went up and kissed her and she was like cold marble and she was as white as a ghost. It was horrible it was like kissing a cold fish. Or a piece of ice or something. And it was the worst thing I ever did. I should have remembered her the way she was. ... And there is a lot of difference in somebody that is just dead or even an hour dead than somebody who is eight hours dead. They are not the same person.
(Cathy, p.20)

Cathy's talk reflects a play on words. Cathy states that her mother was "lying in her double bed". She then proceeds to utilise a series of double meanings to describe her experience of seeing her mother. She describes her mother's body through utilising metaphors that are descriptive of both life and death, of activity and passivity.

Life

*My mother was warm, and she was funny
and she was loving*

I went up and kissed her

Death

*the person lying there was cold
her blood had all drained away
and she was white*

*she was like cold marble
she was as white as a ghost
it was like kissing a cold fish or
a piece of ice or something*

Cathy goes on to explain her reactions and her views.

And I think that if people need to view a body, I mean it's different for everybody, if people don't have that same sort of relationship. And I know a lot of people

*who go to the funeral parlour to see somebody, but in my case it was wrong because that was not my mother... So it challenges the theories doesn't it?*⁴⁹

[It does indeed.]

And it depends on how long the person is dead. If they are still warm and they look like your mother fine, but eight hours later they are not the same person.

So if anybody says to me what is the worse thing that's ever happened to you up to this stage in my life I would say seeing my mother like that. (Cathy, p.20-21)

A medical interpretation of the above events could propose that Cathy's response is inappropriate, and indicative of 'death denying' behaviour. An alternative viewpoint might be that Cathy's greater need was to remember her mother as a 'social' communicative body not as the objectified body of death. The 'body' has become less and less part of social Western practices surrounding death rites. The decision to view or not view is complex given the changing rituals and attitudes toward death⁵⁰. The appropriateness, or not, of such an action can only be known and understood in retrospect.

As nurse, I have often said that it helps to view the body. The view I have held is that the dead should be seen, and that viewing the body makes clear the fact of death, and helps the 'grief process'. However, since undertaking this project and thinking about the different understandings of death, I am less certain about such proclamations. Different understandings and rituals surrounding making meaning around grief continue to emerge. The challenge for health professionals is to accept difference and diversity, and to support each person's decision making process. Cathy had no difficulty in understanding that her mother's death had occurred, which is one of the reasons for viewing the body. Her difficulty was in accepting the loss of the social dimension

⁴⁹ Cathy's narrative is laden with her ontological and epistemological understandings surrounding this event in her life. Frank (1995) suggests that the narrative is a way to both re-conceptualise events, and to teach and learn from.

⁵⁰ Hera (1995) researched the after death policy, practices and beliefs in Aotearoa/New Zealand. She argues that death should be demystified, and that people should once again be involved more significantly in after-death practices.

of their relationship so early in her own life, and of her need to construct meaning around this event.

Changing connections: Recovered continuity

In this section I focus on the discursive resources that the women draw upon in their talk surrounding the maintenance of some form of continuing bonds with their mother following her death. Any sociological analysis on death discursively draws from our understandings of the dominant discourses of psychology, history, and the world religions. I discuss in this section the particular repertoires the women who were adult when their mothers died articulate to explain or justify their understandings of continuity.

These women drew from a variety of alternative discourses to resist the 'popular' discourse that death is sited within the body, that is, that death is absolute. This is despite the fact that "the two professions to which our society has entrusted the interpretation and ritualisation of death—medicine and the media – are, or have been, almost uniquely embarrassed by the subject" (Walter, 1991). The women who were interviewed draw from within their own cultural practices their differing ideological understandings of death. However, whilst the women have different beliefs, their understandings have much in common, namely a belief in some form of 'life' after death, with a greater tendency toward secular spirituality than organised religion as the basis for this belief.

The women now depict their mothers as either psychically and/or spiritually present in their lives. This is achieved by reflecting on past memories, by reiteration of family rituals, and by the utilisation of narrative and ideological belief⁵¹. Often, 'healing' from the death experience occurs through the woman's revivifying of her mother through the narrative, and through a belief in spiritual transcendence.

⁵¹ Seale (1998) suggests that "talk at the level of discursive consciousness [creates] the effect of a ritual of inclusion as a member of the moral community" (p.33).

Whatever modality they use, the women hold, as part of their ongoing lives, an ongoing connection with their mothers.

In Em's interview, she moved from talking about her mother, to describing their relationship as transcending death. She utilises the discourse of the Christian faith, as the basis of her personal faith.

Fortunately, with my Christian belief I know that we are going to be together again, and I have to take comfort from that.

[You said that your Christian faith is your hope, can you tell me what you mean by that?]

I have made a commitment of my life to Jesus as my personal saviour, and I know that he died and rose again for my salvation. And I know, ... that in heaven we are going to see each other again, we are going to be there without all these problems.

[Right, so that's your comfort?]

... that's my comfort side... that is my comfort zone. (Em, p.62-63)

Em also drew support from the explanation of a friend of hers who told her that "it's just like with my parents...there's only a veil covering where we can't see them. And one day that veil's just going to be taken away" (p.65). Em did not consider that she currently had any link with her mother but, paradoxically, occasionally spoke of contact.

I have a little photo of her and me that was taken in [place] and I love to say to her I'm cross with you for going, or I love you Mum. But, um, oh no, I don't have any link to her whatsoever. (Em, p.66)

... I would say to her "You should be here doing this with me". (Em, p.67)

Em's link is through memory, her ongoing conversation with her mother, her faith and her beliefs about death.

Catherine recognises that her own understanding of continuity within a religious discourse.

I do see it as the end of life on earth ... I do have this sense of continuity, and of, yeah, that's very religious, very much based in my religious beliefs. Yeah, I didn't realise [starts to laugh] I hadn't realised how strong it was actually ... it makes as much sense to me that there is a life hereafter and that there is a God as if there's

isn't and that there be some continuity. ... but I can't really get my mind around heaven as such. (Catherine, p.32-33).

Catherine sees “it”, that is death, as an event that all of us have to face. Interestingly, she views life as needing to be lived without a cognisance of death all the time: “It’s not something to live thinking about all the time” (p.34). Dumont and Foss (1972) suggest that both an acceptance and denial of death is necessary in order to cope with the vicissitudes and commitment required of people in their life and work. This understanding is also supported by Mellor and Shilling (1993), Prior (1989), and Seale (1998).

Julie also draws on a spiritual discourse. She explains a number of serendipitous happenings just following the death of her mother. For example, at the time of her mother’s death a very particular and favourite song was played on air, and, when she had to travel back overseas to her work, another of her mother’s special songs was played as the aeroplane took off. She tells of how, in the years following her mother’s death, her own spirituality that had previously existed as little more than a vague possibility in her life, was more strongly felt. Her mother is now strongly incorporated into these understandings. I asked Julie how she saw death.

Oh beautiful, just a transition.

[What’s it a transition to?]

Well I feel you know, the physical body’s gone, the subtle body is still there. And I would say there would be a transition to a stage, to a subtle state. And there will be some point at which whatever this life time was about, ...something new will be recast and it will be the next thing that has to kind of balance the evolution of this soul.....I’ve always got a kind of experimental searching view about things...I just thought it was right that she died when she did, I couldn’t believe how perfect it all was, and it just makes you feel that it’s all stage managed ...She was a wonderful soul. (Julie, p.14-15)

Julie views herself now as in connection with her mother, and derives great comfort from this. Her ontological understanding is of her mother

as a “wonderful soul” who deserved the best. She sees her strengthened understanding of yoga has helped her connection with her mother.

... its more than a sense of knowing because she knows and I know, and I know and she knows ...every now and again, I'd just sort of say, I'd be thinking of her, and I'd be talking to her or something.... I just feel she's on my side you know. (Julie, p.19)

Megan explained her connection through drawing on past religious beliefs, as well as her experience of being with her mother in her dying. Megan has some reservations surrounding Christian ideology, but incorporates these with her understanding of “the spirit”.

I also felt for quite a long time afterwards that she wasn't very far away. You know, that she was just quite present. (Megan, p.38)

... I certainly chose at that time anyway to have the Christian view that her essence, her spirit, whatever you want to call it, would go to be with God. (Megan, p.39)

*... she **hadn't** ceased to exist. You know I was very aware of the veil and it's quite a thin one ... you know, she's just on the other side of it. I felt that quite strongly ... I don't know, some months. (Megan, p.40)*

Alice speaks of her mother as having always been there for her prior to her death, and as still with her. She talks of being “in tune with her” (p.1).

[Can you tell me a little more about that, when you say in tune?]

Well, I just sort of feel/

[Is it a sense of her, or/]

Yes that's what it is, it's a sense of her, but I just, you know, it's not quite the right word. It just seems to be the right word “in tune with her”, ...I feel the feeling I had which I always had when I was with her. (Alice, p.1)

Alice's understanding came to her in part through a dream. “Your soul just joins this light ...becomes part of that light ...I will be part of that light you see, and she is part of it” (p.40). She acknowledges the dream as the primary source for constituting her understanding. “I had a dream and that's how I thought of it ... it was very comforting and so I just kept it” (p.41). She speaks of having “this firm belief...it is quite solid within me” (p.41). Alice explains that this was her second dream

about death, and the continuity of death within life. When her husband Phil died some years previous to her mother's death, in her dream she saw him shaking his head "as though to say, no, do not come ... you are not part of this"(p.42). It was then she had the dream about the light. Alice also referred to Elisabeth Kübler-Ross's teaching about spirit guides⁵², but acknowledged her preference toward Maori belief: "I actually think the Maoris might have something when they say, you know, our ancestors are standing behind us" (p.43). Alice explains this as "you know, we are part of them. I mean it has to be like that doesn't it" (p.44).

Like Alice, Jean articulates a secular spiritual discourse. Whilst she acknowledges her mother had a strong "spiritual connection" it doesn't manifest itself in a life after death or in a Christian way. "She would have snorted at the concept" Jean suggests "It would be a hell of a lot easier if you had a myth!" (p.38) Jean now views her resources in terms of "women's spirituality and, um, in terms of Maori culture" (p.38). These are not viewed as myths. They are resources that Jean has sought out, because "I don't feel in that sense my family actually helped me a lot" (p.39).

Elisabeth, like Alice, speaks of the comfort she derived from dreams following her mother's death.

And I would say to her sometimes, "But you're dead", and she would say "Oh yes, that's right" and we would carry on chatting. And it didn't seem, I mean, to matter. I knew she was dead but she didn't feel dead at all in the dream... And I would often sort of hear her voice. ...I would hear her just say "Oh Elisabeth" ...and I would look around and she wasn't there but it was as though she had been there. I didn't feel, Oh she's not here". [voice more animated and happy than at any other time during the taping]. I just felt, "Oh, that's Mum". Good...and it was just the, the way she used to say it, you know. (Elisabeth, p.16)

⁵² See Chapter twenty-nine of Kubler-Ross (1997)

Elisabeth, on two other occasions, speaks of experiencing her mother's presence. The first occasion occurs when she views her mother's body.

And I did feel that she was still there. But not in the bodyI felt that she was sort of up in the corner of the room somewhere. You know, just a presence there ...that she was there sort of looking down. And it was an O.K sort of feeling.

(Elisabeth, p.15)

Elisabeth also acknowledges feeling her mother's presence for some time after her death. Whether the experience was real or not did not concern her as she found the experience comforting. Elisabeth also feels as if she got something back of her mother in the subsequent birth of her daughter, and that there is comfort in her own physical appearance. "I find it comforting in some ways that I look very like her" (p.22). Continuity, in this sense, is viewed as being maintained through nature. As a younger person Elisabeth had defined death as "the last great adventure" (p.18). She utilises the metaphor of "bungy jumping" which is suggestive of movement and flight (p.18). In her middle age she acknowledges that death worries her more. It is less the "great adventure" and more, now, "the natural progression" (p.18).

Val simply operates on the basis that her mother's spirit was now free.

I got there and she'd died. Now it was like she was out, like, it was amazing 'cause I had no sense of recognising her, you know, she didn't even look like Mum...like she, her spirit did not linger in that room...there was no sense of her being present, um, around her body. She'd gone off the diving board (Val, p.18).

...I found myself at the tree, and that's where she was. She knew that's where I would go.(Val, p.19)

I've got a tape recording of her, so I'll keep her voice but, but not ever feeling her touch my cheek again, yeah. (Val, p.24)

Val both recognises and invokes her mother and sister into her ongoing life. She recognises that they are part of her being.

I have a really strong sense and I mean I always had that... of calling on them to just, um, kind of keep an eye on me really. (Val, p.24)

Val considers that she has “access” to her sister’s knowledge “if you like, her knowledge of the universe and where this fits in” (Val, p.24).

Ann utilises a supernatural discourse following being told of her mother’s death.

I feel as if mother’s spirit is somehow hovering around. And it doesn’t seem to be the usual critical one ... though I’m not very clear what it actually is. And I’m not sure that I actually feel linked to her. (Ann, p.30)

In the course of the interview Ann spoke of her current understanding of death. Her response was to acknowledge death as something you don’t come back from, but she is not certain.

I don’t really know where one’s soul goes ...I don’t have any religious beliefs that help me to sort out what death is or anything like that. Though I seem to feel fairly clear that there is a part of the person that doesn’t die. (Ann, p.36)

Jane also articulates a discourse of the supernatural, and espouses beliefs surrounding the concept of reincarnation. She has been told that her guide’s name is “Jacco” (p.35). She doesn’t visit her mother’s grave site, as she views ‘the body’ as just the “shell” (p.26).

Um, I believe in incarnations, reincarnations, that Mum was on one of her last journeys. (Jane, p.21)

...I believe that when you die your spirit goes, ah, I don’t know about God, but goes to another place. And I don’t know about heaven, but that’s what they like to call it... and each plateau I believe in your life makes you a better person ...Because there has to be something out there. I’ve had experiences and I know that there’s something going on with Mum and also with Dad, and also with an aunty who came back to tell me something. ...you learn from every life you live. (Jane, p.31)

Jane discusses at length how, following her mother’s funeral, she felt her mother’s spirit around her, “And I truly believe that the spirits are around you for a short time comforting you ...I’ve felt it before” (p.24).

In summary, this chapter has presented the patternings of continuity, discontinuity and recovered continuity revealed in the narratives of

women who were adults when their mothers died. Their narratives indicate how they make sense of the death. It is through the narrativisation of their experiences that they are able to link with and to relive the past in the present. The women often seek to maintain continuity and links with the deceased through drawing on a discourse of spirituality to support the discourse of continuity.

In the next chapter I will discuss the impact of silencing on this group of women. The order of chapters for this group was deliberately changed to reflect silencing as the less pervasive discourse.

CHAPTER TWELVE

SILENCING DISCOURSE IN THE TALK OF WOMEN BEREAVED AS ADULTS

For us in the West, within our
boarders, death would be, and
increasingly so, almost prohibited,
dissimulated, disposed of, and
denied.

Derrida, *Aporias*.

This chapter analyses the narrative form utilised by eleven women to describe the politics and impacts of silencing they experienced around the death of their mothers. Overarching these different storylines of politics however, was a general plot in which the women feature themselves as moving from victims to, and/or complicit with, the silencing to heroic resisters who are in quest of continuity and reconnection. Their mothers occupy a complex place in the talk of these women. Initially, there are elements of accusation of, or betrayal by, the mother, but this is reconstructed to 'place' their mother as heroic, providing evidence for their desire for mutuality and connection in life and/or continuity in death.

There is a strong moral code or tone pervading these narratives. An ethic of mutual care emerges as the 'proper' morality both before and after death. Some women judge themselves, for a time, as failing in this ethic, particularly when they have been complicit with the silencing.

However, all move to a final point of resisting silence and pursuing connection and continuity of the mother-daughter relationship.

In my interpretation of the empirical data I primarily use Cathy and Val as exemplars - the former of family silencing, the latter institutional silencing. The talk of other women fits these two patterns and is used to elaborate, validate or confirm the emergent patterns within this discourse.

Adult silencing: Victimhood, betrayal and complicity

Often the feeling of betrayal is tied up with the act of disclosure itself, especially when parental values include silence over family matters.

Miller, *Bequest and betrayal*.

Most women initially accept the silencing around death and see this acceptance as both imposed - rendering them victims or betrayed - and as actively colluded with.

Cathy indicates an awareness of her knowing and of her complicit self. It is some time before she is prepared to challenge family silences.

... in the days before she went into the hospice we all knew that she was weeping and dying. But she would not speak to me about it, TO ME, about the fact she was dying [quietly emphasised]. She would talk to my father, and I knew they talked everything through because he told me about it. Um, I think she would talk to my eldest brother, but she would not talk to me about the fact of dying. That word was never used, because I was the baby...and during our relationship I could have talked to her about anything. (Cathy, p.16)

Although she colluded with the silencing, Cathy does not hold herself wholly responsible. Cathy indicates that she could have spoken with her mother about “anything”, but this “anything” was anything other than death, because death is not named by her mother, or by herself. Frank (1994) states that “people cannot recognise that their silences will not protect them, because those silences have developed as part of a family myth that they do protect” (p.17). I interpret Cathy’s mother as deeply

grieving the loss of her daughter to her because of her own impending death and of the lack of words to adequately explain how she feels about this.

Cathy recalls her mother's response in talking about the death of her mother's sister in childbirth:

[That must have been a grief for her with her sister dying in childbirth.]

*She told me about it at one stage, but **she didn't linger about it.*** (Cathy, p.2)

This silence was a significant failure to speak explicitly about dying; previously *they would* speak about anything and everything:

I mean I could talk to her about things I never would have spoken to my father about. You know, in those days, you didn't talk about a lot of things. (Cathy, p.16)

The silencing around death was therefore initiated by the mother and maintained by the mother:

*But she would not admit to me that she was dying, because she didn't want to upset me...And that upset me more [emphasised]. Um and so one day I sent Dad out shopping [joint laughter]. When I was sitting with her, I thought you are not going to get away with this. And I sat down beside her, and I um I told her what a wonderful mother she had been and we both ended up in tears. ...And **she still didn't admit that she was dying** ⁵³ ... **She sort of did, but she wouldn't use that word.** And I thought I'm not going to have any ... [of what] Elisabeth Kübler-Ross calls it, um, unresolved baggage. (Cathy, p.17)*

For Cathy, this issue of silence was one of the most stressful and emotionally charged parts of the interview. She placed great emphasis on the quality of their relationship, and this moment of silence was a contradiction. Cathy's discomfort regarding this emerged very early in the interview.

[How well do you think you knew your mother as a person, say?]

I thought I knew her really well until she was dying and then some of that came into question. (Cathy, p.7)

⁵³ Seale (1988) discusses how "affirmation of love through intimate talk [can be] a valued reward of mutual awareness" for the families of the dying. These "confessional disclosures" he suggests imbue the grieving family with a "secure sense of membership up to the point of death" (p.177).

This moment of silencing is viewed as a betrayal of the long standing quality of their relationship. Cathy attempts to justify her mother's silencing by linking it to a 'protectionist' discourse. She speaks of herself as "the baby of the family", and explores the possibility her mother had wanted to protect her. However, Cathy does not accept this potentially disempowered position and demands communication from her mother. She claims agency and becomes her adult and professional self, rejecting the "baby of the family" role that had been imposed upon her. Cathy's demand is responded to more symbolically than she desired, although she is able to live with the outcome.

I said that she had been the most wonderful mother, ... and that she was the most wonderful person that I could ever have wanted. And I told her everything a mother would have wanted to know. And she still didn't admit that she was dying...She sort of did, but she wouldn't use that word... And so I have no, no regrets about my mother whatsoever, because she heard what she needed to hear.

(Cathy, p.17)

Cathy's talk raises a number of important issues, one of which is the whole issue surrounding "death talk". We need to consider the difficulties that people have in being able to speak of death, as within western society death is now quite removed from life experience. Death in this sense has almost ceased to exist⁵⁴. How can people meaningfully speak of death when death is excluded, that is, sited away from life and silenced from everyday talk? How can grief be spoken if the rules connote silence?

Like Cathy, Jean speaks of imposed rules about silencing in the face of death. She tells of her mother's war time service as a radar operator tracking plane signals. When she was tracking her fiancée, his plane crashed. Jean's mother experienced other losses at that time, including that of her mother. The impact of such loss was kept private and not

⁵⁴ Baudrillard (1993) states that "our whole culture is just one huge effort to dissociate life and death ... no other culture had this distinctive opposition of life and death in the interests of life as positivity: life as accumulation, death as due payment" (p.147).

discussed. Jean attributes this primarily as due to the cultural practices and discourses that pertain to her English ethnicity.

I do remember her telling me that she was frightened...she was a very proud person and you didn't tell anyone about those things. I mean, she's middle class English for god's sake [emphasised]. So, in a sense, that is just about everything really [joint laughter]. (p.3)

This same pattern of silencing was later applied to the manner in which Jean's parents dealt with her mother's ongoing problems with cancer.

I just hated everything about, about being English ...I rang Mum in hospital in [place], and said, "What's going on?"...they must have gone into a blind panic, I mean, because ...she was having a mastectomy. (Jean, p.9-10)

Jean depicts her parents as consistently rigid in enforcing silence. They failed to include her in adult discussions throughout her adolescence; they excluded her from their talk regarding her mother's deteriorating health status, right up until the time of her mother's death, despite the fact that Jean was now an independent adult. Jean tells of how such a heritage rendered impossible any speech with her mother about her dying. This silence still remains a grief for Jean because it interrupts her vision of her relationship with her mother as one of profound relatedness. The silencing around death, Jean's complicity with it, and her feelings of betrayal by it are attributed to cultural influences.

Val sees herself as having been 'protected' from death as a child, when her sister was dying. Silence was part of the family dynamics. As a result of this, and her own life experience, Val has thought about the importance of encompassing understandings of death within life. She describes her childhood self as, being "kind of too young" to have been told (p.2). Her child self reads the silence and complies with the family dynamics of that time. In effect, Val conformed to the protectionist discourse outlined in Chapter Eight, although she was confused by the practices through which silence was maintained.

...in kind of a split second thing I saw Mum sitting on [sister's] bed and she was just absolutely sobbing...but she pulled, [herself together], but it was incredibly

private... she had kind of pulled herself together. And it was so intense that, and I think, I was so shocked by that, ...it was like it was so huge, so intense, but also so private, that I couldn't actually say to her "What's going on?" So I guess that, that, actually haunted me for years actually... I was kind of too young...

[So were things discussed in the family?]

No... We knew [she] was ill, but we didn't know... I used to wake up at night and worry and think what on earth was that about. And think what on earth was going on that Mum was so grief stricken. (Val, p.2)

Firstly, Val “reads” the situation and determines that whatever was causing her mother so much distress was very “private”, and not open for discussion. This response is similar to Margaret’s reading of her father (discussed in Chapter Eight). His love for her “didn’t need to be put into words in a way” (p.33). In both situations this silence is read, but its cause is not named. It is possible that today we have too few discursive resources available to be drawn on to describe the poignancy of that moment of approaching death. Val’s experience is of being denied knowledge about how ill her sister was and the subsequent distressing experience of her hospitalisation and death. She determined that her knowledge and understanding of this experience would always influence her nursing practice. She also resolved to support her mother in her dying. Val’s narrative then moves promptly into resistance to silencing when her mother is institutionalised and dying, and her dying is not recognised by the ward staff.

Catherine describes her mother as a very “private” person, “she wasn’t a very talkative person”. She had “lots of non verbal ways of doing things”, she did not “want conflict” (p.6). Yet, Catherine presents her mother as a strong and quietly heroic person in her life and dying. Her mother’s usual pattern of coping is repeated in that her mother did not speak of the possibility that she might have cancer until some months after her husband, whom she had spent much of her life nursing, had died. Following hospital investigation of her mother’s described symptoms, the cancer was confirmed. Catherine tells two ‘stories’ of

subsequent events that illustrate the rupture of prohibitions surrounding death talk. The first is when a general practitioner, a locum, visits her mother:

...he started to ask her about her condition and she didn't say what was wrong with her. And that upset me very much, and I said "Oh Mum, you do know, you'll have to tell him" and I feel as though I pushed her about that. Yeah, but that sort of stuck, but she was very good about it ... It's good to be able to say that because in a way ... I wonder how I could have handled that better. (Catherine, p.14)

Catherine requires her mother to speak 'her truth'. She expects her to name her illness, and describe what was worrying her. This particular exchange between mother and daughter has remained a pivotal and poignant moment for Catherine for over twenty-two years. For Catherine, her concern was that the locum had the best information in order to treat her mother. Catherine also argued that she had required her mother to face her death. The interview process became a modality for catharsis and transformation: "It's good to be able to say that, in a way ... I wonder how I could have handled that better..." (p.14).

The impact of silencing, and the difficulties of its rupture, are also articulated in Catherine's second story. Whilst Catherine makes no comment about the priest's request in this story, I find the social meaning expressed in her language a good example of institutional, namely religious, silencing. Her mother's impending death is spoken about with Catherine, but not with her mother.

...the next day the priest called, ...he said "You know, do you think I should....[statement not finished] He said "It might be good if I anointed your mother, will you ask her?" So I went back inside, and she wasn't that keen. But anyway, I said "Oh well, you haven't got anything to lose, why not?" ...I don't know if that helped or I don't think it hurt. (Catherine, p.15)

Whilst a priestly role in the Roman Catholic church has always been the anointing of the terminally ill⁵⁵, the priest uses Catherine as the conduit to access permission of her mother. Catherine wants to offer her mother all possible care, because “it can’t do any harm,” but ultimately recoils from naming death. Neither Catherine’s mother nor her priest are yet able to speak of death and the symbolism that surrounds the anointing of the terminally ill. Catherine states that their priest “was aware that she wasn’t going to live very long”, yet her mother is protected from such discussion. This view of protection is reinforced when Catherine tells of how she and one of her sisters conversed with another family member using “the phone ...in the hall, and my mother could overhear everything. We were being very careful about what we said” (p.16). Whilst Catherine says that they “didn’t realise *it* was so close” (p.16), the implication is that the family also used silence to protect. When complicity is named as protection, silencing is difficult to break through.

Em also speaks of silence as an unspoken family rule. Problems were not discussed, so her mother did not confide with a willing neighbour “She didn’t, she couldn’t do that” (p.9). The justification for this behaviour was that “she had been bought up that you didn’t talk to people about your problems” (p.11).

Jane tells of how she was complicit in the silencing of death talk in order that she might ‘protect’ her mother from worry about her family and death. She implicates most of her family in this.

I had been saying to Mum, and the others hadn’t thought I shouldn’t of said it, but

I had been saying to Mum “You’re going to be all right Mum, and I’m going to take you home just as soon as you come right. And I’m going to look after you”.

That was the way I wanted her. I wanted to talk to her.

[Can you tell me why you decided that?]

I didn’t want her to worry. She was dying. I didn’t want her to be scared that she was leaving her family. I didn’t want her to be worrying about us.

⁵⁵ Reference has previously been made to the Vatican’s softening of the language from ‘the last

[Right]

That feeling.

[Yes]

So I had been saying that to her, and she put her hand up when I said that to her and she stroked my face. And I got the feeling that she was saying to me "I know what you're saying, but I also know I'm dying". (Jane, p.17)

Jane's comments suggest that silence can be understood as an act of love and as a benevolent act. She 'reads' the situations as her mother clearly understanding this untruth, and loving her for her act of care.

Critiquing silencing: Moving between victimhood, complicity and resistance

I was going to die, if not sooner then later, whether or not I had ever spoken myself. My silences had not protected me. Your silence will not protect you.

Lorde, *The cancer journals*.

The past can be retrieved and relived in the present. Narrative organizes the experience of time into personal historicity.

Richardson, *Fields of play*.

Foucault has argued how our era is one of the confessional, in which we have to police and define ourselves - endlessly overacting from this confessional basis⁵⁶. There is often little ability to read and value the subtle and understated but symbolically charged gesture. This can be seen in the talk of the women who argue that their mothers did not speak to them of their dying. But, there are many contradictions in their talk. Three of the women were able to recount moments when their mothers either symbolically or in a few words did speak of their dying;

rites' to 'the anointing of the sick'. I suggest that this aids in the psychological denial of death.

⁵⁶ See Grosz (1990) for a discussion on "Foucault's analytics of power". Foucault's view is that the techniques of confession are "one of the major procedures of modern punitive powers by which the individual is tied to processes of normalization" (p.84).

these words are acknowledged, but not given value. I suggest that this is because, for these women, the message was not explicit or confessional enough. In their narratives they speak of an expectation that their mothers should have openly discussed their dying with them, but didn't.

At times the stories are of complicity with the silencing, at other times there is rejection. As the narrative continues, although stories of victimhood and collusion persist, the narrative telling itself helps the women to break the silence. Reflection upon the silencing increases resistance, and there is talk about this. In talking they move towards a sort of catharsis in which there is a making of new meaning. They begin to take control and become the heroes of their own stories - to heal themselves.

Healing, ... is to actually express, ... not to be in a rage really. (Val, p.30)

Jean tells of how her mother was all the time "protecting" - perhaps herself and those she loves. Jean utilises a "make up" metaphor to symbolise the kind of actions that support the silence around her mother's changed body image and her way of dealing with her cancer.

... she was all the time protecting, because Mum was as I say before beautiful, ... but a veneer, when she put on her make up it seemed to me you know though she covered um herself. And it was her way of coping, and I got there [to the hospital] before she had time to put on her cover really. (Jean, p.12)

Jean clearly recognises her mother's use of the symbolic.

I may have selective memory, but her death was all done in symbols. (Jean, p.22)

However, symbolic communication is not enough. It lacks the deep intimacy of a confessional. Instead, Jean perceives that "we didn't talk" (p.16). Rather, they would both sit and listen to music.

She used to play "My time is nearly done"⁵⁷. I don't know if you know that one, ... I think that was the closest we ever got to talking about it. You see, I was as

⁵⁷ From the musical "Jesus Christ Superstar". The actual words are from a dialogue between Christ and the crowd. Christ says: "My time is almost through, Little left to do, After all I've tried for three years, Seems like thirty, Seems like thirty". The crowd replies: "See my eyes, I can hardly see, See me stand I can hardly walk, ... Will you touch will you mend me, Christ?" The actual words

inadequate as she was really. I didn't know what to do...And it almost seems like she was not wanting to talk about it. (Jean, p.22)

Jean's narrative illustrates how death has become a highly contradictory phenomenon in our era. Whilst death is expected to be generally sequestered from life⁵⁸, denied and silenced by the living, on the approach of death, hegemonic discourses demand the dying reconcile themselves and openly discuss its approach. There is tension and contradiction. Jean wanted her mother and her family to be able to openly talk about death, perhaps to reassure each other, yet the family tradition of silencing meant this openness was something they were all unable to achieve. Jean uses the family culture to justify her inability to act.

*...we cared for her in every way we could physically ...But, but we **didn't talk**, we shut ourselves off. When I say we, I have to say Dad led that. But I allowed that to happen too. We shut ourselves off from any support that could have possibly been there. (Jean, p.30)*

Jean's difficulty is better understood in knowing that their family culture viewed death as failure.

*I don't know that it was all right for people to die and I think there was a sense in which, um, with, um, it was almost as though she was letting us down, **she wasn't doing her bit**. (Jean, p.22)*

Three times during the interview Jean tells of how she learned of her mother's cancer through her best friend at school who said: "I don't think I feel very comfortable in telling you this, but Emily's dying". Jean recounts her rage on hearing this, and the reaction of her father when she rings her parents from school - "She knows!" Jean critiques the silences within her family during her mother's medical therapy and dying - a period of some years - and still feels a sadness about it. She

convey a message of impending death, of struggle and of those in the crowd wanting to be healed, not wanting to die.

⁵⁸ Baudrillard (1993) believes that today's society considers death to be a "delinquency", and goes on to say that, "strictly speaking, we no longer know what to do with them, since, today, it is *not normal to be dead*, and this is new. To be dead is an unthinkable anomaly"(p.126).

describes the family as “dysfunctional”, thus drawing on hegemonic discourses of medicine to justify her position.

Yeah, they didn't tell me at all, and, um, you know this grand bloody family, that everyone admired and thought was wonderful, on, on that level failed completely, was completely dysfunctional really. (p.20)

By implication, Jean, in wanting to break the silencing, is more ‘functional’ and more healthy, and yet she speaks of failing her mother at the time of her dying. Paradoxically, she colludes with her mother’s silence.

...so I spent about three months, um, with most of the time studying next to her bed. And that was very, very special. And I just spent hours and hours and she would try not to intrude, but we would natter. Again, we didn't talk about her dying because she absolutely denied any thought of her dying (p.16)

But, on reflection, Jean acknowledges her anger with her mother over her silence, and her anger at the hospital for their seeming collusion.

I think the hospital lied to her ... I hated the way they told her she had had a complete cure, she was riddled with cancer. And maybe she didn't want to hear, I mean now, that would figure um in the way that she died. (p.18)

Jean depicts herself as available and desiring to be with her mother. Her use of the phrase we would “natter together” suggests comfortable familiarity and intimacy. Yet, while she speaks of wanting to “emotionally accompany⁵⁹” her mother in her dying process, she actually did “a bunk”, quitting the family home when her mother’s death was imminent:

But the closer she got to death, I just did a bunk and took off. The day before she died, and um, I just couldn't. ... [my] brother had arrived and after I had made sure he was all right ... I just ran really back to [the city]. I don't know what I feigned, but I had feigned something.

[Mm]

And so that I couldn't stay with her.

⁵⁹ Seale (1998) calls the desire to be with a person as they die “emotional accompaniment”.

[Do you know why? [pause] what it was?]

Um, not consciously, a fear. (Jean, p.24).

The extent of the family silencing is evident in Jean's account of being told about her mother's death.

When Dad rang me to say she'd died he said, um "This thing has happened".

[So he didn't say your mother has died?]

No, he said "This thing has happened". And ah, I mean, he would have just been beside himself. And um, "We're having the, she's being cremated in ... Do you want to come?" And I said "Dad it's my mother, of course I'm coming". So it was sort of the walking wounded. (Jean, p.26)

Why was it so difficult for Jean to speak of death? Her answer can be interpreted as being more than family dynamics. The reassurance and emotionality that had characterised the relationship between mother and daughter was interrupted. Jean argues that her family is silent because of their adherence to middle class English values which advocate "just getting on with it". Jean presents herself in struggle. There is the self that complies with and is part of family silencing, a protectionist discourse, and the self that wishes to speak of death yet finds it an emotional and psychological impossibility to express what she would like to say.

In their narratives at some time all of the women include talk of breaking the silence, taking control, and being the heroes of their own stories.

Em outlines how there is both confusion regarding her mother's health status, and silence regarding the details of her mother's condition. She portrays herself as a concerned daughter who instructs her father that she will be taking over the role of taking her mother to the hospital specialists and, in effect, becomes her mother's primary supporter.

Dad used to get her so agitated and upset that when she went to the specialist that I said that I would take over, and take her. ... I took over going to the doctor with her ... She could just not face going into hospital. ... And I said "Well, I will stay with you, you know, I won't leave you, I will stay with you". (Em, p.19)

Em's narrative supports her action: "She really did rely on me". She relates of her childhood: "I was the one that stopped the arguments when I was younger" (p.5) and in her adulthood: "I managed to get her in for more treatment. They were giving her chemotherapy at this stage, and I would go with her and stay with her all the time" (p.21). Despite her action the silencing is not totally broken. She still does not have access to all the information.

They sort of said it wasn't a cancer. They just said It was a blood disease. Oh, what's that but cancer? (Em, p.17)

They seemed to think they could treat it ... they put her on certain tablets and sort of seemed to keep it under a while, I suppose it was the last nine months I think that it really went. (Em, p.18)

...[specialist] is a very bad, um, you know with talking to you about things. He couldn't communicate, he couldn't communicate at all. Well, in the end, the only way he really communicated was he'd um he'd dictaphone ... He dictated a letter to [doctor] ... he wanted me to sit and listen to that. And I think that was his way of telling me. And then, after I'd been a few times, he said well that daughter was taking over the support, so at least they had somebody strong and reliable that was there as the main caregiver. (Em, p.19)

Em believes this silencing led her to underestimate her mother's condition even though, when her mother "really went downhill" (p.28), Em was caring for her at her home. And had even suggested to her mother that she go back to her own home. Em acknowledges her failure of care but attributes this to her lack of knowing, to having been disempowered by silencing.

She was dying for heaven's sake. And nobody actually said to me "Your mother is dying". I mean, that's what I needed.

[But did you, but you didn't know that?]

No, but why didn't someone tell me. Why didn't the doctor tell me, there's so much more I could have done. I sent her home, God Almighty [said regretfully] ...terrible, I mean, she just loved here [Referring to Em's home]. (Em, p.28-29)

Em's statements, like "Why didn't someone tell me?"⁶⁰, enable her to salvage herself from guilt and position herself as a heroic daughter, doing what she could in the light of the ignorance imposed on her by the politics of silence.

Although Val's talk has some features in common with the pattern of the women who were children when they experienced the death of their mothers, her narrative still develops the storyline from victimhood to resistance. She moves from a justification for the prohibitions that surround death to a resistance of complicity, and a determination that her mother's death will be recognised and talked about.

I remember ...making a promise in some sense to myself that, um, that this wouldn't ever happen to anybody that I was responsible for.... (Val, p.5)

This promise really that, um, to make dying be a good thing, make it safe, you know, safe for families, and I think that really did happen. (Val, p.8)

She too depicts a process of resistance by health professionals, and outlines various examples of institutional silencing that occurred and of how she saw her mother's dying process being controlled. Val uses a telling metaphor: "The nightmare started" (p.14).

Val repeatedly argues her concern for her mother as she recounts how they had talked, how her mother "clearly stated that she wanted to die", (p.12) and how they talked together about what was holding death back. She suggests that her mother was not primarily concerned with the issue of death itself, but of "letting us go" (p.12), of surrendering her link with the family.

There were numerous times when Val's mother's death was thought to be imminent but, according to Val: "They kept on wanting to make her drink, and wanting to make her eat" (p.15)⁶¹. Val emphasises the point

⁶⁰ Street (1998) identifies a number of competing discourses in palliative care. One of these is "truth-telling" which is based on the assumption that the dying need to make informed choices.

⁶¹ Megan also makes the same point about care givers trying to 'make' the dying person eat and drink.

that her mother was dying by describing her mother's physical appearance.

She was like, um, some of those emaciated figures that you see in, you know⁶², concentration camps, and it was like they wouldn't, they just wouldn't let her go really. (Val, p.16)

She speaks of feeling that she became 'other'; she was the problem for the resident health professionals, and not her mother. Part of her grief comes from a sense of betrayal by 'her' colleagues in the nursing and medical professions.

She just totally invaded my kind of privacy with my mother ... I kind of wanted to say to them, you know, "Look, you've known her for maybe two years ... she's been my mother for 46 years you know, so don't cut me out". (Val, p.15)

It was like they⁶³ wouldn't, they just wouldn't let her go really... I could see her eyes and that was all she could use to communicate, you know... and the minutest kind of pressure of her fingers. But they wouldn't take any notice of me... we had absolutely no control in the end. (Val, p.16-17)

...the doctor ... said to me, um, whose problem is this, you know. (Val, p.18)

It is possible that, within the trajectory of care of the dying person, the family reach the point of accepting a parent's death, and are in the process of 'letting go', but staff still hold on to the relationship and persist with therapeutic care activities. Clearly Val remembers feeling that it is best, and it was time, for her mother to die - and she became the 'problem'.

I got home to John, my brother-in-law, and I was just in tears. And it actually didn't feel safe for me to go back into that environment again ... John was just great and he said to me "I'll come back with you" ... it was like I was the wicked alien coming into this environment. (Val, p.16)

⁶² Baruch (1981) drew my attention to specific devices, such as the use of "You know", to aid the creation of inter-subjectivity. I became very aware of this throughout the interviewing process, and found these utterances had the effect of drawing me in as a collaborator in the stories.

⁶³ Note the use of the depersonalising plural form - "they" - to refer to nurses and doctors. This term is used to connote "otherness" in many of the women's narratives. The daughter's speak of "I/we" when speaking of their mothers, and of "they" when speaking of staff.

Val's planned "journey" with her mother, and her desire to achieve a 'good death' for her mother, are now depicted as thwarted. And yet she has been able to play a part in achieving this for so many people in her nursing of terminally ill people.

I have made this good for so many people, and there's not a single person here that will help me. (Val, p.16)

The moral ethic of care highlighted through Val's narrative is prevalent in all of the women's accounts. It is the driving force that compels the women to critique the silencing that surrounds the death experience. Some of the other women provided accounts of their potential to care being thwarted because of processes of institutional or family silencing. Or, they demonstrate their "moral adequacy" in other ways⁶⁴.

Elizabeth justifies her father's protecting of the family:

Both of my parents were the sort of people who didn't trouble doctors. So finally they troubled a doctor, and it was really too late...And again, typical of Dad, he wouldn't sort of concern anybody. He didn't want to tell us anything late at night ...he didn't really, I think, know how serious it was. He just said Mum was in ...and that visiting time was at 2 o'clock, and that we could go and see her then. (Elizabeth, p.11)

And the control imposed by health professionals through their attempting to resuscitate her mother impeded her from being able to be with and support her mother in her dying. She considers the potential for final communication with her mother was denied to her.

...they finally came out and said that she had died and that we can go in. I thought how ridiculous. You know, how come we can go in now when she's dead, but we couldn't go in before. ...She would have been in there on her own and frightened, and there was no one there. (Elizabeth, p.14)

Elizabeth positions herself morally as a caring daughter while acknowledging the ethical dilemma the medical and nursing staff faced when 'they' were trying to save her mother's life. However, the fact

⁶⁴ Seale (1995) discusses this term in relation to issues of dying alone.

remains that, from Elizabeth's perspective, she was 'not there' for her mother. Her statement that "there was no one there" indicates that the staff were the 'they', health professionals who were there but not there. 'They' did not form part of her mother's social body, and those who did were absent.

Elizabeth recalls her experience with anger. "We couldn't go in before when it might have been some comfort to her" (p.14). Identifying with her mother's position, she says she "would have liked her to have had us with her" (p.14). These words are more powerful when cross referenced back to a comment Elizabeth's mother made to her, that "they say as you get older you get more reconciled to death, but it is not true" (p.14).

In Em's case she takes issue with the societal expectation to "get over it" even while she obeys the imperative. On the one hand, she discusses how she continues to talk with her mother, whilst on the other hand, she recognises that there is a cultural imperative to be "over it". "I mean I control it, I don't go around with long faces, and I don't talk to people about it" (Em, p.67). However, she privately subverts this expectation. She continues to speak to her mother, thereby recreating meaning through the incorporation of talk as ritual⁶⁵. "And I love to say to her ...I love you Mum ... I would say to her 'You should be here doing this with me'" (p.66-67). This talk brings comfort as it brings to life again the self-in-relationship as well as recognising the experience of loss.

Cathy's response to her mother's death is of one of extreme sadness, a sadness that lasted for a long period of time. Cathy acknowledges that her response to loss is considered inappropriate by both family and friends, and it is tolerated but only up to a point.

And I cried, and I cried, and I cried like I have never cried in my whole life, like I think my husband thought I had gone nuts. And I cried for hours because I had lost my best friend. Because she was my best friend. (Cathy, p.19)

Whilst there is a societal expectation that women cry, loss of control is not considered acceptable. This is despite the fact that women are portrayed through the media as emotional and as grief stricken, the opposite of the strong silent male partner. Hockey (1997) argues that there is an expectation of an emotional division of labour. She cites the work of Doyal (1979) and Showalter (1987) who trace the negative linkages between emotionality and femininity to “women’s reproductive cycles as having an overriding influence upon their nervous systems” (p.90). Hockey argues that these cultural and historical representations are inadequate and pathologising, and that women do not grieve publicly in this way.

The mothers of Ann, Julie, Alice and Elizabeth died suddenly. Their grief was compounded by sudden shock, and a family politics of silencing. Silence pervaded not only the issues of death but also the funeral arrangements. Arrangements were made without reference to, or recognition of, their effect on daughters.

Ann asserts that silence was always part of her family politics. At the time of her mother’s death, Ann had little communication with any members of her family. On her mother’s death she represents herself as striving for reconnection, as trying to bring together and create for herself some semblance of family connection. She attributes her “awkward position” to her previous claims of incest and physical abuse.

Heather was the one who organised the funeral and everything else, mm. She had virtually taken on the role that I would have taken on as the older daughter if it hadn't been for the things that had gone on in our family.... So I found myself in a difficult position in that I was really not communicating very well ...I hadn't been communicating well with [the family]...and I didn't want to be left out of the funeral altogether if you know what I mean. (Ann, p.14)

⁶⁵ See Seale (1998) for a discussion on everyday ritual. He cites Scheff’s (1990) ideas that narratives “of the self characteristically contain justifications, excuses and rationalisations” (p.31) that present the self in an acceptable way to the “moral community”.

So, Ann not only attended her mother's funeral, but also spent time with her mother at the undertakers prior to the funeral, speaking with her in death as she was not able to in life. Ann is able to name her anguish and assert this as a belated act of reconnection and integration. This acknowledgment of her grief is the beginning of her empowerment.

There were things that I wanted to say to Mum, so it took me quite a while for me to work it out, um to work out a list of things that I wanted to say to her. ... I could never have said any of them if she had been alive, which was a great pity I guess, isn't it. Yeah. (Ann, p.15)

Ann then went on to indicate her sadness about her relationship with her mother. "I was never close to my mother ... and our relationship was such that I could not fulfill that role, and I periodically feel very angry" (p.17). Her very act of telling the events in her life, recreates the situation, and refuses the silence. Ann currently works with her counsellor and friends to recreate an understanding that she can live with. Lorde (1980, cited in Perreault, 1995) claims "fears are most powerful when not given voice ... because the transformation of silence into language and action is an act of self-revelation" (p.23-25).

In Julie's narrative, the politics of silencing are over the thirty years of silence about her adoption, and her mother's refusal to speak of the adoption despite Julie's knowledge that her younger sister was also adopted. Hearing through another source of her own adoption, Julie confronted her mother. She "swore it wasn't true ... she said, 'Well I ought to know'" (p.3).

I felt betrayed, and I felt very shocked. ...it was very difficult ... Sort of like [I was] shot down you know. ...I wanted to talk to my mother about it but she just, she just swore that it wasn't true, she just wouldn't discuss it ... they lived the myth. I mean they created the myths, they did everything to stop anybody knowing ... she had sort of taken it on board almost like she believed it herself. (p.3)

Julie's confrontation resulted in her mother saying that "there must be some mistake ...that was the end of story, so never, never, never would she talk about that" (p.4). Julie felt betrayed but never stopped loving

her mother, appreciating their relationship and constructing understandings around the silence and deceit.

Her mother was “eighty-one when she died, so you know she was in that age group” (p.12), she had a magnificent death with “no pain, [and] no suffering,it was perfectly timed” (p.16). Yet, even here there is betrayal, and silence, and deceit.

She'd told me she'd left a will. ... half an hour before I went to the funeral I found out she hadn't left a will. And once again, once again, so many times I had believed what she had said, it simply wasn't true. I went dry eyed to that funeral thinking bloody hell, it's happened again ... not that she would say something that wasn't true... but that I would believe it. [Said with style, resulting in great laughter on both our parts]. (Julie, p.16)

Somehow, Julie's ethic of care enables her to resist and survive the silence and deceit. She speaks of wanting “the best thing for my mother” (p.16) and of bringing her mother's body back to her own home because “...she would never want to go and live in someone else's house, and so that was the most fitting tribute after her death” (p.16). Julie strongly adheres to a spiritual belief that life is part of a transition to another form of being, and insists on incorporating her mother into her life now.

I began to feel kind of gratitude for a lot. It was really, it was just a summing up of how much I owed them, both her and my father... I feel like somehow all the things that she wouldn't have understood, she would understand now. (Julie, p.17)

For Alice, the silence meant exclusion and the family's refusal to bring the mother's body back to the house, in opposition to Alice's wishes.

And I said to Dad “Why don't you have Mum back home, you know, while we are all here”. But he didn't want that. I was really cross, but nobody else wanted that either. So, yes. [pensive] So it was quite nice ... 'cause it was just a small hospital and you could go and stay as long as you like. And, you know, they just knew Mum. (Alice, p.33)

Alice's ethic of care provides her with a rationale to accept the family veto, and to gain comfort from the fact that the hospital staff “knew” her mother.

Although Elizabeth's family spoke little about what was happening at the time of her mother's death, she also indicated her sadness about not having her mother's body at home with them.

... not even knowing where Mum was, between the couple of days between when she died and when the funeral was. I don't know where she was... I would have liked her to have had us with her. (Elizabeth, p.32)

Val uses metaphor to convey her attempts to maintain connection in the face of silencing and indifference. In recounting what turned out to be the last of her journeys to visit her dying mother, Val speaks of the new understandings she gained at that time.

There was this incredible light in the rear vision mirror, and there was this most amazing ... amazing rainbow, ... perfect brilliant, brilliant rainbow. ... there's another step in this that I must tell you because it's really important ... I said I would go with her as far as I could. I woke up one night in an absolute panic and thinking how far can I go, you know? I had promised I would go on the journey of her dying ... 'cause it was her loneliness, it was the loneliness, you know... So here was this rainbow, and it was like that's the map you know, that's the journey. ... I would take her to the end of the rainbow and that [family member] ... would be at the other end ... So the journey she had to go, was you know, just across the rainbow. And it was like, it was fantastic, like that I could go on the journey with her... I knew absolutely that this was the last journey. (Val, p.13-14)

Val feels able to tell her mother of the rainbow because their communication is open.

She just squeezed my hand and smiled and said "You know, that's ok, you know". But she said "It's ok, but it's like a little bit scary". (Val, p.14)

For Megan and Jane, their mothers became acutely ill and died within a week. But, Megan was already experiencing a grief surrounding the lack of emotionality in her relationship with her mother, and a sense of sadness because of her perception that her mother had not been available to her. The lack is as present in a death bed confessional scene as it was throughout Megan's life.

And she did tell John [son] before she died that she loved him. And I was dying for her to tell me that, and I made sure I told her that several times, but she never did.... But you see there wasn't the emotion, I mean, I decided that I would do that, um, I guess that it had been all along that John had had this relationship with her, so it was that natural thing to do.... I felt in many ways you know that I'd never really had a mother. (Megan, p.8-9)

She'd said to John earlier, um, that she didn't think, she was sorry that she didn't think she could go on any longer... And she did say to Dad ... that she couldn't go on any longer. So those, but those were the only references. (Megan, p.23)

I found it difficult because everybody else was talking about her treatment and about the possibility of her getting better, and I knew inside that she wouldn't and there just seemed to be a big gap between my reality and the other reality.

[And do you know how you knew?]

No. I just thought she had come to the end of her strength. (Megan, p.20)

Jane's mother died within five days of being acutely admitted to hospital. Despite Jane not wanting to tell her mother, who was aphasic as a result of a severe stroke, that she was dying, her brother decided she must be told, because of his Christian beliefs.

He'd turned Christian, very Christian and he wanted to talk about God to Mum.

So we let him, but I sort of worried about it.... So we had that, that to sort of deal with... I do believe that when you come from a big family and the mother dies there's always going to be arguments, ... you should be prepared for it, ... I wish I'd known that it was going to be like that. I would have been defusing perhaps more.

(Jane, p.16-18)

Val insists on breaking the silence surrounding her mother's impending death, she utilises the imagery of her mother "waving" on a "high diving board" (p.14). She outlines how at the beginning of her mother's dying the process was "ok," as she had spoken with one of the medical staff and told them how important it was that her mother maintained this "pathway" (p.14).

...you know they kept on wanting to make her drink and wanting to make her eat... look, she was so close to, you know, that a puff of wind would take her away

really...they got quite horrified that I would actually use the word "dying" to her.

[You said the word..]

I said the word, ...and um...I mean it was like a nightmare for me ...I thought, like, what's happened, you know, we've got stuck, she's got stuck on the rainbow, and it was like we couldn't move really. (Val, p.15)

Val discusses how she starts to be viewed as the problem because she is too up-front about death. She identified a number of issues that constitute her "nightmare" for example, "it was like who owned Mum" (p.14) Val speaks of how again she discussed her mother's dying with her. She tells how, within the framework of their understanding, she tells her mother to "get on with it really" (p.15), and she relates how she was overheard by a staff member, "it was like, how dare I kind of do that really" (p.15).

By the time of interview, these women do not discuss their mothers' deaths as something that belongs to the past. Breaking the silence brings a new openness, a new connection. Their understandings of death have been fluid, dynamic and changing. As their life understandings changed, so do their understandings of death. For example, Julie's construction of her mother's death now incorporates her spiritual understanding, a 'knowing' that is derived from the ideology of Siddha Yoga. Her narrative *now* incorporates her mother within this framework.

These women incorporate the past into the present. They speak of a 'past self-in-relationship' and of a 'new self', a present self that incorporates new ways of understanding connection. Whilst not all of the women construct a view that incorporates a belief in some type of explicit spiritual continuation of life, they all maintain connection through the use of the narrative.

Val consciously works at reclaiming her stories that had "kind of got buried" (p.1) in her caring for her mother, and in the reversal of roles that ensued as a result of her mother's long illness. Val tells of how her

friend is “giving those back to me”. This has enabled Val to revivify, and psychically re-live, and incorporate past memories into present time.

She's the person that has a lot of my memories, like my memories of Mum, so she's kind of in a sense giving those back to me and it's fantastic. Like I had forgotten, um, not forgotten Mum's delightful sense of humour ... it kind of had got buried I guess. (Val, p.1)

Val also feels a sense of connection with her mother when she sees her sister's child rearing practices which she perceives as being similar to those of her mother. Continuity is also therefore achieved in the reiteration and practice of past rituals.

The process of narrative telling enables Val to rediscover memories that over time had become submerged and lost under the experience of illness and loss. Val also utilises the narrative in a pedagogical way when pointing out the danger of people “using labels” as a means of categorisation.

I remember, you know, Elisabeth Kübler-Ross, and, and like the kind of labels and the guidelines and what happens, and I think one of the dangers ... you know, is that people use labels... it's a label that is a criticism ... like [sister's] death and Mum's death are part of my life, you know. They will be part of my life forever, and um, I don't um, I wouldn't, I wouldn't want that taken away. (Val, p.30)

Val saw taking part in this research as an opportunity to make a “small difference” to nursing understanding. She discusses the need for health professionals to listen and learn from the experiences of the bereaved, which is something that did not happen to her, and gives an example of how wrong it is that protocols changed only because they were sanctioned by a doctor.

What concerns me is now they've got into grading kind of the validity of different kinds of evidence, you know... When [doctor] had chemotherapy, I mean, instantly he had one course of chemotherapy, the protocol changed. Absolutely instantly, because it was too tough. And he said, "You know, I've been hearing people say it's too tough for a long time"... What do we have to do to make, you know, consumer evidence valid? (Val, p.35)

Elizabeth also indicates that “talking about things can be helpful” (p.26). Initially, she was unable to express her grief in words, “it was just a huge thing inside me” (p.23). She later went to a course not specific to death related grief, and tells of her amazement when undertaking an exercise on loss that “I found myself just overwhelmed by it. I fell to pieces basically” (p.24). The course provided an opportunity for dialogue, and created for her a pivotal moment of exchange with others. Her narrative was affirmed by those present and her understandings validated. This was part of a healing process.

Megan’s experience on the day of her mother’s funeral is of being silenced. She discusses how she is explicitly silenced by the family and how from that time she goes on to subvert the silence.

I know when the relatives came we had the evening together and we had a family meal, and I wanted to talk about mother and nobody wanted to talk. I couldn’t talk about, I couldn’t generate conversation ... everybody talked about everything else. And I was really distressed, and I thought why can’t we talk about mother, that’s what we’re here for, I want to talk about her but I didn’t know what to say. And it just never happened. ... And the rest of the family said “oh don’t worry”, I mean it’s been the focus all day and they need to have, you know, a break now, we all do”. But I didn’t want to. I wanted to talk about the family and I wanted to talk about her, and it was probably the beginning’s of wanting to understand her life a bit more. (Megan, p.35-36)

Within the next eighteen months Megan travelled to different parts of Australia visiting her mother’s brothers in her quest to make meaning around her mother’s life.

While I was interpreting the silencing, and the critiquing of it, I was confronted time and again, by the number of the women who, in describing their mothers’ lives, depicted them as heroines within their narratives. This has been discussed in Chapter Eleven and is one of the reasons I suggest for why the women critique the silence around their mothers’ lives. Their actions are viewed as heroic for two reasons. Firstly, because of how they lived their lives, and secondly, because they

died well, that is heroically. This is an important contrast to the depictions of active male heroism. Seale (1998) discusses how heroism is changing in late modernity:

...new forms of heroic narratives have replaced the traditional masculine warrior hero. These new forms emphasise inner journeys, enacting a drama scripted by the psychological complex and made readily available through a variety of media representations and institutional practices. (p.119)

Because of the absence of writing on the death of the mother, it is important to consider the value of these narratives in maintaining and confirming the social bond between that existed between mother and daughter. The following examples outline how the women interviewed perceive their mothers:

*I think what I admired most in my mother was from the fact that when she was told that she had three months to live **she didn't crumble**. ... she never complained, she never said "Oh, I'm nearly dead" and "I've only got this" **she never once said anything**. And I think that's pretty good. (Em, p.68)*

.....

I mean your mother is your mother, and she is that one person that's always there and who's always committed to you and loyal to you no matter what. And even though there were lots of inadequacies obviously in my relationship with my mother she was still that ... (Megan, p.28)

In summary, this chapter has outlined the impact that silencing had on the grief of this group of women. The women have discussed how they became located within certain discursive practices, which valorised silence/silencing. However, movement is seen in their subject positioning, as the women challenge their experience of being made victim or complicit within family or institutional politics. The women demonstrate movement and resistance, as well as contradiction in their subject positioning. They depict themselves when silenced as psychically carrying on a conversation about the events within themselves. The cost of silencing for this group of women has been

significant, in that, the silence has rendered them unable to share important aspects of their lives with those they care most about.

Again, through the narrative form these women indicate how they deal with the tragedy of death and the grief of silencing. However, the narratives in themselves are not tragic. The women present themselves as moving from an oppression under prescriptions about how to grieve, to self discovery and transformation of their grief experience. In the creation of the narrative the women provide comfort to themselves and in the telling give a gift to the hearer and co-participant in the "story".

CHAPTER THIRTEEN

THE FINALE: REFLECTIONS ON HEGEMONY, RESISTANCE AND TRANSFORMATION

In this thesis I have presented an explication, using discourse analysis informed by feminism and poststructuralism, of the talk of a group of women whose mothers have died. They are women in a particular place, at a particular time, and each has her own story to tell. During the process of discourse analysis I was able to identify three distinct discourses within the metadiscourse of grief: *Continuity, Discontinuity and Silencing*. Also I was able to distinguish distinctive discourse patterns among the women who were children when their mothers died, and those who were adult.

In Chapters Eight, Nine, Eleven and Twelve I have outlined how the women's talk indicates a narrative form, that demonstrates a movement through time and in subject position. Richardson (1997) indicates that the narrative "relates events by causality, encapsulating a miniplot and addressing the question of "why" [Whereas] in a story "something" happens because of something else. ...Narrative is both a mode of reasoning and a mode of representation" (p.28). The women's narratives were constructed around the story of their mother's death, their self-in-representation and the impact of the death of their mother.

I am not intending to summarise the findings, as this has already been done in a number of ways throughout the work. Rather, I reflect on the study findings and make some general comment about possible areas for further research. I acknowledge, and hope, that others will read this study and make their own journey of discovery in relation to the many issues surrounding death and grief and the self-in-relation with other. The chapter concludes with a brief discussion of some of the issues which emerge from the study and their potential implications for nursing practice. In this I use, once again, the feminist poststructural gaze.

Subversion of the hegemonic

The research set out to explore how a group of women, whose mothers have died, understand grief. Also, I was seeking to use the strategies associated with discourse analysis to identify the nature of the major discourses which dominated and constituted the women's understandings of both grief and loss, as well as to consider the primacy ascribed to the mother-daughter relationship within these discourses.

Early in the thesis I discussed how the hegemonic discourses of medicine have structured and prescribed how grief 'ought' to be experienced. Working within these hegemonic understandings, researchers examining the grief of the bereaved have generally regarded the failure to 'get over it' as 'pathological'. In this context, boundaries and divisions between self and mother have been essential to "good grief" resolution. For instance, Hammer (1975) interviewed women about their relationships with their mothers, and suggested that they had "a poor sense of the boundary between self and other, which makes it difficult to undertake activities that demand a secure sense of the existence of a separate self" (p.xiii). Thus, in this context the self-in-relationship may be viewed as a barrier to, and valued less than, the autonomous self.

However, there was no support for the need for boundaries to separate mother and daughter in this research. Rather, I found that the women's

grief was linked primarily to the loss of the social relationship of interconnectedness with their mothers. In fact, what the women both celebrated and grieved for was the loss of the primacy of the relationship. Through their use of the narrative form, the women reassert continuity in their relationship with their mothers, reassert a self that is a self-in-relationship, and reassert mother-daughter intersubjectivity. In their stories they explore the politics of silencing that threatened this relationship after death and resist this silencing to reassert connection. It is in the telling of narratives that the women revivify and maintain ongoing connection. Both mother and daughter live 'socially' in that moment again, and, for a number of the daughters, live eternally because of their various spiritual beliefs.

The failure to 'get over it' has often been interpreted as a denial of death as a physical end to life, because death has been seen primarily as a physical and embodied process. Implicit in such hegemonic discourses has been the view of the grieving subject as rationalistic and needing to 'process' grief in a linear fashion. Thereafter, the self is left uncomplicated, unitary and separate.

This research points to a different understanding of self as complex, confluent and arising in tensions generated by the ongoing concurrence of potentially conflicting discourses. Foucault (1982) researched understandings of subjectivity, and reflected upon the concept of objectification and "dividing practices", before considering the phenomena of power and the complexity of power relations.

My objective, ... has been to create a history of the different modes by which, in our culture, human beings are made subjects...I have studied the objectivizing of the subject in what I shall call "dividing practices." The subject is either divided inside himself or divided from others. This process objectivizes him [her]. Examples are the mad and the sane, the sick and the healthy.... (p. 797-8)

In the literatures I have reviewed I have been able to identify some of the historical discourses that have aided present day understandings of

grief. These discourses give a social and historical context in which to understand medical and psychological perspectives on grief. Foucault (1982) speaks of the interconnectedness of historical and concurrent processes.

All types of subjection are derived phenomena, ...they are merely the consequences of other economic and social processes: forces of production, class struggle, and ideological structures which determine the form of subjectivity. (p.782)

The existence of hegemonic forces were indeed apparent in the stories of the fifteen bereaved women in this study. However, there was clear evidence of a *desire* on the part of a number of these women to experience and understand grief quite differently from those routes prescribed by medicine and some areas of psychology. They were subverting the hegemonic prescriptions about the nature of grief.

It is yet to be seen whether women from other populations, other cultures, times and places experience the same 'desires' in making sense of the deaths of their mothers. Also, I have no basis for determining whether women confront and rework discourse in the way I have identified when in the throes of grief for reasons other than the loss of their mother.

The potential for transformation

The women in this study fully recognised the physical event of death of their mother but were understanding death in a wider context and as more than the physical cessation of life. Whilst death is understood as a physiological process that results in the concomitant loss of the 'conscious self', the women do not limit understandings of death to the 'embodied self'. They reject the notion that physical death should mean social death. In this sense one can talk of these women as transforming death.

Clearly, these women *desire* continuity of relationship after the physical death of the mother. This desire can be seen in the talk of both those women who were bereaved as adults as well as those who were bereaved as children. The discourse of continuity is irrepressible in their talk; it erupts even while they acknowledge the hegemonic discourse of discontinuity. Their talk of continuity will not be suppressed by knowledge. This desire is in continuous tension with knowledge which may subjugate but does not suppress the discourse of continuity.

Inevitably, there are tensions between prescriptions to disconnect, and the assertion of a desire to maintain connection. Women who have been bereaved as adults, valorise the mutuality that they insist characterised their relationship with their mothers and insist on its retention, however it is reconfigured after physical death. Women who have been bereaved as children speak of mythical loss of a mother either never known, or denied by the people who inhabited the place of mother but refused the relationship of mother. In their talk continuity is expressed as a continual longing. They reflect upon an archetypal mother they would like to have had.

Seale (1998) discusses how talk around the subject of illness has acceptability, yet how talk surrounding subjective or existential understandings of death are rarely dealt with. He supports Giddens (1991) view that death remains the great extrinsic factor of human existence; and that it remains firmly located outside the “internally referential systems” of modernity (p.162). The result is that the women in this study tend to perceive a need to present as having ‘gotten over it’ to the ‘external’ world. It is not to be talked about. However, for the people they entrust with their story, their narratives continue to incorporate an ongoing search for connection, and a need to understand themselves in relationship.

In all cases the politics of silencing are known and acknowledged. Where once they may have either been colluded with or experienced as

repression, they are eventually rejected. In some sense they have been surmounted through reintegration of their mothers into their ongoing experience of living.

The potential for nursing practice

This study gave me an opportunity to consider the implications for nursing practice of a discursive approach to understanding grief. The way in which the women sought to make sense of their grief has demonstrated the importance of narrative as a discursive resource. Analysis of the women's narratives indicate that there is no simple linear progression to 'getting over' grief. Rather, the process is complex, convoluted and impacted upon by discourses that construct understandings of issues surrounding gender and ethnicity and death.

Hunt (1992), when researching health visiting of the terminally ill, utilised Lofland's (1978) concept of "cultural scripts". She found that these were jointly produced or created by nurses and patients to understand and make meaning around each person's dying, and in the facilitation of 'a good death'. One of the elements of these "scripts" was an "acceptance of cancer and its prognosis" (p.1297), and there was evidence that nurses were shaping "the way the patient and relatives adapted to the dying role" (p.1299). Although Hunt's (1992) work, and that of Seale (1998) are interesting and reveal relevant insights/explorations, the concept of "scripts" has problems. It begs the question of the origin of such "scripts" and disallows understanding of the conflicted and evolutionary development of meaning which are allowed by the concept of narrative and subject position.

This research does confirm the importance of the joint production of meaning in the telling of grief. The narratives the women utilise demand a listener, a listener 'placed' by the speaker in a particular subject position. Narratives are co-created within discourse as the speaker assumes a particular subject position and requires a particular

subject position of the listener. The narrative is a well known universal and endemic means of organising talk that is available for use in nursing. It is accessible and recognised from childhood, it is designed to be told and heard. While it is not a confessional form, it still allows for exploration of self and meaning.

The potential of narrative has been largely overlooked in understanding grief and, in particular, the roles it offers for both teller and listener. A nurse who listens to the grieving person is in the position of validating and facilitating a transformative process. As the narrative is told by the grieving person, the listening nurse is able to be witness, and enable if needed, a move from the experience of loss characterised by diminishment and debilitating separation towards the creation of a greater, and more affirming, understanding of loss. The telling of the narrative is part of the process of renewal.

There is a strategic role here for the nurse. Nurses are often witness to death and, as such, are in a position to be the listener to narratives of grief. Not only is there the potential to assist people to ventilate their feelings but also to help them configure their grief in a way that is relevant to their culture and circumstances. Together, they can reach toward continuities after physical death, and explore the politics of silencing.

The simplicity of narrative lies in the fact that it is fundamental to how humans organise themselves and give meaning to their lives. In listening to and deconstructing the narrative, in being aware of how the women characterise themselves in their own personal dramas, nurses have an opportunity to support bereaved women in their understandings of continuity. Grief does not have to be pathologised.

It is important to note that the narrative as a tool does not demand a unitary resolution. Reintegration can be achieved in a multiplicity of ways. While this approach clearly accommodates poststructuralist understandings of the self, it is firmly rooted in vernacular modalities of

self expression. As previously stated, nursing has begun to recognise the importance of the vernacular of storytelling for understanding and making meaning of the experience of loss and grief. For example, Newman (1994) and Litchfield (1993 & 1997), both nurse researchers, refer to the place of “story-telling” and narrative in nursing research and practice and maintain the importance of understanding “pattern” within dialogue. Newman (1994) suggests that “the focus of nursing is [in understanding] the *pattern of the whole*, ...with caring as a moral imperative” (p.xix).

If, as I have argued, language plays a key role in our reality, a greater understanding of the place of narrative in understanding grief is still required. Nurses, and nursing must confront the challenge of understanding the importance of language in configuring grief and loss, and not merely have recourse to understandings that maintain medical hegemony. There is a need to deconstruct received understandings of grief in order to consider the interplay of power and knowledge. As all discourses make available certain subject positions, nurses can strive to understand the ‘rules’ that are implicit within the various and competing discourses, and be aware of how language is being used and the image being portrayed. These understandings make up either the dominant or normalising discourses of grief, or form part of the subjugated knowledges that surround the grief experience. It is important to reflect on whose interests are being served by the particular discourses in use.

Hall & Stevens (1991) discuss the importance of feminist research in its “valuing of women and ...validation of women’s experiences, ideas and needs” (p.17). They stress the importance of recognising the existence of “ideological, structural, and interpersonal conditions that oppress women; and a desire to bring about social change of oppressive constraints through criticisms and political action” (p.17). Nursing research like that presented in this study is important for this very reason. In researching the women’s narratives, women’s talk can be heard and validated.

Undoubtedly, there is room for research into the ways in which the nurse/listener can actively co-create an enabling narrative of self and grief, but there must be recognition and support for the plurality of ways in which women themselves come to terms with their grief. In order for nurses to provide wise and informed nursing practice, it is also important for nurses to explore the self-in-relationship as well as the social and material conditions of the mother-daughter relationship. Contact with the nurse is but a phase in the storied life of a grieving person, but that nurse's contribution can be of great significance. Nursing is rightly concerned with both science and technology; but its primary concern is social. Foucault would argue that understanding the social dimension of care necessitates an understanding of language and a deconstruction of the institutions of family, and medicine that impact on these understandings. Through listening to narratives, and being in dialogue to validate reconstructed hearings, nurses will be able to identify subjugated knowledges, and, be better positioned to support the women with whom they work.

This study suggest, indeed demands, a need to move beyond the prescribed understandings of grief. For this to happen, there will need to be an ongoing attention to understandings of the meanings and assumptions, and the discourses, that the 'lay' person holds regarding death and grief. To be effective today, observation, long an essential component of the art and science of nursing (Nightingale, 1859/1970), requires the nurse working with people who are bereaved to have an understanding of the discourses that have become institutionally prescribed for those who grieve.

If nurses attend to the ways in which the narrative is and can be used, they will be well positioned as a potential place of support for women who desire, in their own time and at their own pace, to subvert the hegemonic, to develop their own appropriate understandings. Nurses can offer encouragement as each woman develops her own knowledges surrounding physical death, and "continuing bonds", whilst recognising

and supporting the grieving of physical death, and the inevitable sense of loss. Then, perhaps daughters can be freed from the demand to disconnect from their mothers, and can be supported in their desire to maintain, and benefit from, continuing bonds.

In conclusion

The journey from planning this study to becoming listener and guardian of these women's narratives, through the processes of analysis and generation of the research outcome, has been a long and challenging experience for me, as nurse and as researcher. Through it all, the women's voices have been powerfully guiding the process. Their narratives give energy as well as enlightenment. I hope that you, as reader, have been able to capture some of the privileged experience that has been mine, and that your own understandings of grief and loss have also been challenged, as mine have been.

BIBLIOGRAPHY

Ainley, R. (Ed.). (1994). *Death of a mother: Daughter's stories*. Hammersmith, London: Harper Collins.

Althusser, L. (1971). *Lenin and philosophy and other essays*. (B. Brewster, Trans.). London: New Left Books. (Original work published 1968).

Anderson, W. (Ed.). (1995). *The Fontana postmodern reader*. London: Fontana.

Aries, P. (1974). *Western attitudes toward death: From the middle ages to the present*. (P. M. Ranum, Trans.). Baltimore: Johns Hopkins University Press.

Aries, P. (1981). *The hour of our death*. (H. Weaver, Trans.). London: Allen Lane.

Armstrong, D. (1984). The patient's view. *Social Science and Medicine*, 18(9), 737-744.

Armstrong, D. (1987). Silence and truth in death and dying. *Social Science and Medicine*, 24(8), 651-657.

Armstrong, D. (1995). The rise of surveillance medicine. *Sociology of Health & Illness*, 17(3), 393-404.

Arnoux, L. (1995). *Introduction to discourse analysis and lexicology*. Christchurch: Arnoux Associates.

Attig, T. (1991). The importance of conceiving of grief as an active process. *Death Studies*, 15, 385-393.

Averill, J., & Nunley, E. (1993). Grief as an emotion and as a disease: A social-constructionist perspective. In M. Stroebe, W. Stroebe, & R. Hansson (Eds.). *Handbook of Bereavement* (pp. 77-91). Cambridge: Cambridge University Press.

Badinter, E. (1980). *Mothers love: Myth and reality*. New York: MacMillan Publishing Co.

Barthes, R. (1977). *Image-music-text*. (Trans. S. Heath) (pp.142-148). New York: Hill and Wang.

Baruch, G. (1981). Moral tales: Parents' stories of encounters with the health professions. *Sociology of Health and Illness*, 3(3), 275-294.

Bateson, M. C. (1990). *Composing a life*. New York: Plume Penguin.

Bateson, M. C. (1994). *Peripheral visions*. New York: HarperCollins.

Baudrillard, J. (1993). *Symbolic exchange and death*. (I.H. Grant, Trans.). London: Sage Publications. (Original work published 1976).

Bauman, Z. (1992a). Survival as a social construct. *Theory, Culture & Society*, 9, 1-36.

Bauman, Z. (1992b). *Mortality, immortality & other life strategies*. Stanford, CA: Stanford University Press.

Beilin, R. (1981). Social functions of denial of death. *Omega: Journal of Death and Dying*, 21, 25-35.

Belsey, C. & Moore, J. (Eds.). (1989). *The feminist reader: Essays in gender and the politics of literary criticism*. London: MacMillan Education.

Benjamin, J. (1988). *The bonds of love: Psychoanalysis, feminism, and the problem of domination*. London: Virago Press.

Benjamin, J. (1995). *Like subjects, love objects*. New Haven: Yale University Press.

Benner, P. & Wrubel, J. (1989). *The primacy of caring: Stress and coping in health and illness*. Menlo Park, CA: Addison-Wesley Publishing.

Benner, P. (1991). The role of experience, narrative, and community in skilled ethical comportment. *Advances in Nursing Science*, 14(2), 1-21.

Bowlby, J. (1961). Processes of mourning. *The International Journal of Psycho-Analysis*, 42, 317-340.

Bowlby, J. (1971). *Attachment and loss. Vol.1: Attachment*. Harmondsworth: Penguin.

Bowlby, J. (1975). *Attachment and loss. Vol 2: Separation anxiety and anger*. London: Pelican Books.

Bowlby, J. (1980). *Attachment and loss. Vol 3: Sadness and depression*. London: Hogarth Press.

Bruni, N. (1991). Nursing knowledge: Processes of production. In G. Gray, & R. Pratt. (Eds.). *Towards a discipline of nursing* (pp 171-191). Melbourne: Churchill Livingstone.

Buijs, H. (1997). The imperfect woman. In M. de Ras, & V. Grace, (Eds.). *Bodily boundaries, sexualised genders & medical discourses* (pp. 146-158). Palmerston North, NZ: Dunmore Press.

Burr, V. (1995). *Introduction to social constructionism*. London: Routledge.

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. London: Routledge.

Butler, J. (1993). *Bodies that matter*. New York: Routledge.

Butler, J. (1997). *The psychic life of power: Theories in subjection*. Stanford, CA: Stanford University Press.

Carryer, J. B. (1997). *A feminist appraisal of the experience of embodied largeness: A challenge for nursing*. Unpublished doctoral thesis, Massey University, New Zealand.

Carter, S. (1989). Themes of grief. *Nursing Research*, 38(6), 354-358.

Chalmers, A. F. (1982). *What is this thing called science*. St.Lucia: University of Queensland Press.

Charlton, R., Ford, E., & Manderson, D. (1995). Dealing with dying. *Kai Tiaki: Nursing New Zealand*, 5, 13-16.

Cheek, J. & Rudge, T. (1994). The panopticon re-visited? An exploration of the social and political dimensions of contemporary health care and nursing practice. *International Journal Nursing Studies*, 31(6), 583-591.

Chodorow, N. (1986). Toward a relational individualism: The mediation of self through psychoanalysis. In T. Heller, M. Sosna & D. Wellbery. (Eds.). *Reconstructing individualism*. Stanford, CA: Stanford University Press.

Chodorow, N. (1978). Mothering, object-relations, and the female oedipal configuration. *Feminist Studies*, 4(1), 137-58.

Chodorow, N. (1978). *The reproduction of mothering: Psychoanalysis and the sociology of gender*. Berkeley, CA: University of California Press.

Chodorow, N. (1997). Feminism and psychoanalytic theory. In S. Kemp & J. Squires. (Eds.). *Feminisms* (pp.182-188). Oxford: Oxford University Press.

Christensen, J. (1990). *Nursing partnership: A model for nursing practice*. Wellington: Daphne Brasell & Associates Press.

Cixous, H. (1986). Sorties. In H. Cixous. & C. Clement (Eds.). *The newly born woman*, (B. Wing Trans.). (pp.63-132). Minneapolis, MN: University of Minnesota Press. (Original work published 1975)

Cline, S. (1995). *Lifting the taboo: Women, death and dying*. London: Little, Brown and company.

Cook, R. D. (1995). Ethical issues in bereavement research: An overview. *Death Studies*, 19, 103-122.

Cowles, K. V. & Rodgers, B. L. (1993). The concept of grief: An evolutionary perspective. In B. L. Rodgers, & K. A. Knafl. (Eds.). *Concept development in nursing: Foundations, techniques, and applications* (pp.93-96). Philadelphia: W. B. Saunders.

Cowles, K. & Rodgers B.L. (1991). The concept of grief: A foundation for nursing research and practice. *Research in Nursing and Health*, 14, 119-127.

Cowles, K. (1996). Cultural perspectives of grief: An expanded concept analysis. *Journal of Advanced Nursing*, 23, 287-294.

Craib, I. (1994). *The importance of disappointment*. London: Routledge.

Crotty, M. (1997). Tradition and culture in Heidegger's *Being and Time*. *Nursing Inquiry*, 4, 88-98.

Dane, B. O. (1989). Middle-Aged adults mourning the death of a parent. *Journal of Gerontological Social Work*, 14, 3-4.

Davies, B. (1990a). The problem of desire. *Journal of Social Problems*, 37(4), 501-515.

Davies, B. (1990b). Agency as a form of discursive practice. A classroom scene observed. *British Journal of Sociology of Education*. 11(3), 341-361.

Davies, B. (1991). The concept of agency: A feminist poststructuralist analysis. *Journal of Social Analysis*, 30, 43-63.

Davies, B. & Harre, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, 20(1), 43-63.

Derrida, J. (1995). *The gift of death*. London: The University of Chicago Press. (Original work published 1992)

Derrida, J. (1993). *Aporias*. (T. Dutoit, Trans.). Stanford, CA: Stanford University Press.

De Beauvoir, S. (1983). *A very easy death*. (P. O' Brian. Trans.). Harmondsworth, England: Penguin Books. (Original work published 1969)

Dickson, G. (1990). A feminist poststructuralist analysis of the knowledge of menopause. *Journal Advances in Nursing Science*, 12 (3), 15-31.

Dinnerstein, D. (1987). *The rocking of the cradle and the ruling of the world*. London: The Women's Press.

Doane, J. & Hodges, D. (1992). *From Klein to Kristeva: Psychoanalytic feminism and the search for the "good enough" mother*. Ann Arbor: The University of Michigan Press.

Doka, K.J. (1995). Disenfranchised grief. In J. Williamson & E. Shneidman. (Eds.). *Death current perspectives* (pp 216-224). London: Mayfield Publishing.

Douglas, J. (1990). Patterns of change following parent death in midlife adults. *Omega*, 22(2), 123-137.

Down-Wamboldt, B. & Tamlyn, D. (1997). An international survey of death education trends in faculties of nursing and medicine. *Death Studies*, 21, 177-188.

Dumont, R. & Foss, D. (1972). *The American view of death: Acceptance or denial*. Cambridge: Schenkman.

Durkheim, E. (1915). *The elementary forms of the religious life*. (J. Swain. Trans.). London: George Allen & Unwin.

Edelman, H. (1994). *Motherless daughters: The legacy of loss*. Rydalmere, NSW: Hodder & Stoughton.

Edelman, H. (1995). *Letters from motherless daughters: Words of courage, grief and healing*. Adelaide: Hodder & Stoughton

Emden, C. (1991). Ways of knowing in nursing. In G. Gray & R. Pratt. (Eds.). *Towards a discipline of nursing* (pp. 11-30). Melbourne: Churchill Livingstone.

Fairclough, N. (1992). *Discourse and social change*. Oxford: Polity Press.

Field, D; Hockey, J. & Small, N. (Eds.). (1997). *Death, gender and ethnicity*. London: Routledge.

Flax, J. (1978a). Postmodernism and gender relations in feminist theory. *Signs: Journal of Women in Culture and Society*, 12, 621-643.

Flax, J. (1978b). The conflict between nurturance and autonomy in mother-daughter relationships and within feminism. *Feminist Studies*, 4(2), 178-89.

Flax, J. (1990). *Thinking fragments: Psychoanalysis, feminism, & postmodernism in the contemporary west*. Los Angeles, CA: University of California Press.

Foote, C., Valentich, M., & Gavel, L. (1996). When mothers of adult daughters die: A new area of feminist practice. *Affilia*, 11(2), 145-163.

Foucault, M. (1972). *The archaeology of knowledge: The discourse of language*. (A. M. Sheridan Smith, Trans.). London: Tavistock. (Original work 1969)

Foucault, M. (1976). Two lectures. In C. Gordon (Ed.). (1980) *Power/knowledge: Selected interviews and other writings, 1972-1977* (pp. 78-108). New York: Pantheon books.

Foucault, M. (1977). *Discipline and punish: The birth of the prison*. (A. Sheridan, Trans.). New York: Vintage Books. (Original work published 1975)

Foucault, M. (1978). *The history of sexuality: An introduction*. (R. Hurley, Trans.). London: Penguin Books. (Original work published 1976)

Foucault, M. (1980). Truth and power. In C. Gordon (Ed.). *Power/knowledge: Selected interviews and other writings, 1972-1977* (pp. 109-133). New York: Pantheon

Foucault, M. (1982). The subject and power. *Critical Inquiry*, 8, 777-795.

Foucault, M. (1986). *The birth of the clinic*. (A. M. Sheridan, Trans.). London: Routledge. (Original work 1963)

Frank, A. (1994). Interrupted stories interrupted lives. *Second Opinion* 20(1), 11-18.

Frank, A. (1995). *The wounded storyteller: Body, illness, and ethics*. Chicago: The University of Chicago Press.

Fraser, J. & Nicholson, L. (1990). Social criticism without philosophy: An encounter between feminism and postmodernism. In L. Nicholson (Ed.). *Feminism/Postmodernism*. New York: Routledge.

Freedman, J. & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: W. W. Norton & Company.

Freud, S. (1923). The ego and the id. *Standard edition of the complete psychological works of Sigmund Freud*. Oxford: The Hogarth Press. Vol. 19, 13-66.

Freud, S. (1957). Mourning and melancholia. In J. Strachey (Ed. and Trans. J. Riviere.), *The standard edition of complete psychological works of Sigmund Freud*, (Vol.14, pp. 237-258). London: Hogarth Press. (Original work published 1917).

Freud, S. (1961). Letter to Binswanger. In E. Freud (Ed.). *Letters of Sigmund Freud 1873-1939*. (J. Riviere, Trans.). London: Hogarth Press. (Original work published 1929)

Gavey, N. (1989). Feminist poststructuralism and discourse analysis. *Psychology of Women Quarterly*, 13, 459-475.

Giddens, A. (1991). *Modernity and self-identity*. Cambridge: Polity Press.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. London: Harvard University Press.

Gilligan, C. (1986). Remapping the moral domain: New images of the self in relationship. In T.C. Heller, M. Sosna & D. E. Wellbery (Eds.). *Reconstructing individualism* (pp. 237-252). Stanford, CA: Stanford University Press.

Gilligan, C. (1987). Woman's place in man's life cycle. In S. Harding (Ed.). *Feminism and methodology*. (pp. 57-73). Bloomington, IN: Indiana University Press.

Gilligan, C., Ward, J., Taylor, J., & Bardige, B. (1988). *Mapping the moral domain: A contribution of women's thinking to psychological theory and education*. Harvard, MA: Harvard University Press.

Glaser, B. & Strauss, A. (1974). *Time for dying*. Chicago: Aldine.

Gorer, G. (1965). *Death, grief and mourning*. London: The Cresset Press.

Grace, V. M. & Arnoux, L. (1994). *Lexicology as a method of discourse analysis*. Christchurch: University of Canterbury.

Grace, V. M. (1995). Problems women patients experience in the medical encounter for chronic pelvic pain: A New Zealand study. *Health Care for Women International*, 16(6), 509-519.

Grace, V. M. (1995). *Women's experience(s) of using the health services for chronic pelvic pain: A New Zealand study*. Research Report for the New Zealand Endometriosis Foundation. Christchurch: The University of Canterbury.

Grace, V. M. (1998). Researching women's encounters with doctors: Discourse analysis and method. In R. Du Plessis & L. Alice, (Eds.). *Feminist thought in Aotearoa New Zealand* (pp.111-119). Auckland: Oxford University Press.

Graham, D. (1995). Mothers, daughters and death. *Kai Tiaki: Nursing New Zealand* Sept. 13-15.

Gray, G. & Pratt, R. (Eds.). (1991). *Toward a discipline of nursing*. Melbourne: Churchill Livingstone.

Grosz, E. A. (1990). Essentialism and difference. In: S. Gunew (Ed.). *Feminist knowledge: Critique and construct*. London: Routledge.

Grosz, E. A. (1990). Foucault's analytics of power. In S. Gunew (Ed.). *Feminist knowledge: Critique and construct* (pp. 80-92). London: Routledge.

Grosz, E. A. (1992). Julia Kristeva. In: Wright, E. (Ed.). *Feminism and psychoanalysis*. (pp.194-200). Oxford: Blackwell Publishers.

Hall, J. M. & Stevens, P. E. (1991). Rigor in feminist research. *Advances in Nursing Science*, 13(3), 16-29

Hall, S. (1997). The work of representation. In S. Hall, (Ed.). *Representation: Cultural representations and signifying practices* (pp. 13-75). London: Sage/The Open University.

Hallum, E. (1997). Death and the transformation of gender in image and text. In D. Field, J. Hockey, & N. Small. (Eds.). *Death, gender and ethnicity* (pp. 108-123). London: Routledge.

Hammer, S. (1975). *Daughters and mothers: Mothers and daughters*. New York: Signet, Quadrangle.

Hare-Mustin, R. & Marecek, J. (Eds.). (1990). *Making a difference: Psychology and the construction of gender*. New Haven: Yale University Press.

Harris, M. (1995). *The loss that is forever: The lifelong impact of the early death of a mother or father*. United States Of America: Dutton Book.

Heidegger, M. (1967). *Being and time*. (J. Macquarrie and E. Robinson. Trans.). Oxford: Basil Blackwell. (Original work published 1927)

Hekman, S. (1990). *Gender and knowledge: Elements of a postmodern feminism*. Boston: Northeastern University Press.

Hera, J. (1995). *Reclaiming the last rites (rights)*. Unpublished doctoral thesis, Massey University, New Zealand.

Hertz, R. (1960). *Death and the right hand*. (R. and C. Needham. Trans.). London: Cohen & West. (Original work published 1909)

Hirsch, M. (1981). Mothers and daughters. *Signs: Journal of Women in Culture and Society*, 7(1), 200-222.

Hirsch, M. (1989). *The mother/daughter plot: Narrative, psychoanalysis, feminism*. Indianapolis: Indiana University Press.

Hoagland, A. (1983). Bereavement and personal constructs: Old theories and new concepts. *Death Education*, 7(2/3), 175-193.

Hockey, J. (1997). Women in grief: Cultural representation and social practice. In D. Field, J. Hockey, & N. Small. (Eds.). *Death, gender and ethnicity*. (pp.89-107). London: Routledge.

Hollway, W. (1984). Gender difference and the production of subjectivity. In J. Henriques., W. Hollway., C Urwin., C.Venn & V. Walkerdine. (Eds.). *Changing the subject: Psychology, social regulation and subjectivity* (pp.227-263). London: Methuen.

Hollway, W. (1989). *Subjectivity and method: Gender, meaning and science*. London: Sage.

Horacek, B. J. (1991). Toward a more viable model of grieving and consequences for older persons. *Death Studies*, 15, 459-472.

Horowitz, M., Krupnick, J., Kaltreider, N., Wilner, N., Leong, A., & Marmor, C. (1981). Initial psychological responses to parental death. *Archives of General Psychiatry*, 41, 209-218.

Horsfall, J. (1994). *Social constructions in women's mental health*. Armidale, NSW: University of New England Press.

Horsfall, J. (1997). Some consequences of the psychiatric disintegration of the body, mind and soul. In J. Lawler. (Ed.). *The body in nursing* (pp 177-196). Melbourne VIC: Churchill Livingstone.

Hunt, M. (1991a). Being friendly and informal: Reflected in nurses' terminally ill patients' and relatives' conversations at home. *Journal of Advanced Nursing*, 16, 929-938.

Hunt, M. (1991b). The identification and provision of care for the terminally ill at home by 'family' members. *Sociology of Health & Illness*. 13(3), 375-395.

Hunt, M. (1992). 'Scripts' for dying at home — displayed in nurses' patients' and relatives talk. *Journal of Advanced Nursing*, 17, 297-1302.

Hyden, L-C. (1997). Illness and narrative. *Sociology of Health & Illness*, 19(1), 48-69.

Illich, I. (1976). *Medical nemesis: The exploration of health*. New York: Pantheon.

Irigaray, L. (1980). When our lips speak together. (C. Burke, Trans.). *Signs: Journal of Women in Culture and Society* 6(1), 69-79. (Original work published 1977)

Irigaray, L. (1981). And the one doesn't stir without the other. (H. Wenzel, Trans.). *Signs: Journal of Women in Culture and Society* 7(1), 60-67. (Original work published 1979)

Irigaray, L. (1993). *Je, tu, nous: Toward a culture of difference*. (A. Martin, Trans.). New York: Routledge. (Original work published 1990)

Irigaray, L. (1994). *Thinking the difference: For a peaceful revolution*. (K. Montin, Trans.). New York: Routledge. (Original work published 1989)

Ironside, V. (1996). *'You'll get over it': The rage of bereavement*. London: Hamish Hamilton.

Jackson, S. (1986). *Melancholia and depression*. New Haven: Yale University Press.

Jebali, C. (1995). Working with women in mental health: A feminist perspective. *British Journal of Nursing*, 4(3), 137-140.

Justus, C. (1993). Part nurse, part daughter. *Journal of Emergency Nursing*, 19(1), 7-8.

Kahane, C. (1992). Object-relations theory. In E. Wright. (Ed.). *Feminism and psychoanalysis* (pp. 284-290). Oxford: Blackwell Publishers.

Katzenbaum, R. (1977). Death and development through the lifespan. In H. Fifel. (Ed.). *New meanings of death* (pp. 17-45). New York: McGraw-Hill.

Kemp, S. & Squires, J. (Eds.). (1997). *Feminisms*. Oxford: Oxford University Press.

Kerr, R. B. (1994). Meanings adult daughters attach to a parent's death. *Western Journal of Nursing Research*, 16(4), 347-365.

Klass, D., Silverman, P., Nickman, S. (Eds.). (1996). *Continuing bonds: New understandings of grief*. Washington, DC: Taylor & Francis.

Klein, M. (1940). Mourning and its relation to manic-depressive states. *The International Journal of Psycho-analysis*, 21, 125-153.

Kleinman, A. & Kleinman, J. (1994). How bodies remember: Social memory and bodily experience of criticism, resistance, and delegitimation following China's cultural revolution. *New Literary History*, 25, 707-723.

Kristeva, J. (1980). *Desire in language*. (Ed. L. S. Roudiez. Trans. T. Gora, A. Jardine, & L. S. Roudiez) New York: Columbia University Press. (Original work published 1979)

Kristeva, J. (1986). About Chinese women. In Toril Moi. (Eds.). S. Hand (Trans.). *The Kristeva reader*. (pp.138-159). Oxford: Basil Blackwell Publishers.

Kristeva (1989). *Black sun: Depression and melancholia*. (L. S. Roudiez, Trans.). New York: Columbia University Press. (Original work published 1987)

Kristeva (1986). Stabat Mater. In Toril Moi.(Ed.). L. Roudiez (Trans.). *The Kristeva reader*. (pp160-85). Oxford: Blackwell Publishers.

Kubler-Ross, E. (1970). *On death and dying*. New York: Macmillan.

Kubler-Ross, E. (1997). *The wheel of life*. London: Bantam Press.

Kuipers, J. (1988). "Medical discourse" in anthropological context: Views of language and power. *Medical Anthropology Quarterly*, 99-123.

Lather, P. (1988). Feminist perspectives on empowering research methodologies. *Women's Studies International Forum*, 11(6), 569-581.

Lawler, J. (1991). *Behind the screens: Nursing, somology, and the problem of the Body*. Melbourne: Churchill Livingstone.

Lawler, J. (1997). Knowing the body and embodiment. In Lawler. J. (Ed.). *The body in nursing* (pp 31-51). Melbourne: Churchill Livingstone.

Lee, C. (1994). *Good grief*. London: Fourth Estate.

Levi-Strauss. C. (1969). *Totemism*. Harmondsworth: Penguin.

Lewis, M. (1992). *Shame: The exposed self*. New York: The Free Press.

Lindeman, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry*, 101, 141-148.

Litchfield, M. (1993). *The process of health patterning in families with young children who have been repeatedly hospitalised*. Unpublished thesis, University of Minnesota, Minneapolis, Minnesota.

Litchfield, M. (1997). *The process of nursing partnership in family health*. Unpublished doctoral dissertation, University of Minnesota, Minneapolis, Minnesota.

Littlewood, J. (1992). *Aspects of grief bereavement in adult life*. London: Routledge.

Loewenstein, S. F. (1981). Mother and daughter an epitaph. *Family Process*, 20, 3-10.

Lofland, L. (1978). *The craft of dying*. Beverly Hills: Sage Publications.

Lupton, D. (1997). Foucault and the medicalisation critique. In: Petersen, A., & Bunton. R. (Eds.). *Foucault health and medicine* (pp.94-110). London: Routledge.

MacIntyre, A. (1981). *After virtue*. Notre Dame, IN: University of Notre Dame Press.

Mamo, L. (1999). Death and dying: Confluences of emotion and awareness. *Sociology of Health & Illness*, 21(1), 13-16.

May, C. (1992a). Individual care? Power and subjectivity in therapeutic relationships. *Sociology*, 26, 589-602.

May, C. (1992b). Nursing work, nurses' knowledge, and the subjectification of the patient. *Sociology of Health and Illness*, 14(4), 472-487.

May, C. (1995). 'To call it work somehow demeans it': The social construction of talk in the care of the terminally ill patients. *Journal of Advanced Nursing*, 22, 556-561.

May, R. (1991). *The cry for myth*. London: Souvenir Press.

Maynard, M. (1994). Methods, practice and epistemology: The debate about feminism and research. In M. Maynard and J. Purvis. (Eds.). *Researching women's lives from a feminist perspective* (pp. 10-26). London: Taylor and Francis.

Mattingly, C. (1994). The concept of therapeutic 'emplotment'. *Social Science Medicine*, 38(6), 811-822.

Mellor, P. & Shilling, C. (1993). Modernity, self-identity and the sequestration of death. *Sociology*, 27(3), 411-431.

McLean, G. (1993). *Facing death: Conversations with cancer patients*. London: Churchill Livingstone.

McLoughlin, J. (Ed.). (1994). *On the death of a parent*. London: Virago.

McLellan, B. (1995). *Beyond psychoppression*. Melbourne: Spinifex Press.

Middleton, W., Raphael, B., Martinek, N. & Misso, V. (1993). Pathological grief reactions. In M. Strobe, W. Strobe, & R. Hansson. (Eds.). *Handbook of bereavement: Theory, research and intervention* (pp. 44-62). New York: Cambridge University Press.

Miller, J. (1991). The development of women's sense of self. In J. Jordan., A. Kaplan., J. Miller., I. Stivar., & J. Surrey. (Eds.). *Women's*

growth in connection: Writings from the stone center (pp. 11-26). London: The Guilford Press.

Miller, N. (1996). *Bequest and betrayal*. New York: Oxford University Press.

Mishler, E. (1986). *Research interviewing: Context and narrative*. London: Harvard University Press.

Mitchell, J. (1974). *Psychoanalysis and feminism*. New York: Vintage Books.

Moller, D. W. (1996). *Confronting death: Values, institutions, and human mortality*. New York: Oxford University Press.

Moss, M. & Moss, S. (1983-4). The impact of parental death on middle aged children. *Omega*, 14, 65-75.

Moss, M. S., Moss, S. Z., Rubinstein, R., and Rescgm B. (1993). Impact of elderly mothers death on middle-aged daughters. *International Journal of Aging and Human Development*, 37(1), 1-22.

Newman, M. (1979). *Theory development in nursing*. Philadelphia: F.A. Davis.

Newman, M., Lamb, G., & Michaels, C. (1991). Nurse case management: The coming together of theory and practice. *Nursing and Health Care*, 12(8), 404-408.

Newman, M. (1994). *Health as expanding consciousness*. New York: National League for Nursing Press.

Nightingale, F. (1970). *Notes on nursing*. London: Duckworth & Company Limited. (Original work published 1859)

Oakley, A. (1981). Interviewing women: A contradiction in terms. In Roberts, H. (Ed.). *In doing feminist research* (pp. 30-61). Boston: Routledge & Kegan Paul.

Opie, A. (1992). Qualitative research, appropriation of the 'other' and empowerment. *Feminist Review*, 40, 52-69.

Parker, J. (1997). The body as text and the body as living flesh. In: J. Lawler (Ed.). *The body in nursing* (pp.11-29). Melbourne: Churchill Livingstone.

Parker, J. & Aranda, S. (Eds.). (1998). *Palliative care: Explorations and challenges*. Sydney: Maclellann & Petty.

Parkes, C. M. (1965). Bereavement and mental illness. *British Journal of Medical Psychology*, 38, 1-12.

Parkes, C.M. (1975). *Bereavement*. Harmondsworth: Penguin.

Parkes, C.M. (1985). Bereavement. *British Journal of Psychiatry*, 146 11-17.

Parkes, C. M. (1986). *Bereavement: Studies of grief in adult life*. London: Tavistock publications.

Parkes, C. M. (1995). Guidelines for conducting ethical bereavement research. *Death Studies*, 19, 171-181. .

Parry, A. (1994). *Story-revisions: Narrative therapy in the postmodern world*. New York: The Guilford Press.

Perreault, J. (1995). *Writing selves*. Minneapolis, MN: University of Minnesota Press.

Pincus, L. (1974). *Death and the family*. London: Faber & Faber.

Popek, P. & Scharlach, A. (1991). Adult daughters' relationships with their mothers and reactions to the mothers' deaths. *Journal of Women & Aging*, 3(4), 79-97.

Potter, J. & Wetherell, M. (1987). *Discourse and social psychology*. London: Sage Publications.

Potter, J. & Wetherell, M. (1995). Discourse analysis. In J. Smith, R. Harre, & G. Van Langenhove. (Eds.). *Rethinking methods in psychology*. (pp. 80-92). London: Thousand Oaks.

Prior, L. (1989). *The social organisation of death: Medical discourse and social practices in Belfast*. New York: Avon Books.

Rando, T. A. (1992). The increasing prevalence of complicated mourning: The onslaught is just beginning. *Omega, Journal of Death and Dying*, 26(1), 43-59.

Raphael, B. (1984). *The anatomy of bereavement*. London: Routledge.

Rathgen, E. (1996). *On good authority: Towards feminist pedagogies*. Unpublished doctoral dissertation, University of Canterbury, New Zealand.

Reanne, D. (1996). *After death: A new future for human consciousness*. New York: Avon Books.

Reed, P. (1989). Nursing theorizing as an ethical endeavor. *Advances in Nursing Science*, 11(3), 1-9.

Reed, P. (1995). A treatise on nursing knowledge development for the 21st century: Beyond postmodernism, *Advances in Nursing Science*, 17 (3), 70-84.

Rich, A. (1977). *Of woman born*. London: Virago Press.

Richardson, L. (1997). *Fields of play*. New Brunswick, NJ: Rutgers University Press.

Ricoeur, P. (1986). Life: A story in search of a narrator. In Doeser, M. & Kraay, J. (Eds.). *Facts and values* (pp. 121-132), Dordrecht: Martinus Nijhoff Publishers.

Ribbons, J. (1989). Interviewing – An “unnatural situation”? *Women’s Studies International Forum*, 12(6), 579-592.

Robbins, M. (1990a). Mourning the myth of mother/hood: Reclaiming our mothers’ legacies. *Woman and Therapy*, 10(1-2), 41-59.

Robbins, M. (1990b). *Midlife women and death of mother*. New York: Peter Lang.

Rodgers, B.L. (1989). Concepts, analysis, and the development of nursing knowledge: The evolutionary cycle. *Journal of Advanced Nursing*, 14, 330-335.

Rodgers B. L & Cowles, K. V. (1991). The concept of grief: An analysis of classical and contemporary thought. *Death Studies*, 15(5), 443-458.

Rodgers, B. L. (1993). Philosophical foundations of concept development. In B. L Rodgers., & K. A. Knafl. (Eds.). *Concept development in nursing: Foundations, techniques, and applications* (pp. 7-34). Philadelphia: W.B. Saunders.

Rosenblatt, P. C. (1995). Ethics of qualitative interviewing with grieving families. *Death Studies*, 19, 139-155.

Rowley, H. & Grosz, E. (1990). Psychoanalysis and feminism. In S. Gunew. (Ed.). *Feminist knowledge: Critique and construct* (pp 175-204). London: Routledge.

Rubin, S. (1984). Mourning distinct from melancholia: The resolution of bereavement. *British Journal of Medical Psychology*, 57, 339-345.

Seale, C. (1995a). Dying alone. *Sociology of Health & Illness*, 17(3), 376-392.

Seale, C. (1995b). Heroic death. *Sociology*, 29(4), 597-613.

Seale, C. (1998). Theories and studying the care of dying people. *British Medical Journal*, 317, 1518-1520.

Seale, C. (1998). *Constructing death*. United Kingdom: Cambridge University Press.

Sawicki, J. (1991). *Disciplining Foucault: Feminism, power, and the body*. London: Routledge.

Sigsworth, J. (1995). Feminist research: Its relevance to nursing. *Journal of Advanced Nursing*, 22, 896-899.

Silverman, P.; Nickman, S., & Worden, J.W. (1992). Detachment revisited: The child's reconstruction of a dead parent. *American Orthopsychiatric Association*, 62(4), 494-503.

Silverman, P. & Nickman, S. (1996). Bereaved children and children's construction of their dead parents. In D. Klass, P. Silverman, & S. Nickman (Eds.), *Continuing bonds* (pp.73-86). Washington, DC: Taylor & Francis.

Silverman, P. & Klass, D. (1996). Introduction: What's the Problem? In D. Klass, P. Silverman, & S. Nickman (Eds.). *Continuing bonds* (pp. 1-27). Washington, DC: Taylor & Francis.

Stanley, L. (1990). Method, methodology and epistemology in feminist research processes. In L. Stanley. (Ed.). *Feminist Praxis: Research, theory and epistemology in feminist sociology* (pp. 20-60). London: Routledge.

Stanley, L. (1994). The knowing because experiencing subject: Narratives, lives and autobiography. In K. Lennon, & M. Whitford (Eds.). *Knowing the difference: Feminist perspectives in epistemology*. (pp. 132-148). London: Routledge.

Staudacher, C. (1987). *Beyond grief: A guide for recovering from the death of a loved one*. Oakland, CA: New Harbinger Publications.

Street, A. (1998). Competing discourses with/in palliative care. In J. Parker, & S. Aranda. (Eds.). *Palliative care: Explorations and challenges* (pp. 68-81). Melbourne: MacLennan & Petty.

Stroebe, M., Gergen, M., Gergen, K., & Stroebe, W. (1996). Broken hearts or broken bonds? In D. Klass., P. Silverman., & S. Nickman. (Eds.). *Continuing bonds* (pp.31-44). Washington, DC: Taylor & Francis.

Surrey, J. (1991). The self-in-relation: A theory of women's development. In J. Jordan., A. Kaplan., J. Miller., I. Stivar., and J.

Surrey. (Eds.). *Women's growth in connection: Writings from the stone center* (pp. 51-66). London: The Guilford Press.

Tierney, T. (1997). Death, medicine and the right to die: An engagement with Heidegger, Bauman and Baudrillard. *Body and Society*, 3(4), 51-77.

Timmermans, S. (1994). Dying of awareness: The theory of awareness contexts revisited. *Sociology of Health and Illness*, 16, 22-39.

Ussher, J. (1991). *Women's madness: Misogyny or mental illness?* London: Harvester Wheatsheaf.

Volkan, V. (1981). *Linking objects and linking phenomena*. New York: International Universities Press.

Vozenilek, H. (Ed.). (1992). *Loss of the ground-note: Women writing about the loss of their mothers*. La Mesa, CA: Clothespin Fever Press.

Waitzkin, H. (1984). The micropolitics of medicine: A contextual analysis. *International Journal of Health Services*, 14(3), 339-378.

Walter, T. (1991). Modern death: Taboo or not taboo? *Sociology*, 25, 293-310.

Ward, B. (1993). *Healing grief: A guide to loss and recovery*. London: Vermilion.

Watson, J. (1995). Postmodernism and knowledge development in nursing. *Nursing Science Quarterly*, 8(2), 60-64.

Weedon, C. (1987). *Feminist practice and poststructuralist theory*. Oxford: Basil Blackwell.

Whitford, M. (Ed.). (1991). *The Irigaray reader*. Oxford: Blackwell.

Whitford, M. (1992). Mother-daughter relationship. In E. Wright. (Ed.). *Feminism and psychoanalysis* (pp.262-265). Oxford: Basil Blackwell.

Williams, A., Cooke, H., & May, C. (1998). *Sociology, nursing & health*. Oxford: Butterworth-Heinemann.

Williams, R. (1989). Awareness and control of dying: Some paradoxical trends in public opinion. *Sociology of Health & Illness*, 11(3), 201-212.

Wittmann, L. K. (1998). *Interactive identities: Jewish women in New Zealand*. Palmerston North: The Dunmore Press.

Woodward, K. (1997). Concepts of identity and difference. In Woodward, K. (Ed.). *Identity and difference* (pp. 39-44). London: Sage Publications.

Worden, J. W. (1982). *Grief counseling and grief therapy*. New York: Springer Publishing Company.

Zola, I. (1972). Medicine as an institution of social control. *Sociological Review*, 20, 487-504.

APPENDIX A

Information sheet

ISSUES FACING DAUGHTERS FOLLOWING THE DEATH OF THEIR MOTHERS.

Introduction

My name is Daphne Manderson, I am enrolled in a doctoral programme at Massey University. I am carrying out a study of the issues that surround the experience of women following the death of their mother. You are invited to take part in this study but should feel no pressure to do so. Take your time to think about if you would like to take part in the study which is described below. If you decide that you would like to be part of this study please contact me at the address on the end of this form.

About the Study

What are the aims of the study?

The study aims to understand more about the experiences of women who have experienced the death of their mother. I would like to speak with you about your relationship with your mother, of her death and of your experience of living without a mother. You would be part of a group of approximately twenty women who will be interviewed on an individual basis about this special experience.

Where will the study take place?

The study will be based in Christchurch, and the researcher will visit you at a time and place that is suitable to you.

How much of my time will it take?

The time involvement will be approximately 7 hours. I will meet with you from four to six times over a period of about six weeks. You will be

invited to speak about your experience of the death of your mother, and any other related issues that come up in the course of our conversations together will be discussed.

What about confidentiality?

No information that could identify you will be made available to any other person other than my research supervisors if requested. Our conversations will be tape recorded and transcribed. In addition to myself, only the transcriber will have access to the tapes, and she will sign an oath of confidentiality. My supervisors will see some of the transcribed data when code names will be used.

All research material will be kept in a secured cabinet at my home. None of the material will have your name on it. All of the material will be coded and known only to the researcher. The transcripts and tapes will all be kept until after the study is completed. Once the study is completed you have the option of having your tapes returned to you, archived or destroyed. The transcripts will be kept securely for three years. The information may also be used for ongoing research, but this would not happen without consultation with you.

What are the benefits of the Study?

The study will identify the grief issues faced by daughters' and will allow you and other women access to more information about such an important life event. The study will help to make public many of the issues that the researcher believes are important to support women in the loss of their mothers. A summary of the research findings will be given to you if you would like a copy and I will be happy for you to see and read the full thesis if you wish.

This study has received ethical approval from the Massey University Human Ethics Committee and the Southern Regional Health Authority Ethics Committee (Canterbury).

Please feel free to contact the researcher if you have any questions about this study. Whilst you have been invited to take part in the research it is important that you exercise your right to decline to take part should you wish to do so any time after the interviews have begun. You are free to withdraw from the study at any time, for any reason, and you are also free to refuse to answer any question. If you have concerns about any part of the study, my supervisors can be contacted at the addresses below. I would encourage you to speak with me about any issues, or to contact them at any time should you wish to.

People involved in the study.

Sole Investigator	Supervisors
Daphne Manderson	Dr Judith Christensen
Doctoral Student	Senior Lecturer
Department of Nursing and Midwifery	Massey University
Massey University	Ph (06) 350-4332
Palmerston North	Dr Victoria Grace
	Senior Lecturer
Home phone number:	Canterbury University
8 Revelation drive	Ph (03) 364-2962
Christchurch. 8.	
Ph. (03) 326 5939	

APPENDIX B

Consent form

I have been invited to take part in a study to examine the issues facing women who have experienced the death of their mother.

I have heard and understood an explanation of the study, and have been given an opportunity to discuss the study and ask questions about it. My questions have been answered to my satisfaction, and I understand that I can continue to ask questions at any time.

I know who to contact if I have any questions about the study.

I understand that:

- my taking part in this study is voluntary (my choice).
- I am free to withdraw from the study at any time and for any reason.
- the interviews will be taped.
- I am free to stop the interview at any time, and that I can decline to answer any question's I do not wish to answer.
- the information may be used for conference papers and journal articles following Daphne's thesis requirements, and that these will be drawn from the thesis.
- I give permission for working transcripts to be kept by Daphne for use in subsequent related study.
- the tapes will be returned to me, archived or destroyed following discussion with me.
- my participation in this study is confidential, and no information that could identify me will be used in any part of the study.

I have read and understand the information sheet. I understand that I will be given a copy of this consent form following the signing of the two copies of the form.

I understand that this research has received ethical approval by the Massey University Human Ethics Committee and the Southern Regional Health Authority Ethics Committee (Canterbury).

I wish to receive a copy of the findings of this study: Yes / No

I consent to take part in this study. Yes/ No

Participants signature: _____

Researchers signature: _____

Date: _____

Daphne Manderson (Doctoral student).

Department of Nursing and Midwifery

Massey University.

Palmerston North.

Ph. (03) 326-5939.

APPENDIX C

Interview prompts

Can you tell me a little about your mother's early life?

Can you talk a little about your relationship with your mother.

- how well do you think you knew her?

What age were you when your mother died?

- can you tell me a little about how that was for you?

or

- what were the events leading up to this?

What does the death of your mother mean to you?

what do you think of first?

or

- and what about her dying.

You have touched on the grief experience, can you talk a little more about that?

Or

tell me a little about your grieving.

What does grief mean for you now you have had this experience?

How do you understand death?

Is there anything in the present that suggests a link or represents a link with your mother?

What does it mean not having a mother now?

Are there any religious/spiritual issues that are or have been important to you in making sense of your mother's death?

Does in anyway your knowledge of your own mothers life experience influence your understanding of this experience?

APPENDIX D

Themes

The following themes were identified during the process of typing up the transcripts, and from early readings of the data in respect to the research objectives:

- A. Relationship
 - 1. Mother's personal history (stories told)
 - 2. Daughter's personal history (stories told: mother as hero, imperfect but 'good' mother, archetypal mother, and the bad/abusive mother).
 - 3. The 'primacy' of the mother daughter relationship (mutuality)
 - 4. The mother daughter relationship (alienation)
 - 5. Sadness over the type of life the mother had.
- B. Grief related to the illness and dying process (diagnosis, tests, hospitalisation).
 - 1. Medical history (+ve)
 - 2. Medical history (-ve)
 - 3. Grief related to mother's life
 - 4. Grief related to the death of the mother.
 - 5. Death story, type of death narrative
 - 6. Grief related to living without a mother
 - 7. The meaning attached to death.
 - 8. Subjectivities surrounding viewing the body.
- C. Ontological views re: life and death

1. Christian discourse
2. Secular 'spirituality'
3. Reincarnation
4. Yoga
5. Nature
6. Nothing

D. Politics of grief

1. Parental power (father)
2. Parental power (mother)
3. Family secrets / silences
4. Understandings surrounding the 'mental health' of the mother
5. Understandings surrounding the physical health of the mother

APPENDIX E

A selection of key words and phrases from the text depicting connection and continuity

Examples of key words and phrases that comprise the fields of meaning around mother-daughter mutuality - contributing to a discourse of connection and continuity.

'She and I'

my mothers love was profound
 we would sit there for hours
 We had an extremely close relationship
 She was a wonderful, wonderful mother
 she was an encourager
 we would chat about this and that
 she would rather sit and talk
 made me closer
 I knew her pretty well
 she was more like a sister...
 we could always talk ...I never hid anything from her you know
 we were the greatest of friends
 we really created our lives around each other
 she was always there you see, she was always there...
 I was more my mothers friend
 I remember her as very nurturing
 my mothers loving of me was the finest quality of loving I've ever known...

Selected phrases on daughter's depictions of their mother's

she would have done anything for me
 she'd sit down and talk
 she was a very nurturing person
 that motherly thing
 taking an interest
 she spent so much time with us...helping me
 she did one extraordinary valuable important thing ...valued me
 you know she made me think I was great
 she was a very strong woman
 she just lived for us...always there for me
 she was absolutely amazing actually damn her...not perfect but a pretty extraordinary person.
 she was always welcoming and warm
 she loved me to bits
 she would ...listen like no one else really
 my mother was just a wreck (over my operation)

she was um a sort of a rock person

I was very, very loved to the point of distraction

she really always affirmed me
always there

always meant well

this was for her the primary relationship

she was a wonderful soul...

I have this memory... of loving, loving, loving her.

I was the pet as it were...

greatest of friends

we went to every concert pianist together

I would see her or contact her every day...

I was always mums girl

I felt almost alienated from dad because of the feeling that I was mums girl

it was mutual

she was a person who was very much loved

she felt more like a sister

mum was always there...one of those really nice people.

He watched us talking and relating and connecting in a way that he longed for

very nurturing

she was a special lady

she loved me you know

she loved me to bits

she knew me pretty well

she was a good mother she really was

she ...just made sure that I was on the top of everything

she was good, she was always there for me

she was the one that got us to where we were going

she was a special lady

she could sort of see things you see

she never complained

she was a wonderful, wonderful mother

she would have much rather of sat and talked to me

she'd sit down and talk

she loved me, you know, I have a feeling ...

she would actually teach me

she could sort of see things

she was quite clever

**SELECTED PHRASES
REFLECTING CO-
EXISTENCE - 'WE'
STATEMENTS**

so we've matriculated
we'd sit there for hours
we were very excited
we were going
I kept saying its fine, we'll cope
we were able to
we came away feeling quite
excited
we were very alike and minded
about things hugely
we really created our lives
around each other
when we went to live in...that
was just devastating for her
we were just so much alike
we are so close really
we would be sitting there talking
we'd chat away for hours
we were the greatest of friends

'I' STATEMENTS

I was the lucky one who got the
visits from her
I was always buying ... to please
her
I was the closest you can be
I had the opportunity to be with
mum every day
I always felt very protective
towards her
I made the decision to take her
to Mexico (further treatment)
I wanted to nurture her
I encouraged, and set up that
she...
I always got on well with her
I would see her or contact her
every day, I mean it was mutual
I've promised that I would stay
with her, and I do want to stay
I'd go home and be so
joyful...she would do all these
lovely little things for me
I realised I was sort of more my
mother's friend

***SELECTED PHRASES
CONNOTING THE
EXPERIENCE OF
CONNECTION***

had a premonition about it
overwhelming sense of sadness
I am aware that mum is
standing in the eves
she's just there somewhere, I'm
quite aware
The two of them vie in me for
supremacy
Mother makes me do these
outrageous things
I felt her presence ...it was a
calming feeling
I have this sense of her being
hugely proud of me
I just felt oh that's mum
I felt her presence for some time
how often she seems to be there
I know that she's around me
so mum was around but she's
gone now
I still feel in tune with her
I would often sort of hear her
voice
I linked into my mother strongly
she's been watching over me
I have a really strong sense
...like of calling on ...calling on
them to keep an eye on me really
she seems to be there

***PHRASES INVOLVING
PSYCHICAL
INCORPORATION AND
CONNECTION***

It makes as much sense to me
that there is a life hereafter
that there be some continuity
the ritual around death, the
religious ritual is quite
important
can smile and say "giddy, I
wonder where you are".
fortunately with my Christian
belief I know we are going to be
together again
In heaven we are going to see
each other again
Only a veil covering
it was just there ...just this
incredible peace
I don't believe in going to graves
because ...isn't there
Whatever there is, ...is likely to
be totally different from what,
you know, this kind of life.

APPENDIX F

A selection of key words and phrases from the text depicting discontinuity

SELECTED KEY WORDS AND PHRASES DEPICTING DEATH EVENT AS DISCONTINUITY

scared of dying myself
 I don't imagine ever meeting
 with them again...
 I never really think about that...
 I find death quite scary...it's
 really final
 the legacy is that I'm absolutely
 paranoid about death
 death is with me
 life is terribly fragile
 strong sense of the mortality of
 people that I love
 hard for me to live with...I'm
 always worried
 intellectually understand but
 the emotional response is so
 strong
 constantly on my mind death
 it would be a hell of a lot easier
 if you had a myth.

SELECTED KEY WORDS AND PHRASES DEPICTING DEATH EVENT AS DISCONTINUITY

I feel cheated, very cheated
 the last great adventure
 can't stand death and dying
 as good a death as you can have
 reconciled to death, it is not true
 birth and death followed so
 closely
 she could not face going into
 hospital
 I realised the jolly thing was
 terminal
 she died
 death does stop you
 death notice

***SELECTED PHRASES
DEPICTING GRIEF OVER
DEATH AS DISCONTINUITY***

expect her to be there
I wish I could have her for a day
Sometimes I think I want my
mum
...for me my comforts gone
biggest loss in my life so far
I miss that, I miss someone
caring (voice breaking), just
being there
a terrible loneliness that nothing
can ever fill at times
I think of her death
death is also being grateful for
the life
that feeling...walking out of
there just knowing we wouldn't
talk to her again (voice breaks)
terrible (voice is weak and
almost like that of a child saying
"te ible")
just coming home to an empty
house.
Greatest loss in my life
couldn't believe she'd gone
huge loss - never get over it
emptiness and a terrible
loneliness that nothing can ever
fill at times
not ever again experiencing that
theorists are wrong...I suspect I
miss her more
there is a part of it that is rage

***SELECTED PHRASES
DEPICTING GRIEF OVER
DEATH AS DISCONTINUITY***

always sense of loss
I opened Pandora's box
real sadness
can't throw it off
you just kid yourself that you've
cope with it...until I guess it just
has to blow up in your face
quite a scary thing
overwhelming feeling that just
comes out of the blue
you will just be off
I can yeah get upset
I cry quite a lot...maybe I am the
strong one...that can't be
healthy to keep it inside
realising that it's a life long
effect
the biggest impact is on
relationships
I can't stand close people
leaving...
I will always carry...unfinished
business
a terrible loss a mother of five
children
we have this word coping ...a
most ghastly word
a great big hole, a great big hole
always someone missing and
that was Mum

APPENDIX G

A selection of key words and phrases from the text depicting silencing

WORDS DEPICTING THE SILENCE AND CONTROL OF DEATH TALK WITH THE FAMILY

she would not speak to me about it

that word was never used

she would not admit to me

we would have taboo subjects

she said I love you but I have to go now (the mother then went to her room and died unexpectedly) wouldn't concern anybody

couldn't actually say what was going on

so intense but also so private

we didn't know

you didn't tell anyone

she didn't share she had cancer

she would not talk to me (emphasised)

my parents were not honest with me

he said "this thing has happened (mother's death)

she never really said very much she didn't use that word

she didn't tell us until quite a few months

she didn't say what was wrong

my father had been going and I

WORDS DEPICTING INSTITUTIONAL SILENCING

they can't mention the word death...these things get turned into something abnormal

the abnormalness is that it's not OK, she wasn't told that she was close to death

total avoiding of any contact

there was real dishonesty

it was like she was the problem really

labelled as difficult

everybody avoided

how dare I do that (use the dying word)

they wouldn't, they just wouldn't let her go really

we had no control

just like shut up really

doctors don't talk enough or make you understand

they told her she had a complete cure she was riddled with cancer

they were rather equivocal

they didn't say too much about what the outcome would be

they sort of said it wasn't a cancer. They just said "it was a blood disease

had been getting (information)
second hand...

I really wasn't happy with the
information coming out

I'm going to ask the questions,
and I'm going to find out what's
going on

...was terminal and he had
really not said to us it was

she knew she was dying

she didn't say to us but she
knew

in those days you didn't talk to
your children about the fact you
were dying

she carried that on her own

so intense but so private

there was real dishonesty

a veneer

she covered herself

I felt betrayed

why didn't they tell me?

I remember it as betrayal

he dictated a letter to (*another
specialist*)...I think that was his
way of telling me

nobody actually said to me "your
mother is dying"

why didn't someone tell me?

why didn't the doctor tell me

it might be good if I anointed
your mother, will you ask her?

it must have been obvious she
was dying, we should have been
allowed in

the nurse said to me...just out of
the blue "we expect her to go
today"

nobody has said a word to us

they were rather equivocal

societies inability to kind of cope
with pain

we mask it and then we become
unconscious to it

its not safe to be sad

I wish they'd listened to me

SUBVERTING THE SILENCE

I HAVE/HAD A RIGHT TO KNOW

I'm not going to have...what is it
Elisabeth Kübler-Ross calls it,
um unresolved baggage.

Don't cut me out, you know.

your not getting away with
this...I told her...we both ended
up in tears.

I was a 'wicked alien' coming
into this environment (talking
about death)

(silence) prompted me to go on
this quest with her family...I
thought I've never known this
woman.

I was the only one who would
actually talk about X

I need to be able to say about the
rage...and not pretend it didn't
happen

use the word dying straight up

I wished they'd listened to
me...why couldn't they have just
listened to me...valued my
experience

I was furious

that wasn't the answer

incredibly jerky start which was
pathetic. I mean their not
telling