

PART I

FAMILY AND COMMUNITY LIFE

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Becoming a Mother – Becoming a Father

Rachel Mayes and Hanna Björg Sigurjónsdóttir

Introduction

Research into parenting by people with intellectual disabilities consistently refers to parents and parenting. However, the overwhelming majority of studies are about mothers. Fathers with intellectual disabilities are largely ignored and when the discussion is about parents, the particularities of mothers with intellectual disabilities are glossed over. Although “mother” and “father” are gendered terms (Bergum, 1989), there is a lack of critical examination of the role of gender within these families.

We believe that a focus on gender is important for three reasons. The first is because “mother” and “father” are not the same as each other. Becoming a mother is something only women do. Becoming a father is something for men only. In always describing parents with intellectual disabilities without reference to gender, researchers have ignored the fact that the experiences of men and women might be very different.

Historically, men and women with intellectual disabilities have been treated quite differently. The practice of involuntary sterilization, while not exclusively focused on women with intellectual disabilities, was aimed at them (Brady & Grover, 1997). In those societies practicing sterilization it was thought that women had to be prevented from reproducing or society risked the eroding of national intelligence (Pfeiffer, 1994; Radford, 1994; Walmsley, 2000). Almost nothing is known, however, about how these policies affected men with intellectual disabilities.

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Second, the genderless orientation of the literature means that the experiences of women as mothers have been absorbed in a discussion of parents and parenting, while the experiences of men with intellectual disabilities as fathers have been largely ignored. A search of a regularly updated database of empirical literature identified 445 publications about some aspect of parenting by people with intellectual disabilities (www.healthystart.net.au). Only two of these titles specifically referred to fathers with intellectual disabilities. 67 (15%) referred to mothers alone, while the remainder referred to parents. The majority of empirical studies in the literature include only women participants. Feldman (1994) conducted a meta-analysis of the efficacy of parenting programs for parents with intellectual disabilities. In this analysis, 190 parents were included across 20 studies. In this sample of 190 parents, there were only two fathers; the sample of parents was almost exclusively mothers. In the 20 studies, 18 were about mothers only despite the titles referring to parents. In an updated meta-analysis published in 2008, there is little to suggest that the situation has changed in the intervening 15 years (Wade, Llewellyn, & Matthews, 2008).

A number of researchers have reported that people with intellectual disabilities typically face opposition when they decide to become parents. Such opposition usually occurs when pregnancy is announced (e.g., Booth & Booth, 1992, 1995; Llewellyn & McConnell, 2005; Mayes, Llewellyn, & McConnell, 2006; Pixa-Kettner, 1998; Traustadóttir & Sigurjónsdóttir, 1998). Because the majority of studies are about women, it appears that such opposition is largely aimed at the pregnant woman and not the expectant father. However, the very limited evidence we have about men with intellectual disabilities suggests that they may also face negative reactions when they have children (Llewellyn, 1994; Sigurjónsdóttir, 2004). There is much more work to be done to understand the experiences of men with intellectual disabilities and how these are similar to, or different from, the lived experiences of women with intellectual disabilities.

The third reason a focus on gender is important is that research on families headed by parents with intellectual disabilities informs policy and practice in the field of social services, child protection, and disability services. Traustadóttir and Kristiansen (2004) noted that "Gender is one of the most important yet often unacknowledged dimensions influencing and shaping services and supports for disabled people" (p. 1). A gender-insensitive approach masks potential differences, and so cannot take into consideration the possibly quite different support needs of mothers and fathers who have intellectual disabilities.

A few studies have considered the needs of men and women separately in the context of providing support services to parents with intellectual disabilities. The earliest study, conducted by Mattinson in 1970, examined 32 marriages of people with intellectual disabilities who had been discharged from an institution. She concluded that for 25 of these marriages the relationship was affectionate and largely supportive even in the few where there was considerable

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stress. Couples were considered to be better off married than single. The remaining marriages were characterized by one partner's heavy reliance on the other. No marriage was deemed predominantly unsatisfactory.

In Australia, Llewellyn (1995) demonstrated the importance of the parent partnership in managing everyday parenting and the central role of the father as a source of support to the mother. Additionally, in Britain, Booth and Booth (2002) found that the majority of male partners played a supportive role in the family. These two studies indicate that fathers are often the primary support to the mother, which highlights the importance of including both parents when providing formal support to these families. In practice, however, this rarely happens. A small study conducted by O'Hara and Martin (2003) demonstrated that family support was not regarded necessary where the father had an intellectual disability unless the mother also had an intellectual disability so "little was offered to help these men to understand the situation or the psychosocial implication of fatherhood" (O'Hara & Martin, 2003, p. 21). Recent research from Iceland reveals that formal family support is typically directed at the mother and child (Sigurjónsdóttir, 2004). The findings indicate that if fathers are not included and embraced as part of the family unit, both fathers and the practitioners can become resentful.

Even fewer studies have taken a gendered perspective in examining the roles and identities of mothers and fathers with intellectual disabilities. Mayes, Llewellyn, and McConnell (2008, in press) examined the experience of pregnancy for women with intellectual disabilities. Their work highlighted that contrary to the asexual stereotypes often used to describe women with intellectual disabilities, these women have similar desires to other women such as wanting to become a mother.

The purpose of this chapter is to examine the experiences of becoming a parent for people with intellectual disabilities and how they negotiate this new role. Our aim is to consider the place of gender in these experiences and particularly to determine the implications of a gendered perspective for policy makers and service providers.

The Studies

This chapter is based on the findings of two doctoral studies: one from Australia (Mayes, 2005) and the other from Iceland (Sigurjónsdóttir, 2005). Both studies focused on the lived experience of parents with intellectual disabilities during pregnancy and following the birth of the baby. A relatively small number of studies have examined parenting experiences from the parents' own perspectives (e.g., Booth & Booth, 1994; Llewellyn, 1994). The studies we describe in this chapter are the only two we are aware of that deliberately sought parents' experiences prior to the birth of their children. The studies employed

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qualitative methods and data were collected through both in-depth interviews and participant observation (Emerson, Fretz, & Shaw, 1995; Kvale, 1996; Taylor & Bogdan, 1998).

The Australian study was a phenomenological enquiry into the meaning of becoming a mother for women with intellectual disabilities. This study was conducted over a three-year period from 2002 to 2005. Seventeen women with intellectual disabilities were interviewed on multiple occasions throughout their pregnancies to understand the pregnancy experience and what becoming a mother meant to them.

The Icelandic study on family support services and parents with intellectual disabilities was conducted over a five-year period from 2000 to 2005. This ethnography and narrative inquiry examined how the health and social services systems respond to the diverse needs of these families from the time of pregnancy. The participants were eight families headed by parents with intellectual disabilities and all their support personnel, a total of 75 people. Special emphasis was placed on understanding the fathers' role within the family and the gendered aspect of support (Sigurjónsdóttir, 2004). Below we describe the findings from both studies, paying particular attention to experiences that are gender related.

Finding Out We're Having a Baby

Only one-quarter of both the Australian and Icelandic families had planned the pregnancy prior to discovering they were expecting a child. Physical signs such as missed periods, tender breasts, or feeling nauseous signaled to the women in both studies that perhaps a baby was on the way. The women told their partners of their suspicions. A visit to the doctor or a home pregnancy test confirmed the pregnancy. Most families, even those who had not planned to have a baby, or who had not planned to have a baby at this time, were delighted with the news.

While the parents-to-be in both studies were excited about the pregnancy, other people around them were not. Extended family members suggested abortion and/or adoption because they were worried about the parents' ability to take care of a child. This discussion was initially aimed more at the mothers than the fathers. One mother described her family's comments as abusive. Her family told her that because of her disability she should not be having a child. They believed her child would be better off cared for by someone else. Another mother sought her partner's strong support after comments from her mother that she would not be able to cope with another child.

In the Icelandic study suggestions about abortion came from the mothers' side of the family, with one exception. The reason most of the fathers' families did not suggest abortion was possibly due to the fact that abortion has to do with

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the woman's body. Most families, however, did suggest their sons and daughters-in-law give up the child for adoption. When the expectant parents refused to do so, families emphasized that the couple should seek support from social services. In two instances the families of the fathers contacted social services to express their doubts about the expectant parents' abilities. In one case the father's parents notified the expectant couple to child protection authorities. This was in spite of the fact that the parents already had a social worker and good family support organized. To its credit, the child protection agency decided not to interfere.

Disapproval of the pregnancy went beyond what people said to the expectant parents. The actions of families in response to the news illustrated their poor expectations of the couple. One Icelandic expectant mother was pregnant at the same time as her brother's wife. Her family went to a great deal of trouble knitting baby clothes and preparing for the arrival of her nephew or niece. No one in the family knitted clothes for her baby, or anticipated the arrival of her child. This hurt her deeply as it indicated to her that her baby was not as welcome in the family as her brother's baby.

Whether planned or unplanned, discovering a pregnancy leads to intense emotional reactions, ranging from delight to distress to fear. For the Australian women with intellectual disabilities, acknowledging their pregnancies meant the discovery that life was now very different. Their bodies were now working to preserve the life of the unborn child. These bodily actions continued despite the expectant mothers' physical symptoms such as nausea and discomfort, and were unaffected by her emotional reactions or the reactions of her partner and others around her. In this situation of heightened emotional response, the expectant mothers had to make decisions about their pregnancies.

The fathers-to-be in Iceland also experienced heightened emotional responses; however, they had to try harder to ensure that they were consulted on any decisions about the pregnancy. They did not want to be excluded. One Icelandic expectant mother decided to have an abortion. Her mother and her support worker agreed with her decision. Her partner, Halli, was not aware of this as the three women kept him out of the discussion and the decision was made without consulting him. When Halli learned of his partner's intention, he was devastated both because he was looking forward to the birth of this child and because he was a member of a religious group that holds life to be sacred. Halli asked his partner not to go through with the abortion, but her mind was made up. The night before the operation was scheduled Halli showed her an educational DVD about abortion that he had rented from the National Library. The next morning the couple turned up at the hospital to inform them that they had changed their mind and had decided to keep the baby.

The expectant parents in both countries took into account many factors in making decisions about the baby. This decision making was not straightforward. There were financial considerations to think about. There was also the question of whether the baby would be healthy or have a disability. For two Australian

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women their pregnancies were discovered too late for an abortion to be legally available, despite their requests for one. Importantly, the experiences of the Australian women with intellectual disabilities show that any decision revolves around a baby who is now living inside her. Women with intellectual disabilities do not respond to a hypothetical pregnancy; there is no longer a choice about whether or not to have “a child” in the abstract. The women with intellectual disabilities knew that they must respond to *this* particular baby, their own child.

Doing the Work of Becoming a Mother

For the expectant mothers the work of becoming a mother centered on their pregnant bodies. Once the decision-making phase was over, the women delighted in their bodies and in their unborn babies, whose physical presence first became more outwardly obvious to them and then to other people. No longer were their pregnant bodies just a swath of symptoms such as morning sickness that had to be endured. Each woman began to consider quite differently the baby she carried. She was not only pregnant; she was going to have *her* baby. After recognizing and accepting the pregnancy, each woman now began to accept the baby as her very own. Rowan, a mother in the Australian study, described how, early in her first pregnancy, she wanted to have an abortion. However, she changed her mind:

it's also exciting because you sort of see yourself, like another part of yourself . . . because . . . you think, “I have got another little me growing inside me and I wanna see how that turns out.” . . . I decided I would have the baby.

Women described the joy and excitement of feeling the baby move inside them, and imagining life with the baby once it was born. Sandelowski and Black (1994) have shown that expectant mothers are involved with their unborn baby in a concrete, personalized way. Bailey (1999) has described women's changing experience of their own bodies and their sense of self as their unborn child became more and more outwardly apparent. For the Australian women with intellectual disabilities, the boundaries between the self as an individual and the self as a mother became blurred, as people commented upon, patted, and prodded the expectant mother's body. Marilyn, an Australian mother pregnant with her fourth baby, said:

It's always better towards the end, because it seems real. You know that it's real. This one's different too, when it kicks and moves I think, oh wow, it's a real baby. And you can actually kind of picture it. I can picture myself as a mother again.

As expectant mothers, the women with intellectual disabilities in both studies were acutely aware of the risk that other people would intervene in their lives. As

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suggested by Llewellyn (1994), negative reactions to their pregnancy signaled that others had little confidence in their abilities to parent. They were also aware that there were people in their lives who had the power to report them to the child protection authorities, who in turn could remove their children. Some mothers had already had child protection authorities involved in their parenting. One of the Australian mothers, Brianna, had a child protection worker visit her within a few days after she brought her first son home. Brianna felt sure that it was her mother who had contacted them, as she was distrustful of Brianna's ability to provide proper care for her infant son.

In response to the risk of losing their soon-to-be-born baby, the expectant mothers in Australia actively arranged their support networks in a strategic way to ensure that the new addition to their family would remain in their care. They sought the support of those people in their immediate and existing network on whom they felt they could rely: those closest to them at the time of their pregnancies. For some women this included their supportive partner, particularly if he was the father of their unborn child. In this well-considered and planned way the expectant mothers secured the support of those they believed would honor their role as mother of their child and excluded those they believed would try to "take over" (Mayes et al., 2008).

Doing the Work of Becoming a Father

The men in the Icelandic study were proud of their new role and wanted to do everything they could to prepare for the arrival of their babies. Antenatal care and antenatal classes were important for these expectant fathers to confirm their new status both to themselves and to others, and as an avenue to receive information and to provide support to their partners. All of the fathers went with their partners to antenatal services and read the information booklets provided as well as questioning the midwives about pregnancy, birth, and infant care. Although the fathers were very eager to learn, they found that many people had reservations about them in the beginning. One of the midwives, who had been asked by the family social worker not to include the father, said:

Initially I had doubts about him but these disappeared as time passed. He was always good to work with. Anna usually didn't ask much so I usually had to tell her but he asked a lot of questions. He wanted to know and be well prepared . . . it was enough for her just to be pregnant.

The midwife was impressed with the father and found his questions "both appropriate and relevant, never asking the same question twice." For the Icelandic fathers this close involvement with antenatal care and classes made the pregnancy more real. The Icelandic fathers saw their babies via an ultrasound

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scan and enjoyed showing the photos of their future offspring to others. This was in direct contrast to the experience of the Australian mothers-to-be for whom antenatal care and classes did not constitute such public recognition of their pregnancy or act as a rite of passage.

When the contractions started the fathers regarded it as their role to call for help and to take their partners to the hospital. Afterward they rang friends and family to proudly announce the arrival of the new family member. All of the fathers were present at the birth except two, who had to wait outside as their partners had unplanned, emergency caesareans. When their partners were taken to the recovery ward, these fathers were allowed to see their babies. One of them said:

She didn't see the baby at this stage but I did, I saw him. That made me happy seeing such a little child that I had never, I mean, I had seen small children but I had never held them or fed them so it was all first time for me.

The fathers visited their partners every day at visiting hours eager to learn how to take care of their babies.

Like the Australian mothers, the Icelandic fathers knew that most people viewed their fatherhood and family life negatively and they were well aware of the danger that they might lose custody of their children. For one father, his first child had been removed from his care. The partners of two other fathers had also lost custody of their previous children. The risk of child removal is very real. Iceland is a small country with a population of only 300,000. All the fathers knew or had heard about parents with intellectual disabilities whose children had been taken into care.

Most of the fathers were expecting their first child and had no experience in caring for children or role models to follow. Some had doubts about their own parenting ability, but all wanted to learn to take good care of their babies and do everything in their power to ensure they would keep the baby. In response to this very real risk of losing custody of their new baby, the expectant fathers strategically negotiated and secured the support of those beyond their immediate family and friends. They worked to establish a support network consisting of people they knew and trusted, and who were regarded credible enough for "the system." For example, some fathers found a well-respected, non-disabled advocate who would accompany them and their families to child protection meetings as most of the families were notified to child protection authorities at the time of pregnancy. Two fathers created a public presence by telling their story in the media, three volunteered as participants in Sigurjónsdóttir's study, and two hired a lawyer.

Prior to the birth of their babies, therefore, the expectant mothers in the Australian study and the Icelandic fathers-to-be set about gaining support to make sure they would be able to keep their babies. Many of the Icelandic fathers also negotiated support for the family with professionals from generic services. When the baby arrived, however, the support from these services did not turn

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out to be quite as they had intended. Although the infant nurses and midwives provided support to the father of the new baby as well as to the mother, the support workers from social services and child protection focused mainly on the mother and baby. These social service practitioners tended to ignore the father, who felt left out as all the conversations and instructions were directed almost entirely to the mother. Support workers clearly regarded the mother as having the main responsibility of caring for the baby.

One father described how a psychologist accompanied by a social worker came to his home and told him that the results of a psychological test revealed that he could never take care of a child. When the father asked why this was the case, the psychologist did not answer his question. Instead, he made the father repeat aloud after him, in front of other people present, “I can never take care of a child.” The psychologist then said that the father had to understand that “In this house it is your wife who is in charge of both the child and the home. You will have to do what she tells you to do.” The father found this extremely hurtful and wondered what kind of marriage it was where one partner had no say in the family or the relationship. He commented:

For our family life to be normal I need to be the man of the house. I need to feel respected and I cannot accept this.

The Icelandic fathers, all of whom wanted to be good partners and fathers, saw it as their role and duty to protect and speak up for their families. Wanting to do well, they asked staff at the maternity unit and support workers from social services and child protection lots of questions both to confirm they were doing things correctly and to clarify when they received mixed and inconsistent messages from support staff. As a direct result of this help-seeking behavior, many of the fathers were labeled non-compliant and difficult to work with (Sigurjónsdóttir, 2004).

Discussion

The two studies described in this chapter are the first to our knowledge to explore the experiences of women and men with intellectual disabilities during the pregnancy period and the transition to motherhood and fatherhood. This work highlights the importance of the gendered perspective. The men and women with intellectual disabilities were engaged in becoming parents; however, they were developing fundamentally different identities. This notion has long been recognized by researchers engaged in gender studies (e.g., Oakley, 1979, 1980), but it has been under-explored by disability scholars. Men and women view and experience pregnancy and the postpartum very differently, and as a result their support needs may be quite different.

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There are three key points which we wish to draw from the experiences of the women in Australia and the men in Iceland. Gender underpins these points. The first point is about culture and social policy. It is important to recognize that these studies come from opposite sides of the globe. Cultural differences and in particular the social policies of each country account for some differences in the mothers' and fathers' experiences. The second point is that all the expectant mothers in Australia and the Icelandic expectant fathers were engaged in negotiating support for their families; however, they did so in a gendered way. The third point demonstrates a key difference in the expectations held by partners for the father's role compared with the practitioner perspective on the place of fathers in caring for the new baby.

Culture and policy

Social policies regarding child bearing and parenting vary considerably between Iceland and Australia. In Iceland fathers have a legislative entitlement to a minimum of three months independent paid parental leave (Ministry of Social Affairs, 2000). In Australia, although maternity leave is quite widespread, there is not a similar broad entitlement for fathers, although there are plans for such a scheme in the near future. Only mothers and fathers in the workforce currently have access to parental leave schemes sponsored by their employer (Productivity Commission, 2009).

Another example of cultural and policy variation between the two countries is found in the provision of antenatal care. The rate of infant death and prenatal mortality in Iceland is one of the lowest in the world (United Nations Development Program, 2008). This is believed to be due to a strong cultural tradition for women to attend antenatal care from the time they are 12 weeks pregnant. Fathers-to-be are encouraged to be full participants from the beginning of pregnancy and employers are sympathetic to fathers attending antenatal care with their partners. Antenatal classes form an integral part of this care and are designed for mothers and fathers. Although antenatal classes are optional, the majority of expectant parents attend and pay only a low fee to participate.

In Australia there are no comprehensive national guidelines regarding antenatal care, although this is recommended from the time a woman is 12 weeks pregnant (Hunt & Lumley, 2002). Antenatal classes are voluntary. Class sizes, program content, and access to classes vary widely, even within one geographical area. In some locations, particularly those where there is a greater concentration of disadvantaged families, antenatal classes are poorly attended (Sydney South West Area Health Service, 2008).

It is difficult to determine whether the participation in antenatal classes so highly regarded by the Icelandic fathers-to-be and less so by the Australian mothers-to-be is influenced more by cultural mores, social policy, or gender. The Icelandic men valued antenatal care and classes responding to the cultural

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tradition or “norm” that expectant parents, including fathers, engage in these activities. Similarly, the women in Australia also followed cultural norms that place less emphasis on antenatal classes. A major point is that in both countries, the men and women with intellectual disabilities acted within their own country’s cultural expectations for expectant parents.

Seeking support

Expectant mothers and fathers with intellectual disabilities reacted to the real or perceived risk of losing custody of their children. How they did this varied considerably. Australian mothers were concerned with garnering support from those closest to them. They wanted to ensure that there were others who would be engaged in caring for their child while still respecting their central role as the child’s mother. Icelandic fathers, on the other hand, acted to harness support for their parenting beyond their immediate family and friends, engaging the assistance of formal support services and advocates.

Llewellyn and McConnell (2002) conceptualized the support networks of mothers with intellectual disabilities as a series of concentric circles. In the innermost circle are those people to whom mothers feel closest: those without whom they could not imagine life. In the next circle are those people who are still very important but not as close as those in the innermost circle, with the outer layer typically being practitioners and health and social service agencies (Llewellyn & McConnell, 2002). In line with their findings, the expectant Australian mothers and Icelandic fathers operated across these circles in securing support for their families to counter the risk of losing custody of their soon-to-be-born child. Gender, however, determined the focus of the expectant parents’ efforts to gain support. Mothers turned to their immediate support network in the innermost circle. Fathers approached and secured the support of advocates and practitioners in the more distant or outer circle of support. The target of support seeking was gender related; the purpose of the strategies was unanimous in ensuring the support needed to care for the new arrival.

Contrasting expectations

That the Icelandic fathers were so involved with service agencies is highly significant given that the support workers from these agencies did not expect fathers to be involved in the pregnancy or the early care of the child and therefore largely ignored their needs. The key exception to this was the midwives at the antenatal care and antenatal classes. The midwives’ recognition of the father’s role and importance in both the pregnancy and birth made each father feel welcomed and that his questions were appreciated. Fathers believed that they had an important part to play in the family and the upbringing of their

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children, and the midwives' support of this strengthened their confidence in their fathering role.

After the babies were born, however, the Icelandic social services system did not expect the fathers to be involved in the "mothering business." Support workers recognized that mothers needed support with the caring and upbringing of their children but did not extend the same recognition to fathers, leaving the fathers feeling sidelined by professionals. In complete contrast, the partners of the Icelandic fathers, as new mothers, turned to their partners for support and wanted them to share responsibility in the care of their newborn child.

The support expectations of the Icelandic mothers with intellectual disabilities and the support workers are therefore quite different. The responses of the mothers are more aligned with contemporary societal expectations for fathers without disabilities in western cultures. This has the potential to cause problems in the working relationship between parents and support workers and in the parents' relationship. The failure of support services to recognize and support the involvement of fathers with intellectual disabilities in the raising of their children sends a conflicting message to fathers about what their role should be. Practitioners and policy makers need to consider the differences between the experiences of men and women who are becoming fathers and mothers, and in the roles they are trying to achieve. Public policies that encourage and support the involvement of fathers also need to be embraced by those providing support services to non-traditional families.

Gendered experience

Disability studies have only recently begun to consider issues of gender (Traustadóttir, 2006). Yet, as the two studies demonstrate, the experiences of men and women with intellectual disabilities becoming fathers and mothers are gendered. This gendered perspective presents a more nuanced understanding of parenthood for people with intellectual disabilities than that which is currently described in the literature. Continuing to subsume mothers and fathers under the term parents and failing to acknowledge the fundamental differences between becoming a mother and becoming a father will continue to negate the unique perspectives of women and men as they take on their parenting role.

Consideration of disability is also relatively new to gender studies. Studies of women becoming mothers have been criticized by feminist scholars with disabilities, such as Asch and Fine (1988), for failing to acknowledge their unique experiences of pregnancy and becoming a mother. As they note, it is unacceptable to assume that having a disability eclipses all other social experiences or to view all social experience through the lens of disability. The voices of women with intellectual disabilities have been largely absent from the debate on mothering (Mayes et al., 2006; Mayes et al., in press). Even less attention has been paid to the voices of men with intellectual disabilities in discussions of fatherhood.

Principles for Practice

The overwhelming focus of practitioners and researchers to date has been on parenting, although in reality this has meant mothers. We strongly recommend that both policy and practice place emphasis on mothers and fathers separately as well as jointly to make visible the gendered nature of parenting. Three practice principles follow from this. First, practitioners must take the time to understand the father's point of view, to value their strengths and abilities, and to support their contribution to their families. This requires practitioners to develop an effective co-working relationship with the father built on recognition of the important role that fathers play in the family. Second, depending on cultural mores and social norms, this may also include recognizing that the father regards himself as the head of his household. He may also be the parent whose role it is to negotiate support services for his family. Finally, practitioners must also recognize that for mothers, mothering also includes their partner or in the absence of a partner, another person with significant responsibility in the upbringing of their children.

The time has come for practitioners and policy makers who support mothers and fathers with intellectual disabilities to consider the influence of gender on each parent's role. Mother and father roles are not the same. The mother identity is not the same as the father identity. Women and men experience parenthood differently and, as a result, their support needs are quite different. Treating their support needs as identical or neglecting the needs of one parent makes the transition to parenthood more difficult for women and men with intellectual disabilities as individuals, as a couple, and for the whole family.

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