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article

Persistent stigma despite social change: experiences of stigma among single women who were pregnant or mothers in the Republic of Ireland 1996–2010

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'Single' women continue to experience stigma during pregnancy and mothering in the Republic of Ireland. This article explores the experiences of stigma of single women who were pregnant and mothering in Ireland between 1996 and 2010. The biographic narrative interpretive method (BNIM) was used to elicit biographical narratives. Analysis on both the lived experience of the women and the social context of the time created a 'situated subjectivity' in a sociocultural context. This article argues that despite large-scale positive social change before and during this period, single women's pregnancy and motherhood continued to be to be stigmatised in Ireland. Women experienced this stigma in their everyday interactions. They negotiated stigma in their personal and social lives, employing strategies that drew on material and symbolic resources available to them. Social class, ethnicity and time were among factors that mediate the experience, but can also intersected in particular social locations to create a more stigmatised identity.

key words gender • stigma • single motherhood • socio-biography • biographic narrative

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Introduction

Using the biographic narrative interpretive method (BNIM), this article explores the experiences of stigma for single women who became pregnant and mothers in Ireland between 1996 and 2010. This was a period of significant social change for Irish women, specifically in relation to social rights, reproductive rights and access to contraception and health services for women. The proportion of births occurring outside marriage increased dramatically, as Ireland moved from being one of the European countries with the lowest extramarital birth rate in 1980, at 5 per cent, to

join those with the highest rates by 2000, at 32 per cent (Hannan, 2008). Ireland is a patriarchal society built on familist ideologies; the 1937 Constitution gives protection to the traditional marital family defined by a breadwinner 'husband' and a full-time 'housewife' with home duties (O'Connor, 2000). Until the late 20th century, many unmarried pregnant women, especially those from lower social classes and rural backgrounds, were interned in religious institutions.

Historically, Ireland placed severe restrictions on women's access to reproductive rights by limiting the sale and use of contraceptives, and the provision of literature about contraception as well as a constitutional ban on abortion. The liberalisation of contraception was slow, spanning 1978 to 2011. The Health (Family Planning) Bill 1978 legalised the sale of contraceptives for bona fide family planning, or on medical grounds, prescribed by a doctor and dispensed by a pharmacist. Since 2011, the emergency contraceptive pill can be bought in a pharmacy without a prescription. Abortion in Ireland remains socially and politically divisive and the focus of public debate and referenda since the 1980s (Smyth, 2005). Until 2019, the option to travel to Britain was available to women but travel was expensive. The uptake of abortion by Irish women in Britain peaked in 2001, with 6,673 women attending clinics giving Irish addresses, 80 per cent of whom identified as 'single' (Clements and Ingham, 2007:26). In 1983, the referendum on the Eighth Amendment of the Constitution was passed (33 per cent to 67 per cent). The amendment upheld the mother and child's life equally. It remained in place until 2018 when it was repealed by 66.4 per cent to 33.6 per cent. Abortion services are currently being rolled out. The period studied also bore witness to several court cases, which highlighted the impact of restrictive healthcare and private stories of medical terminations for health and personal reasons[1] (see Smyth, 2005).

Welfare developments brought support in 1973 with the 'social assistance allowance for unmarried mothers'.[2] Support of this nature had been granted to 'widows' in 1935 and 'deserted wives' in 1970 (DSFA, 2006: 57). In 1990, differentiated payments were consolidated into the Lone Parent's Allowance. There was no longer differentiation based on marital status or gender and prejudicial terms associated with certain categories were removed from the social protection code. In 1997, the name changed to the One-Parent Family Payment, again reflecting a societal shift in the discourse regarding one-parent households (Crosse and Millar, 2015; Bradley, 2017). These changes in statutory nomenclature represent changes in social views as well as considerable campaign work by advocacy organisations such as Cherish[3] and Treoir.[4] Despite these significant changes, single women as mothers have continued to carry the potential of stigmatisation and the real experience of marginalisation (Bradley, 2017; Millar and Crosse, 2018). In the media and in policy-making, the 'single mother' is framed as 'problematic'; she is characterised as welfare dependent with no means of becoming self-sufficient. Current representations of 'single motherhood' focus on the costs to society of limited employment prospects and welfare dependency. While family demographics and morality norms may have changed in Irish society in recent years, the discourse surrounding the drain on collective resources by those parenting alone has not disappeared and is keenly felt by 'one-parent families' headed by women (Millar et al, 2007; 2012; Bradley, 2017; Millar and Crosse, 2018; Kelly and Millar, 2019). One-parent families are the most marginalised and deprived family form in Ireland. In 2016, those living in households with one adult and one or more children aged under 18 had the highest deprivation rate at 50.1 per cent and the highest consistent

poverty rate at 24.6 per cent compared with 6.4 per cent for two-parent households. The 'at risk of poverty' rate for this family form was 40.2 per cent, compared with 12 per cent for two-parent households. Lone parents are almost 3.5 times as likely to be at risk of poverty compared with households with two parents (CSO, 2017).

Using BNIM, we explore single mothers' experiences of stigma during pregnancy and motherhood in Ireland between 1996 and 2010. Drawing on the concept of stigma developed by Goffman, we explore the lived experiences of women and produce an analysis of 'situated subjectivity' in a sociocultural context. Despite the positive social development and policy changes that have taken place in Ireland up to and throughout this period, single-women's pregnancy and motherhood are still stigmatised in their interactions with the state and in their daily social interactions. Women negotiate stigma by using strategies that draw on the material and symbolic resources available to them in their social location. In this article, we highlight factors which alleviated the stigmatised experiences of single women, and how stigma was felt in some social locations in modern Ireland, and not in others.

The concept of stigma

Goffman (1963: 4) defined stigma as a relationship between an individual and a social setting with a given set of expectations. Goffman argues that information about social status is passed through signs and symbols in everyday life. Symbols can be 'prestige' or 'status symbols' or 'stigma symbols' (1963: 43) which 'expose something unusual or bad about the moral status of the signifier' (1963: 11). Goffman distinguished between stigmatised persons who are 'discredited' – where the stigmatised person assumes that her difference is immediately perceptible, and 'discreditable' – where the person's stigma is not known to the observer, or perceivable by her, and management of information is central.

Goffman describes several responses to stigma by the stigmatised. They can attempt to hide the source and 'pass off' as normal; they can claim the stigma is temporary (Goffman, 1963: 4). They can compensate for their stigma by emphasising another attribute. They can refuse to accept norms and reassess the social limitations placed on them (1963: 10–1, 73–6). Goffman uses the term 'moral career' (1963: 32) to describe the socialisation process of the stigmatised who learn about their discreditable attribute and difference and the consequences for them as stigmatised. This first socialisation usually happens in childhood. A second socialisation happens when the stigmatised achieves their discredited status. Goffman (1963: 28) describes 'the wise … whose special situation has made them intimately privy to the secret life of the stigmatized individual and sympathetic with it'. Presence of the wise alleviates the experience of stigma.

Goffman understood stigma as a product of the social sphere and a reflection of societal values. Later theorists developed a macro understanding.

> Individuals do not come to social interaction devoid of affect, values and motivation; and, they exist in larger political, cultural and social contexts which shape their expectations on all these issues. (Pescosolido et al, 2008: 432–5)

Stigma is a central component to reproducing structures of social control and inequality (Link and Phelan, 2001; 2006;Yang et al, 2007; Pescosolido et al, 2008).

Link and Phelan (2001) proposed a comprehensive theory of stigma. First, differences between the stigmatised groups and the 'normals' were identified and labelled. Second, these labelled differences were linked to stereotypes. Third, those with labelled differences were placed in distinctive groups, creating a sense of disconnection between 'us' and 'them'. Fourth, labelled groups experienced 'status loss and discrimination' that led to unequal opportunities and outcomes. This model recognises 'stigma as processual and created by structural power' (Yang et al, 2007: 1524) with the corresponding structural discrimination (Link and Phelan, 2006).

Link and Phelan argue the extent of effects of stigma is entirely dependent on social, economic and political power. That which a society values has power and that which it does not value can be become stigmatised. Power differences between people in the social structure can affect how they negotiate stigma; in other words, the ability to access power in different dimensions of their lives affects their experiences of stigma. Link and Phelan (2001: 363) note that 'the role of power in stigma is frequently overlooked because in many instances, power differences are so taken for granted' they are not problematised. Link and Phelan (2001) highlight that groups with and without power, label and form stereotypes about others, but this only becomes 'stigma' when sufficient power is involved to subvert the life chances of the less powerful group.

Link and Phelan (2001: 375) argue that cultural stereotypes can affect a person's world view and become internalised stigma: 'The extent that stigmatized groups accept the dominant view of their lower status', determines how likely they are to 'challenge structural forms of discrimination that block opportunities they desire'. This study examines stigma as a contextual and transactional process that is constructed in and through social relationships, to develop an understanding of how stigma is experienced by single women who are pregnant or mothers in Ireland.

Methodology

We explored the experiences of single women who became pregnant and mothers in Ireland in the period 1996–2010 and asked what we now know about 'single' 'unmarried' reproduction in Ireland and what can this tell us about Irish society and policy. Ethical approval was granted by NUI Galway's Research Ethics Committee. The research adhered to the ethical guidelines of the Sociological Association of Ireland. Careful steps were taken in this research to ensure the anonymity and confidentiality of the research participants. The women who participated were given pseudonyms and personal identifiers that were not significant to the interpretation and analysis of the narratives were changed. No geographical locations were identified. The voice and informed participation of each woman was prioritised. A full and sincere process of informed consent was taken in advance of interviews; the women were informed about the nature of the research, what to expect at each stage of the process and what the research would be used for. The preliminary analysis was discussed with each woman. This process was revisited several times during the research with sincerity and women who decided to no longer participate were fully supported and their decision respected.

BNIM was the methodological framework utilised. Biographic narrative recognises that humans live interconnected storied lives. It captures 'the particularity and lived

texture' of our lives, while also defining aspects of them which can be seen as 'typical of a particular social context and history' (Chamberlayne and Rustin, 1999: 44). Biographic narrative also reveals cultural narratives, which shape our stories as we construct our stories from and to others around us, with narratives available to us in our immediate social structures. BNIM requires two rounds of sampling – first, potential interviewees are selected from the research population. Inclusion criteria were single women who were not married when they gave birth and who subsequently parented alone in Ireland during the period 1996–2010. Due to the methodological approach, a small number of participants would ultimately be selected for interview and fewer for analysis. To manage the expectations of potential participants in the recruitment process, and on the advice of the ethics committee we took a selective approach. Rather than advertising widely, we approached community-based development projects in urban and rural settings and asked project workers to pass on information to people who fitted the inclusion criteria. Babies born between 1996 and 2005 was a criterion, as we were interested in women who had been parenting for a number of years. Six participants were recruited through this process and six through snowballing.

Second-round sampling was used to select the 'cases'[5] for analysis. In line with the principles of BNIM, from the 12 in-depth interviews that were undertaken, the case that was richest in its potential to respond to the central research question was chosen first: this was the case of Mary as it was rich in narrative and had detailed examples of stigmatising interactions. Next a contrasting case that appeared to be the 'most' dissimilar – in terms of interviewee characteristics and how her experience unfolded – was chosen. This was the case of Brigid: her social class, ethnicity, age, geographical location and how she became pregnant differed from Mary whose story of pregnancy and motherhood was different in almost every way. Next was the analysis of a 'tangential case', which appeared to have 'nothing to do with the main thematics of contrast identified in the first two cases' (Wengraf, 2012: 575). The case that was chosen here was Patricia; her relationship was more stable at the time of pregnancy, her age and her life experience to date made her story tangential in relation to the main theme which emerged in the first two.

A single question 'used to induce narrative' was asked of participants to elicit biographical narratives of 'single pregnancy and motherhood'. Simply, 'Can you please tell me your story'.[6] This created space for the participant to tell her own story with her own 'systems of relevance' (Wengraf, 2001). During the first part, the interviewer took note of key points and key phrases. When the interviewee finished unprompted, we stopped. After a short interlude, using the specific language of the interviewee, the interviewer asked questions about aspects of the story, seeking more detailed 'particular incident narratives' (Wengraf, 2001). The central research question was set aside with emphasis placed on these 'particular incident narratives', which aimed to take the interviewee back to the place and time of her experience, for a rich, contextualised narrative. Following these in-depth interviews, the complete interaction was transcribed verbatim with detailed notes on the interview.

Analysis using the BNIM was four-fold.

- First, biographic details were extracted from the transcript (birth dates, key events and so on) and analysed separately.
- Second, the way the story was told was analysed using the BNIM.
- Third, the experience was painstakingly situated in its historical context.

- Finally, an analysis of the 'case' incorporating the first three analyses was then undertaken. This produced an analysis of the 'situated subjectivity' in a cultural-historical context 'exploring subjective and cultural formations' and 'tracing interconnections between the personal and the social' (Chamberlayne and King, 2000: 9) in keeping with a feminist approach, to 'make visible' these 'aspects of women's lives' (Byrne and Leonard, 1997 : 1).

A 'four foci thinking device' based on each constituent part was devised for analysis of the whole case to create a reconstruction contextualised in the social history of the time. As BNIM research is concerned with space, time and sociality incorporating this sociohistorical material provided context to the stories and cultural narratives implicit within them and highlighted the structural causes of stigma in the experiences of the women. When the case account for each was completed, the cases were brought together and compared.

Findings

There is no one experience of being a 'single mother' in Ireland, but the experience of inequality and discrimination is evident in the stories of pregnancy and motherhood told by the women in this study. Stigma provides a lens that illuminates a deeper understanding of forces that affect the experience of pregnancy and motherhood for single women. This section introduces each of the cases analysed and locates the women and their stories in their social context. It describes the stigma experienced in their interactions with others and with institutions. It presents the strategies they used to manage stigma, which also exposed the stigma at play. This is followed by a discussion of the key cultural and social processes that created conditions for, and maintained, stigma for these women.

Mary was born into a rural farming community in 1962, when Ireland was an agrarian, Catholic society (CSO, 1961). When she became pregnant, she was living in a large town and worked as a secondary school teacher. Pregnant at 34, Mary was not a typical Irish single pregnant woman or first-time mother. In 1996, Mary was six years older than the average first-time mother and nine years older than the average age for an 'unmarried' mother (CSO, 1996; Punch, 2007: 194). Mary's 'unmarried' pregnancy is a story of major biographical disruption, which frames how she conceptualised her pregnancy. However, her life circumstances also provided material and symbolic resources to implement the strategies she used to deal with the stigma she faced.

Ireland is a small country and until the late 20th century had a relatively homogeneous population. In rural Ireland then, and today, it is easy to meet people you know or who know you, in your local area and even further afield. Families and neighbours often live in close-knit communities that are deeply involved in each other's lives. Gossip and intrusiveness were and are mechanisms of social control (Inglis, 1998). Growing up with this experience, Mary knew intimately how people in her rural hometown would treat her if they knew about her pregnancy. She experienced the constant threat of stigma during her pregnancy and chose to conceal her pregnancy for this reason. She also experienced stigma in every one of the limited number of interactions she had with others concerning her pregnancy.

The first person she told of her pregnancy, a cousin and friend, reacted negatively. "So, I said, well, this … I can't say this ever." Mary's doctor treated her "like somebody

in their teenage years" and he made her attend an unplanned pregnancy support service. He falsely told her that "I mightn't be allowed into the hospital" because she was 'unmarried'. She also had stigmatising interactions with institutions of the state regarding her maternity benefit and social protection payments, which she was entitled to as a lone parent. Mary felt anger and resentment about these stigmatising experiences. She addressed issues when they arose but her overall strategy was to avoid such interactions where she could by concealing her pregnancy.

Mary was also concerned about the reaction to her pregnancy at work. Most schools, although state funded, were separate entities predominantly under Catholic patronage, with their own ethos. As such, teachers were required to adhere to this ethos and could be dismissed for living or acting overtly against it (for example, by being unmarried and pregnant, separated or gay). In 1996, it was 14 years since Eileen Flynn[7] had lost her job and 11 years after losing her appeal to the high court. Referring to this issue, Mary said, "I didn't want to put the principal in the position." Similarly, in relation to her mother, "I wanted to protect her from society because we're from … it's out in a rural area."

Mary used three strategies to deal with the threat of stigma, and the real stigma she experienced. First, she actively concealed her pregnancy for a significant period from her family, and more persistently from her work colleagues and wider social network, wearing loose-fitting dark clothes, lying about why she was ill, spending less time with family and friends, more time alone, and travelling to another city for hospital appointments to make sure she did not meet anyone she knew. Second, as she came to terms with her pregnancy, she constructed a narrative of self-differentiation from other 'single mothers'. After the birth of her son, Mary returned to work and came to self-identify as a 'working mother' rather than a 'single mother'. Mary's ability to separate her private and public life through her employment and to provide for her family independently facilitated this and correspondingly the daily stigma she experienced decreased. The stigma from her pregnancy stayed with her, however and was evident in her story.

Brigid was born in 1987 in Ireland and is a member of the Irish Traveller community. Representing less than 1 per cent of the population, Irish Travellers are a minority ethnic group, maintaining a shared history, language, traditions and culture (DTEDG, 1992; O'Connell, 1996). Travellers are one of the most marginalised and disadvantaged groups in Irish society and experience extreme racism and discrimination. Travellers fare poorly on every indicator used to measure disadvantage: unemployment, poverty, health status, infant mortality, life expectancy, literacy, education, political representation, gender equality, access to credit, accommodation and general living conditions (AITHS, 2010).

Brigid left school early and had a relationship with and became pregnant with her cousin who lived next door. Consanguineous marriages are common among Irish Travellers. It is estimated that between 20 and 40 per cent of all Traveller marriages in 2003 were consanguineous (Pavee Point, 2005). In the absence of disaggregated data on the basis of ethnicity, exact figures are not available. Brigid's family were against the relationship. With the aim of consolidating her relationship and with the hope of marriage, she became pregnant at the age of 16. Often Traveller families would encourage marriage in the case of pregnancy outside marriage, but her family wanted her to have an abortion and when she refused, they tried to induce one. Brigid stated

that she didn't agree with abortion except in cases of rape, where the mother's life is endangered, or in the case of a fatal foetal abnormality.

Three years earlier in 1997, there was a high profile case involving a 13-year-old Traveller girl who was taken into state care following a report by her parent's that she had been raped. The girl's parents reported the rape and she was taken into state care. The state sought assistance from the court to bring Miss C to England for a termination in accordance with her wishes (Bacik, 2013). Her parents, who had previously supported her decision, changed their minds and appealed to the high court for an injunction to prohibit travel. Such cases were divisive but brought the complex issues surrounding abortion into the public consciousness and provided a platform for discussion about these issues.

Brigid's relationship broke down and she became the only single mother in her community – "I'm the first" – experiencing a lot of stigma. Unlike Mary, this stigma continued and grew. Brigid told a story of surveillance and social control. Other families treated her and her child unfairly. She felt people were looking down on her and watching her. Referring to her community on 'the hill', a community segregated from the wider 'settled' community she described a further marginalisation and isolation: "Everyone on top of the hill is looking to see how I'm managing and what way he's kept …" To survive, she conformed to traditional patriarchal narratives of family and motherhood, to protect her and her son's future: "Because it was my fault, it wasn't the baby's fault."

Brigid used two strategies to deal with the stigma of her pregnancy and motherhood in her community. First, she used survival tactics to protect herself and her unborn child, by running away from her family during her early pregnancy. Second, while breaking new ground by living as a single mother ("It's not one of them things that happens on the hill") she also carefully and self-consciously observed and conformed to all other cultural and social rules and practices expected of a woman in her community by keeping to herself, parenting her child in the expected manner, not having relationships and not drinking alcohol. Like Mary, Brigid described several incidences where she felt a lot of anger and frustration at the unfairness of her situation where people in her community judged her and her child. She chose to keep her head down as a better survival strategy which allowed her to resist the norms by living in the community with a child outside marriage, while remaining therein. Nevertheless, the stigma she experienced persisted in her daily life.

Patricia was born in 1972 in the West of Ireland into a working-class family. She completed second-level education and began working in retail. Patricia became pregnant at age 19 in 1991. Supported by her family, she travelled to England to have an abortion. She worked hard over the following 15 years, sometimes two jobs simultaneously. In 2007, she bought her own home alone. Patricia became pregnant again in 2008 when she was in a relationship with a man who was an alcoholic. She experienced mental and emotional abuse in the relationship and her relationships with others suffered as a result. She felt she parented alone during the relationship because of her partner's addiction. On ending the relationship, she went to a women's refuge where she received support before applying for a safety order,[8] which was unsuccessful. Later she viewed this as a positive thing as she could more easily facilitate a relationship between her son and his father than if there was a safety order.

Patricia shared the characteristics of a 'typical' lone mother in 2010. She was in the 35–49 age group, like 35 per cent of lone mothers at that time and was single, like 44

per cent of lone mothers. An exploration of the social interactions in Patricia's case reveal a lot had changed in Ireland by 2010. She didn't overtly experience stigma in her daily interactions with her family or in her community. Unlike Mary who gave birth in 1996 and Brigid, a Traveller, she was not alone in her social circle. By 2010, one-parent families made up more than 20% of the proportion of Irish families (CSO, 2011). .

However, like Mary and Brigid, Patricia bore full responsibility for parenting her child. She struggled to maintain employment and cope financially without any financial support from the child's father. Where necessary she engaged with the state for support in the form of social protection. She lived in relative poverty and felt stigma because of this, as well as bearing responsibility for facilitating a relationship between her son and his father. Of this she says, "I'm not that bad." There is a distinct lack of effective legal or policy mechanisms to enforce the responsibility of her son's father, either in terms of parenting or financially. To access the One-Parent Family social protection payment, applicants need to show they have pursued maintenance from the other parent which means parents have to go to court to achieve a maintenance payment. The state has been challenged on this consistently by advocacy groups such as One Family and Treoir. Most recently, the Committee for the Elimination of Discrimination Against Women expressed concern that, 'there is no statutory maintenance authority and no amounts are prescribed by legislation, which compels women into litigation to seek maintenance orders' (CEDAW, 2017: 15). Patricia expressed her frustration at the system and how it placed full responsibility on her as the mother and the assumed primary carer for her child while it neglected to place responsibility on her child's other parent.

Experience of stigma

The women knew about the discredited status of 'single' pregnancy before becoming pregnant and experienced fear of stigmatisation immediately when they learnt of their pregnancies. Goffman (1963: 32) uses the term 'moral career' to describe the two-pronged socialisation process in relation to stigma: social norms in relation to 'single' pregnancy and motherhood were learned from a young age in family, school and social networks, and when one became part of a stigmatised group, a further socialisation process took place (1963: 34). The reaction of others spoiled the 'normal identity' of the stigmatised person, when they become aware they are different and cannot be the same; this causes them to feel shame which can lead to self-hate and self-degradation (1963: 7). Evidence of this is contained in these women's stories where they describe the interactions with others where they felt stigma.

Goffman (1963) describes the process of how information about a social status was passed on through signs and symbols in everyday life. He refers to stigmatising signs as 'stigma symbols' – that is, signs that are particularly effective in drawing attention to a contaminating aspect of identity, and that lead to the devaluation of the individual. The physical appearance of the body transmitted socially charged messages about their status. To those who knew they weren't married, the physical appearance would be important, but the absence of a wedding ring on the finger of a pregnant woman would have transmitted even stronger socially charged messages.

Growing up in a small community, and living in a city as a teacher, created conditions for Mary to be stigmatised, as her personal life and marital status were known to those

around her. The lack of matrimony as a symbol of acceptable motherhood betrayed her status to those who did not know her. For Mary, the fear of stigma was so great that she refused to acknowledge her pregnancy for 13 weeks. Later, she concealed her pregnancy from family and friends for several months. Mary had negative interactions with many people during her pregnancy. She described going to her doctor. Based on his knowledge that she was single, he told her that she might not receive medical care in a hospital. He suggested that she would not be able to cope because of this and recommended that she have her baby adopted. Mary also had negative interactions with the clerk in the 'employment exchange' regarding maternity benefit and with another about her social protection application. While her family were materially supportive, they made comments about the shame she brought on them because of her pregnancy.

Mary felt that she should be less stigmatised because she was older (aged 34) at the time of pregnancy. Hyde (2000) noted that young age of the single mother heightened the experience of stigma. However, contrary to Hyde's finding, Mary experienced her age as stigmatising, feeling that it was perceived that she 'should have known better'. The pregnancy was a temporary state, for Mary; this meant that her experience of stigma was time limited. Brigid, on the other hand, was very young at the time of her pregnancy. Interestingly, membership of her community was a protective factor regarding age, because many Traveller women of her age were pregnant. In her case, the physical appearance of pregnancy was less of an issue, as she had age in common with her peers, but the absence of a wedding ring certainly was more stigmatising. Link and Phelan (2006) describe three different forms of discrimination emerging from stigma. The first 'direct discrimination' is where the stigmatised person is directly discriminated against. The accounts of Mary and Brigid contain detailed descriptions of such discrimination. Changing family norms in Ireland by the late 2000s and Patricia's social network, contributed to a lessening of stigma in her circumstances. The presence of 'the wise' – that is, those individuals in her life who do not subscribe to the values that create the stigma she faces (Goffman, 1963) in her social network mean that stigma was not felt by Patricia in her immediate social circle. Some of her friends were co-parenting inside and outside relationships, while others were parenting alone, which shielded her from the experience of direct stigma.

A further form of discrimination occurs when stigmatised individuals realise that a negative label has been applied to them. They also internalise the stigma they experience, which creates another layer of stigma. They can experience uncomfortable social interactions, constricted social networks, compromised quality of life, low self-esteem and depressive symptoms. They are also 'less likely to challenge structural forms of discrimination that block opportunities' (Link and Phelan, 2001: 375). As the particular stigma experienced by a participant was 'achieved' rather than 'ascribed' stigma (Falk, 2001) this also contributed to their self-stigma. Stigma comes from the direct actions of the participant – they had sexual relations while not married and became pregnant as a result. Their 'achieved' status is gendered, 'blame' is achieved by the mother, but not the father. This was not problematised by any of the participants. Mary concealed her pregnancy and expected little by way of support; she explained away her experiences with her family, her social network and societal institutions because she self-stigmatised and perhaps felt she deserved the treatment she got: "It's probably the way I would have been, had it not happened to me." Brigid blamed herself for her pregnancy and accepts full responsibility: "I did it." She did, however,

admit that her son's father also bore responsibility. Brigid conformed to all social restrictions placed on her by her community and accepted these as conditions of her continued participation in the community. Like Mary, she self-stigmatised and accepted her fate in her community. Patricia facilitated the man who abused her to visit his son, believing it was her responsibility to do so.

Link and Phelan (2006: 528) also identify a 'structural discrimination' whereby the power associated by being part of the majority benefits some groups and disadvantages others. All three experienced structural stigma where they were disadvantaged by being 'unmarried' at the time of pregnancy and motherhood, and their families lacked the legal protection afforded to marital families. They struggled financially, experienced stigma in their interaction with health and social services, bore full responsibility for parenting and for managing the relationship between their child and their other parent.

Negotiating stigma

The women used several strategies to physically and psychologically negotiate stigma; they avoided stigmatising situations; they attempted to 'pass as normal' by managing their information carefully and using prestige symbols; they self-differentiated themselves to others bearing the same stigma; and they compensated for stigma in other areas of their lives. The strategy most readily available to stigmatised pregnant women is to physically hide the source of stigma through avoidance of situations where they may be stigmatised. Both Mary and Brigid described how they deliberately avoided face-to-face encounters with those who might present negative versions of their pregnancies.

Another strategy is to attempt to pass as normal by managing the information shared in social interaction. Visibility of the stigma affects the ability to pass as 'normal', which depends on perceptibility and knowledge of the audience (Goffman, 1963). Mary was clearly aware of her stigmatised identity and kept her information as much as possible to herself. Mary acknowledged her pregnancy, but successfully concealed her pregnancy and 'managed' who had information about the stigma. This demonstrates the level of stigma Mary felt at a personal level in her immediate relationships, at a cultural level in relation to what had happened to others (Eileen Flynn), and at a structural level in terms of job security and challenges to her ability to access social protection support.

The women also used 'prestige symbols' to ameliorate stigma (Goffman, 1963: 43). These include a house, in the case of Mary and Patricia, and education and a job in the case of Mary. In Brigid's case, she used her self-imposed chastity and lifestyle as a symbol of 'goodness' as a woman in her community to ameliorate some of the stigma of her pregnancy and motherhood. According to Goffman, those who are stigmatised learn to manage various degrees of passing as 'normal', from occasional to permanent. However, this can lead to the individual suffering permanent anxiety that they are not passing effectively. Mary certainly communicated this anxiety during her interview, by speaking in hushed tones. Despite her ability to separate public and private and 'pass' in the motherhood state, the experience of pregnancy was so stigmatising for her that she still internally experienced the feelings associated with this. For Brigid, this was impossible; she was in a less powerful position regarding her information. Brigid lived in the same small community she grew up in; she was known to all there and could not conceal her private life. Public and private were one and the

same for her. She had little control in the management of her personal information in this context. She did not have an opportunity through work or otherwise to have another identity separate from that as mother.

A strategy used by the women to psychologically deal with the stigma they experienced was by comparing themselves to others who were stigmatised in the same way. Goffman argues that stigmatised persons tended to display a separation from more evidently stigmatised people within the same broad category. They adopted attitudes close to those of 'normals' regarding individuals obviously more stigmatised than themselves. Goffman (1963: 163) notes that stigma is 'a pervasive two-role social process in which every individual participates in both roles'. On one hand, she felt aggrieved by how she was treated and believed she should have been treated better. On the otherhand, she highlighted her social status, her education and profession and stratified herself as being different from other 'single mothers'.

Another strategy that the stigmatised use to ameliorate the stigma they feel is to make special efforts to 'compensate' for their stigma (Goffman, 1963). We can see evidence in all cases of this. Mary did this by accentuating her difference (self-differentiation) from other single mothers, highlighting the importance of her age, education, employment status and social class. Brigid attempted to compensate for her transgression through conformity to other social expectations in her community, which is borne out of her concern that her child might also be stigmatised in the community and unable to marry; her actions re thus an attempt to redeem his status. She sought to distance herself from the stereotype of a 'loose' woman, believing that her remaining in the community is contingent on good behaviour and management of herself sexually. Brigid did this by conforming to the norms of the 'ideal' woman in her community in every other way; she wanted to be a 'good' mother, which necessitates not having sexual relationships, not drinking, not smoking and raising her child 'correctly'; this is evident in Brigid's acceptance of the rigid rules of living applied to her in her community as a woman and mother. While all three women felt frustration, anger and resentment, they chose to express more controlled emotions to protect themselves and their children while managing the felt stigma and the negative situations they experienced.

Discussion

The questions remain: what can we now know about 'single' 'unmarried' reproduction in Ireland, and what can we learn about Irish society and social policy from this? Simply put, despite a change in societal attitudes to single-women's pregnancy, as reflected in the removal of prejudicial terms from the social protection code, and the liberalisation of contraception which brought some limited improvement to women's reproductive rights between 1996 and 2010, single-women's pregnancy and motherhood continue to be stigmatised during this period. Stigma expresses the gendered cultural hegemony in relation to reproduction and family formation and continues to create conditions for inequality for 'single mothers' both socially and structurally in Ireland.

We describe how stigma is experienced and negotiated by 'single-mothers' through social interactions. The three women in this study have experienced stigma differently in relation to pregnancy and motherhood. For Mary, the stigma of her unmarried pregnancy was the main issue and she managed her situation more easily when

she could manage her identity as a working mother. For Brigid and Patricia, both pregnancy and lone parenthood were more difficult primarily because of their class (and ethnicity in the case of Brigid) and weaker position educationally and in relation to employment opportunities. These findings resonate with the study of Hyde (2000), where she found that age and partnership were mediating factors in the stigma still persistently felt by young 'single mothers'. Social interactions take place in a context in which larger cultures structure normative expectations, that create the space which facilitates stigma (Pescosolido et al, 2008). The women's stories reveal the cultural narratives of 'single motherhood' in Ireland and the material effects of these.

The women's stories feature a narrative of resistance to the moral patriarchal hegemony and narratives of social change. Despite the perceived and felt stigma and repercussions in terms of inequality in social outcomes, for themselves and for their children, the women, by their life choices in relation to their pregnancy and motherhood and through the construction of their narratives, are actively engaged in disrupting hegemonic ideals of maternity. They are part of a change in Irish society, which has moved the position of women giving birth outside marriage, from a small minority, to a common family form. Despite stigma, these women are redefining what constitutes family in Ireland and challenging traditional familist ideologies.

Irish social policy throughout the 20th century was characterised by themes of Catholicism, traditionalism, patriarchy, familism and heterosexuality. Social policy and legal frameworks may have shifted, but the core social category that has underpinned each of these has been a woman's legal relationship to a man. Based on gender inequality, the stigma of single motherhood is legitimised and enabled both by the state's action and non-action. We can see in the Constitution, the legal and cultural primacy afforded to the institution of marriage and the prescriptive nature of reproduction in Ireland. According to Byrne (2000: 32), 'institutions … are both the product of and producer of the social'. The historical esteem and legal priority with which the institution of marriage is held frames the stigmatisation of single women who are mothers. Constitutional protection for the nuclear family facilitates a social policy that generates inequality. Byrne (2000) argues that marital status has always been of vital significance to motherhood in Ireland and is intrinsically linked to a cultural ideal of being a 'good' woman. This is out of kilter with the reality of family formation in Ireland in 2020, but it remains unaltered.

The social characteristics of the women in this study could not have been more different, but an analysis of their stories reveal the dominant ideologies of reproduction in Ireland. Women's reproductive bodies have been the sites of social and political controversy throughout the life of the Irish state. This is evident in the ongoing debate on reproductive rights, at the core of which lie the definitions of morality that give shape to normative ideals of female sexuality, fertility and maternity (Smyth, 2005). Maternity and family are two areas where women experience inequality in social policy. The male breadwinner model, for which the state acts as a substitute for single unmarried mothers, creates and perpetuates inequality. In contrast, men's non-marital sexuality or fertility is not problematised in Irish policy. There are no statutory or social expectations for maintenance or care from the non-custodial parent, which in Ireland is most often the father. The life experience of this inequality is borne out in the experiences of Mary, Brigid and Patricia and other non-married mothers in Ireland.

Conclusion

We argue that widespread stigma towards single mothers still exists in Ireland, affecting women across different socioeconomic contexts and socio-locations. Single women's experiences of pregnancy and motherhood is located within the fabric of the social milieu they inhabit temporally and structurally. The stigma of 'single' pregnancy and motherhood are felt more deeply in some parts of society than in others. Stigma is reproduced in the cultural realm through the subscription to value systems which define hegemonic femininity, prioritise families based on heterosexual marriage and prescribed gendered family roles. In this study all participants struggled with personal and cultural values that prioritise a two-parent family based on marriage. Mary wrestled with the disruption to the life she expected, especially throughout her pregnancy, Brigid suffered the consequences in her community every day and sacrifices herself to try and improve her situation, Patricia struggled with finances and the responsibility of the relationship between her son and his father. At a personal level, stigma occurs most severely where there is significant difference in the immediate social network of the individual, Mary was alone in her social network as a single mother, whereas Patricia had many friends in the same position as her, exemplifying Goffman's reference to 'the wise'. When the value system which underpins stigma is subscribed to by the stigmatised, she internalises oppression and self-stigmatises. Women negotiate stigma they face in personal, cultural and social levels of their lives, drawing on material and symbolic resources where they can. Mediating factors include age, social class, education, ethnicity, access to employment and other resources. This was evident in how Mary managed to negotiate and even ameliorate her stigma when she could access the identity of 'working mother'. Neither Brigid nor Patricia were so lucky.

Stigma is the key social mechanism that allows inequality to be created and perpetuated for these women. The analysis reveals that stigma has a functional dimension in Irish society attempting to preserve the nuclear family as the fabric of society, an aspiration set out in the Constitution and under threat by demographic and social changes, of which these women and their choices are a part.

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Notes

[1] For further information on the events during this period please also refer to: https://www.ifpa.ie/advocacy/abortion-in-ireland-legal-timeline/

[2] For more information on the experience of unmarried mothers prior to this period please refer to Luddy, M. (2011)

[3] Cherish (now known as One Family) was the first support and advocacy organisation in Ireland for single-parent families. Established in 1972 by a group of single mothers 'to provide such women and children with a voice' (One Family, n.d.) and campaign for change.

[4] Treoir was formed 1976 as a federation of various agencies working with unmarried parents to channel efforts to improve the quality of the services provided to unmarried parents and their children. Treoir is committed to ensure that families not based on marriage are recognised, respected and protected.

[5] In BNIM, a case refers to the story in the interview and the processing of the four foci analysis described below.

[6] Can you please tell me your story, all those events and experiences that were important for you personally? I'll listen first, I won't interrupt. I'll just take some notes in case I have any questions for you after you've finished. Please take your time. Please begin wherever you like and finish wherever/whenever you like' (Wengraf, 2001: 122)

[7] Eileen Flynn was a schoolteacher who was dismissed in 1982 for becoming pregnant and cohabiting with a married man. In 1985, the high court ruled this did not constitute unfair dismissal.

[8] This is an order of the court which prohibits the violent person from further violence or threats of violence. It does not oblige the person to leave the family home. If the person is not living with you it prohibits them from watching or being near your home. It can last up to five years.

Conflict of interest

The authors declare that there is no conflict of interest.

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