

Resisting and constructing the good mother ideal: negotiation and knowledge in interactions between mothers and child health nurses.

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Abstract

In this paper we analyse mothers' and child health nurses' negotiations around conformity and resistance to the dominant discourse of the good mother, with a specific focus on the use of knowledge and authority in interaction. We draw upon data generated through 12 observations of consultations between child health nurses and low-income mothers and fathers, 12 interviews with child health nurses and 13 interviews with low-income mothers. Many interactions affirmed the importance of following expert knowledge, but we also find evidence of resistance by mothers, who privilege their experiential knowledge over medical knowledge. This resistance de-stabilises expert knowledge without re-constituting the good mother discourse.

Key words: the good mother, child health nurses, authority, resistance

Introduction

The good mother is a defining element of contemporary parenting but possibilities for resistance remain understudied. In this paper we argue that the good mother is a discourse that is dominant but contested. It can be destabilized through alternative configurations of power/knowledge that are available to mothers through their care practices and dispositions, and used in interactions with child health nurses¹ to affirm, negotiate and contest good mothering.

The discourse of the good mother generates a series of rules for good behaviour that charge women with the practical and moral responsibility for their children's wellbeing. This is a time, resource and knowledge intensive process: mothers manage their children's environments, consumption and activities and closely survey their children for signs of illness or non-normative development (Lupton 2011), and in doing so, also manage their own behaviour. However, mothers' conformity to these expectations does not make them authorities about the needs of their children. Rather, they are expected to enlist expert advice about how best to protect their children from risk and nurture their children to optimise their development (Hays 1996). This expert advice is an important element of a disciplinary regime that produces and sustains conformity with the good mother discourse.

Child health nurses are part of the web of power relationships reproducing ideals of the good mother. The humanistic claims of nursing emphasise care and empowerment (Shepherd 2011) but more critical academic work argues that in this context surveillance becomes a 'routine practice' (Wilson 2001) where mothers are enabled to become successful parents. Utilising scientific knowledge and medical authority and positioned as agents of the state (Perron, Fluet and Holmes 2005), nurses work to constitute mothers' practices and dispositions in ways that conform to the discourses of a good mother. Wilson (2001) characterizes the nurse-mother

relationship as a 'precarious one' – women are voluntary participants in the care relationship, thus surveillance is necessarily undertaken 'gently'. These processes are not always intentional, and professional literature emphasises care and empowerment, not domination (Peckover 2002). Power relations are masked through professional discourses of care, and because nurses need to ensure that the mothers keep attending the service.

However Wilson (2001) and others (e.g. Bloor and McIntosh 1990) suggest that resistance to expert notions of the good mother is possible: 'women are not passive victims of the tyranny of experts' (Wilson 2001: 298). Discourses are not stable and can both reinforce and undermine power. Resistance is possible for even for those women who are marginalised or demonised in public and expert discourses, for example, working class women (Foster 2009). Within the micro-powers evident in interaction and everyday life, mothers may reject and reconfigure the discourse. With respect to knowledge, mothers may draw upon their own expertise, their 'close, day-to-day observations and what they see as their unique, experiential knowledge of their own children' (Lauritzen 1997: 438). This stance can place mothers in conflict with medical professionals, who may not acknowledge a mother's situated knowledge. It also suggests the possibility of resistance through subjugated counter discourses and the knowledge and subject positioning they construct.

In the following discussion, we present findings that indicate both resistance and conformity in interactions between child health nurses and mothers. Child health nurses work to support women to become good mothers. They do so by affirming or redefining the practice of mothers, drawing on authoritative and expert knowledge in doing so. At times these constructions are welcomed by mothers, but mothers may actively negotiate alternative understandings or reject the imposition of the nurse expertise into their situation.

Method

In this research we explored how interactions between child health nurses and mothers shape and reflect women's notions of parenthood. We examined this from the perspective of low-income women because there has been little exploration of how the ideals of the good mother are absorbed, practiced or resisted by this group (with some notable exceptions, for example Foster 2009). A qualitative, interpretive study was designed whereby nurse-mother interactions were observed, followed by separate, individual interviews with the participants. Twelve consultations between low-income mothers, fathers and child health nurses were observed (on one occasion two mothers attended together), followed by 13 interviews with mothers (3 with the father also interviewed) and 12 interviews with nurses. Observations and interviews were audio-recorded, with observations supplemented with fieldnotes. Thus each data-set comprised at least three transcripts. Our methodology and analytic approach are informed by a constructivist perspective: the data we present are negotiated accounts of people's experiences. Data were analysed discursively with particular focus on how meaning was achieved (or not) between participants. In the excerpts below, pseudonyms have been used. The study was approved by the University of Tasmania Social Sciences Human Research Ethics Committee.

Affirming the good mother

In some interactions, both the nurse and the mother used the good mother discourse to affirm the mother's knowledge and practices. The use of scientifically validated knowledge provides nurses with powerful tools to affirm women as good mothers. Perron, Fluet and Holmes (2005: 540) note that 'statistics define the norm and embody the current ideology'. This is most

evident in the weighing of babies – such knowledge provides an indicator of both the baby's health and the mother conforming to expectations. The persuasive power of numbers is shown in the interaction below between nurse Trish and mother Donna. There is the anticipation about what the numbers will reveal, then the result is received excitedly:

Donna Right, the moment of truth, are you nine pounds? I wouldn't be surprised if she's nine pound.

Trish I reckon she's that and more...(weighs baby)...Eleven pound five. (laughing)

Donna She's only two months old and she's put on ...

Trish Four pounds.

Donna Four pound. (Excited voice to baby) You little porky.

Trish (to baby) Your mother must be doing something right then huh?

Drawing on expert knowledge, Trish explicitly affirms that Donna is a good mother. The results identified through expert knowledge are unproblematic, indeed, they are welcomed, and Donna accepts, rather than contests, the discourse and the knowledge that constitutes it.

Negotiating and accomplishing the good mother

Additional work must be undertaken by both nurse and mother when it is evident that children may not be meeting milestones. In the following example, good motherhood is affirmed through the active interactional work carried out by both nurse Eileen and mother Jenni:

Eileen And toilet trained?

Jenni No, I haven't really attempted it yet.

Eileen No, maybe just wait because of the brand new baby, and then
 it's winter months

Jenni's negative response could possibly reflect adversely on her parenting and identity as a good mother. However Eileen then offers reasons that confirm Jenni's decision to leave toilet training is a sensible one. Jenni's position is also reinforced by her experiential knowledge of her child and her seeking other (presumably) authoritative knowledge to guide her actions:

Jenni But he does understand. He tells me to change him straight
 away so he's getting ready.

Eileen That's good

Jenni I'm waiting for the ready signs.

Eileen Exactly. Good, clever

Jenni Because I've been reading up on it.

The interaction above suggests that mothers and nurses can accept and value the good mother discourse. When mothering practices deviate from dominant expectations, mothers and nurses work together to negotiate a shared understanding of the situation. They reframe practices rather than contesting the discourse.

Resisting through counter discourse

In other instances, a mother and nurse may disagree about mothering practices or the needs of the baby, and mothers may resist expert medical framings of the situation. Resistance does not always imply rejection of expert knowledge. Rather, expert knowledge may be incorporated into an existing belief system to produce a counter discourse (Armstrong and

Murphy 2012). In the following account, Sharon recalled being upset by the advice provided by the nurse, which contradicted her own situated understanding of her child:

Sharon [At the last visit] she said I needed to get him assessed by [a therapy service], his head was too big and he should be walking or something or other doing something or crawling or something or other. And I mean, I suppose that upset me a little bit because I thought well, you know, he seems all right to me.

In an interaction in a later visit Sharon imposes her own definition of the situation, on that Joy accepts:

Joy I made a note last time of his head circumference. It looks as though...

Sharon I asked the doctor about that and he wasn't that...

Joy He wasn't worried at all?

Sharon Nuh. Not at all.

Joy Good. I won't bother now.

Sharon He's just got a big head like his Dad haven't you, haha

Joy It wasn't so much that it was big, it grew fast at one point.

Sharon That's your brain growing, wasn't it boy.

In a later visit to the nurse, Sharon's actions and reasoning are legitimated because she had deferred to a higher (medical) authority, enabling her to resist the nurse's advice. However both nurse and mother ensure that their claims and reasoning are justified.

Negotiating good motherhood – creating the good mother

In other instances, mothers and nurses needed to engage in complex negotiations around the ‘good mother’ discourse. The following exchange focuses on Jenni’s parenting practice on introducing foods to her baby. The current health policy followed by the nurses is that babies be exclusively breastfed until six months and that solid foods be introduced at or around six months. However jars of baby food labelled ‘suitable for 4-6 months’ are sold in stores. In the following excerpt, nurse Eileen uses the word ‘we’ consistently, as though speaking for the baby, and affirms Jenni’s identity as a good mother despite being presented with evidence to the contrary.

Eileen And are **we** being offered food other than the breastmilk?

Jenni A little bit. But not a huge amount at this stage. I thought I’d wait till six months plus and then go for it.

Eileen That’s clever, wonderful idea.

Jenni But I make sure I breastfeed more and because of...

Eileen Exactly, the history of asthma (J: yeah) in the family, which you’ve discussed before, and just introducing one thing at a time gradually.

Jenni Yeah. I just introduced the cereal, because I thought that’s safe, ‘cause it’s rice based and no wheat in it, so that’s all.

Eileen Yes. So it’s probably more two weeks’ time because we’re now five and a half.

Jenni Yeah, we’re five and a half now.

Eileen So I'd tend to just breastfeed and wait till six months. And even if you wanted to um start even the vegetables, you can start the rice cereal they say six months and over.

Jenni I just got the 4 month ones to make sure it was safe for him.

Eileen Exactly, yes.

Jenni And I did try a little bit of veggies. He's just not keen on anything like that. (E: No) He likes his milk (laugh).

Eileen And that's wonderful.

Jenni I just thought he might have been a hungry baby, (E: yes) because he wasn't settling at night.

Finally the nurse makes a written record in the baby book reflecting the 'correct' way of exclusive breastfeeding for six months, generating a written record that demonstrates a good mother, an expert account that Jenni does not expressly reject although it does not reflect her chosen practices:

Eileen So we're not being offered food other than milk because we're five and a half months old. (J: Yeah) So I'll just put that [in writing].

Jenni: Give it a bit of time. (E: Mm) Not too much [said in a baby voice to her baby].

In such interactions, nurses and mothers can accommodate accounts of non-complaint practices within the discourse of the good mother. However the power of defining the mother as 'good' remains with the nurse, who fills in 'the baby book'. Thus, they

have charge of the official record of how well the mother is performing, and the 'concrete representation to them of their role as a mother' (Clendon and Dignan 2010: 973).

Rejection through redefinition

As Murphy (2003) argues, most women deviate from expert advice in some way, but we found strategies of redefinition rather than outright rejection prevail. Carolyn's three week old baby had not been breastfeeding well and remained below her birth weight. Carolyn and her ex-partner Graham want to implement shared care of the baby, which would mean that Carolyn would not exclusively breastfeed her baby. Joy's attempts to persuade Carolyn are evident throughout this interaction:

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|---------|---|
| Carolyn | Graham wants to have her overnight ... as soon as possible. |
| Joy | It might be better if you could avoid it because the most effective thing is to have her feeding from you really (Carolyn: yeah), just until she's at least above her birth weight. |
| Carolyn | I don't like the idea of not being with her overnight, I don't want it to happen. |
| Joy | So he wouldn't ... |
| Carolyn | He's got every right to have her as well if you see what I mean. He doesn't live with us so ... |
| Joy | Yes I know that but you couldn't, couldn't compromise by him having her four hours during the day or something? |

Carolyn Well it's difficult because he works and he's got his boys from Wednesday to Friday and ...

Joy I know you're obviously trying to be fair yes, it's just that the breastfeeding is quite vulnerable in the early stages so if there was a way around that ... I mean just three or four hours two or three days a week even really.

Joy is encouraging Carolyn to focus on breastfeeding rather than the family situation, and sees shared care as a hindrance to the breastfeeding she considers best for the baby. Joy uses her knowledge around breastfeeding to give Carolyn an objective argument - of low weight gain - to use in arguing that the baby should not go to Graham's overnight:

Joy But if she keeps gaining 30 grams a day she'll be well and truly over her birth weight in the next couple of days but you don't necessarily have to tell Graham that (Carolyn: Yeah) just say she's below her birth weight. Really by six weeks she should be ... ideally by about um six to eight weeks they're usually about 500 grams to a kilogram above birth weight and she's not going to be there so if you could at least wait to eight weeks if she's feeding well.

However Carolyn does make her own decision, which is contrary to what Joy hoped for. She defines her position without explicitly rejecting Joy's expertise. While acknowledging that Joy's knowledge may be appropriate for some families, she discusses how it is not relevant for her situation:

Carolyn I'm not an impolite person. I just, I don't think that, say for example if Joy is trying to prevent us from, or suggesting we don't put her on the bottle because of the difference from breastfeeding to bottle feeding, the transition from the teat and nipple and all that sort of thing, one of the main reasons why we got the breast pump was so that shared care could commence and he could have her overnight. But she's saying no it's better if you didn't worry about that and exclusively breastfeed, you know. Well we say to that 'no' you know, we've got our reasons and thanks for your input, we appreciate it but you know your way of thinking is good for maybe one set of parents who um don't need what, you know they've just got a different set up to us as individual parents.

In such circumstances, mothers are able to resist dominant constructions of the good mother through emphasising alternative dimensions of the discourse. However, the impact of expert knowledge remains, as Carolyn's difficulty in rejecting Joy's advice outright, shows.

Conclusion

In this paper we have analysed some of the ways in which the good mother is constructed and negotiated in interactions with child health nurses. The good mother discourse can be affirmed or negotiated, but this is open to counter discourse or resistance. Women draw upon their experiential knowledge and situatedness to do this.

Thus, we concur with Murphy (2003) that resistance is not a simple rejection of expert knowledge and we need more nuanced analyses that can highlight instances of micro-politics that hold within them a challenge to the dominant discourse of good mothering.

Footnotes

¹ Child Health Nurses are employed by states. They provide a range of services to parents (predominantly mothers) and their children, and are responsible for assessing and recording specified developmental milestones.

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