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**Power, Care and Knowledge:
The Co-construction of 'Good Mothering' in
Interactions Between Low-Income Mothers
and Child and Family Health Nurses**

Marie Louise Shepherd
RN, BHSc(Nursing), BN(Hons)

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University of Tasmania

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Declaration of Originality

This thesis contains no material which has been accepted for a degree or diploma by the University or any other institution, except by way of background information and duly acknowledged in the thesis, and to the best of my knowledge and belief no material previously published or written by another person except where due acknowledgement is made in the text of the thesis, nor does the thesis contain any material that infringes copyright.

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Statement of Ethical Conduct

The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, the guidelines by the Australian Government's Office of the Gene Technology Regulator and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University.

Marie Shepherd

Date

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ABSTRACT

In this study I explore how good mothering is negotiated and constructed between low-income mothers and child and family health (CFH) nurses. Mothers' interactions with CFH nurses are an almost universal aspect of child-raising. The institutional role of CFH nurses is to support and guide mothers in raising their children within constructions of socially acceptable practice. Thus, the interaction is a site of regulation. Grounded in caring, nurses construct their role within a humanistic approach, focusing on care and empowerment, aiming for a collaborative relationship with mothers. This care (or relational) approach, however, sits in tension with their institutional (regulatory) role, particularly when constructions of good mothering are contested.

Good mother ideologies are a powerful influence on the social regulation of mothers. Medico-scientific discourses, such as those around health and risk, shape the social constructions of mothers and mothering practices. Thus, alternative constructions of mothering – particularly non-middle-class and lay representations of motherhood - are marginalised, with some mothering practices compared unfavourably to elements of dominant good mother ideologies. This has implications for nurse-mother interactions as mothers' knowledges can be subordinated to the expertise and knowledge of nurses. In this qualitative study I use Foucauldian concepts of power and adopt a constructionist and interpretive approach using observation and interview methods.

The findings reveal firstly that nurses' professional expertise and authority formed the basis of the relationships. However, mothers and nurses understanding of the role of expertise differed. Nurses were uncomfortable with using their knowledge and authority to direct mothers' behaviours, as this may undermine the relationship, or claim to an ethic of care. Mothers, however, sought nurses primarily for their expertise rather than a personal relationship, although for some mothers the relationship was a source of interpersonal support. Mothers also resisted nurses' authority to define good mothering practices by asserting their own definitions of good practices or good mother identity.

Secondly, mothers and nurses implicitly reference good mother ideologies. Good mother identity was negotiated in both uncontested and contested ways. In uncontested negotiations, good mothering was affirmed or accomplished together. Where there was not a shared understanding of good mothering practices, nurses' authority was resisted as mothers redefined good mothering practices by calling on their own authority and contextualised, experiential and child-specific knowledge. I argue that constructions of good mothering are negotiated within the encounters with both mothers and nurses calling on their own knowledges and expertise to come to a shared understanding of good mothering.

CHAPTER ONE

INTRODUCTION

Interactions between mothers and child and family health (CFH)¹ nurses are a universal feature of mothering in our society. In Western culture mothers bear the primary responsibility for raising children (Hays, 1996: 54). Child and family health nurses are tasked by the state to provide support and guidance for mothers in their child-rearing role. For nearly a century, mothers and their children in Tasmania, and throughout Australia, have visited or been visited by a child and family health nurse (Brennan, 1998; Knapman, 1993; Reiger, 1985). CFH nurses have specialist medico-scientific training and knowledge in the area of child health and parenting. They frame their role as primarily one of caring. Central to their work, and reflecting the bio-medical imperative to measure 'appropriate' development, is the routine surveillance of children's development and health (Schmied, Fowler et al., 2014: 178; Wilson, 2001: 294). This surveillance is part of CFH nurses' broader role to regulate society and individuals' behaviours (Perron, Fluet et al., 2005: 536). Thus the CFH nurse-mother care relationship is disrupted as their interactions are also a site for the social regulation of mothers. Regulation and surveillance are linked to power. Therefore the interactions between mothers and CFH nurses can be understood to be a relationship which involves power. However this is not as straightforward as a relationship of power of one over another. Rather, from a Foucauldian perspective, power is linked to knowledge, and is produced and exercised in every relation (Foucault, 1990: 93).

Both mothers and child and family health nurses are impacted by normative constructions around good mothering. The dominant 'good mother' ideology in our time is that of 'intensive mothering' (Hays, 1996). These constructions imply that an ideal mother is child centred, well-resourced, informed by and conforming to scientific

¹ In this thesis I use the title child and family health (CFH) nurse to refer to registered nurses working in the community with children under five years and their families. There is a wide variation in titles both within Australia and overseas. For example, in Tasmania it is child and family health nurse while in Victoria the term is maternal and child health nurse, in the UK it is health visitor, in Canada and the US it is public health nurse and CFH nurses are well-known in New Zealand as Plunket nurses.

evidence and expert advice (Apple, 1995; Hays, 1996; Murphy, 2003). These and other dominant constructions of good mothering are referenced to middle-class values and practices. These constructions are complex and contested, however, and discourses around child rearing are debated widely in the media, and scrutinised in sociological and health literature. For instance the health message that 'breast is best' is contested by the reality that the majority of mothers in Australia formula feed (Bartick, 2013; Knaak, 2010; Murphy, 2003; Tarrant, Sheridan-Pereira et al., 2013). Despite these debates, these ideologies marginalise the experiences of certain groups of mothers, particularly low-income mothers, including teenage mothers, mothers on welfare benefits, and single mothers (Breheny and Stephens, 2007; Gillies, 2007; Stapleton, 2010).

The interactions between CFH nurses and mothers involve power. This power is in the form of regulation and surveillance within CFH nurses' institutional role, despite nurses' focus on their caring role. There is also power within the dominant discourses of mothering. Within these discourses low-income mothers are a group whose experiences and practices are marginalised or problematised. Thus these mothers may be less able to negotiate these constructions and position their behaviour within good mother ideology. CFH nurses have a care role, yet their institutional role positions them to regulate mothers' behaviour according to dominant constructions of 'good mothering'. Thus CFH nurse-mother interactions are an important site of exploration for Foucauldian concepts of power.

BACKGROUND

Child and family health nursing services

In Tasmania, the state-government funded Child Health and Parenting Service is tasked by the State to screen and assess children on a number of health measures, and to guide and educate mothers in child rearing. From a Foucauldian (Foucault, 1982: 221) perspective, these health services are a technology of the government in that they operate to regulate the behaviour of the population (Rose, 1999: 52). The service emphasises to parents the importance of regular child health assessments (Department of Health and Human Services, 2014). Child health centres in Tasmania

and throughout Australia have high attendance rates as a result (McCallum, Rowe et al., 2011: 819). In Tasmania 99% of families attend for at least one of the scheduled Health Assessments within the first eight weeks of life (Tasmanian Government, 2013: 15). The recommended ages for these screening assessments in Tasmania, at the time of data collection, were at two weeks, four weeks, six weeks (by the GP), eight weeks, then four, eight, twelve, eighteen months and three and a half years. (This schedule has since changed slightly with assessments now conducted at two, four and eight weeks, six and twelve months, two years and four years). CFH nurses most commonly see and advise mothers on a range of parenting and health issues from standard concerns such as sleep and settling, breastfeeding, and nutrition, to more medically and socially complex problems including perinatal depression (Department of Health and Human Services, 2014). For CFH nurses, the priority and focus of their institutional role is to observe the child's developmental progress. This is surveillance and a technology of governmentality in the guiding and regulating of child rearing.

The ethic of care (or humanistic approach) in child and family health nursing

Care is a central concept in nursing, and the nurse-client relationship is pivotal to CFH nurses' work with mothers (Cody, 1999; De la Cuesta, 1994). This humanistic approach to care features relational power, as the emphasis on collaboration, support and guidance constitutes the exercise of pastoral power. In Australia and in other countries, studies of child and family health nursing from within the nursing discipline describe these relationships as therapeutic, and trusting (Byrd, 1998; Chalmers, 1992a; 1994; Cowley, 1995; De la Cuesta, 1994; Houston and Cowley, 2002; Shepherd, 2001; Walkem, 2004; Zerwekh, 1991; 1992a). These studies laud partnership with families, and posit that effective relationship must be rooted in an empowerment approach that emphasises respect and working together (Davis and Day, 2010: 80; Day, 2013; McNaughton, 2000; Mitcheson and Cowley, 2003; Normandale, 2001; Roche, Cowley et al., 2005: 510). A partnership style requires mother and nurse to work together calling on the expertise of both to understand the problem and come to tailored solutions (Davis and Day, 2010; Jonsdottir, Litchfield et al., 2004: 241). If a relationship is not successful, the reasons lie in the failure of those empowerment ideals (Houston

and Cowley, 2002; Kendall, 1993). These partnership or relational approaches are contrasted with the expert approach where the nurse assumes superior knowledge to the mother and acts in a directive manner (Davis and Day, 2010: 76).

The relational ideals which position the role of the CFH nurses as 'mother's friend' are challenged in more critical works that acknowledge relational power, and CFH nurses' position of authority in their relationships with mothers and children (Peckover, 2002; Wilson, 2003). The Foucauldian concept of pastoral power can be used to critically explore the interactions between CFH nurses and mothers. Pastoral power is the caring and guiding of people in appropriate behaviours that support their health and wellbeing (Dreyfus and Rabinow, 1982: 215; Foucault, 1982). This key Foucauldian concept provides a more critical understanding of the relational nature of power, and how the child and family health nurses' caring role sits in tension with their institutional role.

Child and family health nursing, bio-power and resistance

Child and family health nurses are trained within a biomedical framework, which is a central feature of discourses that dominate the contemporary health landscape. Due to this alignment with scientific paradigms, nurses' health knowledge is privileged as expert knowledge. Due to this positioning, CFH nurses can be located within the webs of bio-power (Fowler, 2000; May, 1992b; Peckover, 2002; Wilson, 2003). The Foucauldian concept of bio-power refers to the regulation of both social and individual actions along scientific and socially approved lines. CFH nurses' medico-scientific practice is at the level of both populations and individuals. From this perspective, CFH nurses are part of processes that actively shape, or 'produce' a particular kind of motherhood through surveillance and normalisation practices (Fowler, 2000 67; Peckover, 2002 375).

Mothering practices have been shaped by biomedical paradigms since the inception of the child health services last century, when medically trained nurses were employed to educate and direct mothers on the basis of scientific knowledge and evidence (Brennan, 1995: 13; Deacon, 1980). The term 'scientific motherhood' describes how mothering practices became increasingly informed by science and the expectation that women needed the help of experts to be competent mothers (Apple, 1995; Brennan,

1995: 13; 1998). Contemporary mothers continue these expectations, and actively seek and value CFH nurses' knowledge and expertise (Fagerskiold, Timpka et al., 2003; Mayall, 1990: 316; Russell and Drennan, 2007: 24; Tarkka, Lehti et al., 2002). The dominance of biomedical discourses, and the privileging of nurses' expert knowledges has, however, subordinated alternative sources of knowledge such as mothers' contextual experiences.

Within a Foucauldian perspective however, wherever power is exercised there is also resistance (Foucault, 1990: 95). For Foucault (1990: 93) power is relational and exercised in all relations. Therefore the interaction between mother and CFH nurse is the site of both power and resistance. Resistance by mothers to CFH nurses' expert guidance and scientific-medical discourses is evident in several studies (Bloor and McIntosh, 1990: 171; Heritage and Sefi, 1992; Peckover, 2002) with mothers calling on their own contextual and experiential knowledge and expertise. Practices of resistance provide a valuable opportunity to gain insight into the negotiation of power within the mother-CFH nurse interaction. Resistance practices also provide insight into alternative understandings of good mothering, in particularly those of low-income mothers. This group of mothers, due to their social positioning, can struggle to successfully challenge dominant ideologies of good mothering.

Motherhood constructions and low-income mothers

Sociologists describe how health and policy literature problematise low income mothers as failing to attain elements of good mother ideologies (Breheny and Stephens, 2007; Butler, Winkworth et al., 2010: 5; Gillies, 2007: 1; Stapleton, 2010). Butler and colleagues (2010: 5) argue this is partly due to the results of quantitative research which highlight negative socioeconomic and health outcomes. In health professional literature low-income mothers are predominantly portrayed from a deficit perspective with their mothering practices depicted as inadequate. For instance a large body of literature focuses on low-income mothers' infant weaning and feeding practices, i.e. the early introduction of solids and low breastfeeding rates, and advocates education interventions to change practices to meet scientific guidelines (Barton, 2001; Bentley, Gavin et al., 1999; Danowski and Gargiula, 2002; Heinig, Ishii et al., 2009). Poor social and

health outcomes for teenage mothers and their children are also highlighted, particularly in health literature (Breheny and Stephens, 2007; Hanna, 2001). This group and other low-income groups of mothers are key targets for many early-intervention and parenting programs (Clarke, 2006; Olds, 2006; Quinlivan, Box et al., 2003; Sawyer, Barnes et al., 2013).

Child and family health nurses are key individuals in the lived experiences of mothers of pre-school aged children. Researchers have interpreted the child and family health nursing role as variously 'mother's friend' and agent of surveillance (Davies, 1988; Dingwall and Robinson, 1993; Peckover, 2002). This makes the interactions between socially marginalised mothers and CFH nurses a particularly important site for exploring negotiations around the meaning of 'good' mothering, and mothering practices.

THE STUDY

In this project I explore the relationships between low-income mothers and child and family health nurses. I study the micro-level of interaction between nurses and mothers and address the research question:

'How do child and family health nurses and low-income mothers negotiate good mothering practices?'

Through my research I aim to identify:

- How low-income mothers and CFH nurses construct good mothering;
- How CFH nurses and low-income mothers negotiate good mothering practices;
- How CFH nurses and mothers understand the role of CFH nurses.

I focus on how mothers and CFH nurses negotiate meanings in interaction. To do so, I designed a qualitative mixed-method study informed by constructionist ontology and an interpretivist approach. I audio-recorded and systematically observed twelve consultations between low-income mothers and CFH nurses (with fathers sometimes attending). This method provided an accurate record of what was said while my notes added data on what was happening including what people were doing, what objects

were being used and displayed, how the space was used. Immediately after the interactions I recorded other valuable information gained from observing the interactions including the unspoken communication that occurred and my impressions of the nature of the interaction between mother and CFH nurse. Following the observations I conducted separate in-depth, semi-structured interviews with five nurses (12 interviews, one for each consultation) and with each of the eleven mothers (13 interviews, two mothers attended twice). The interviews generated data on the participants' views of the interactions, their understandings of parenting, and of child health nursing.

My analysis centred on the existence of power in the interactions and was informed by a Foucauldian-referenced conceptualisation of power and resistance. Specifically, I emphasise concepts of power-knowledge, governmentality, bio-power, pastoral power, disciplinary power, and surveillance as a means of gaining an in-depth understanding of what was occurring in the interactions.

Analysis revealed the duality of the nurses' role through how mothers and nurses saw the role. The basis of the interaction was CFH nurses' scientific knowledge and professional expertise, as depicted by the concept of power-knowledge. Mothers accessed the service primarily for the CFH nurses' authoritative scientific knowledge and expertise in assessing their child's. However for the nurses the initial interactions were the basis for building their relationship of care with the mother. This relational caring work, when viewed through the lens of pastoral power (Foucault, 1982: 214), revealed underlying surveillance and techniques of disciplinary power. The process of building relationship increased CFH nurses' pastoral power and encouraged mothers to return, with a resulting ongoing gentle surveillance. Positioning CFH nurses within governmentality and bio-power (Fowler, 2000; Holmes and Gastaldo, 2002) provided insight into nurses constructions of good mothering practices. The CFH nurses guided and encouraged mothers in the institutionally sanctioned methods of child rearing, such as the introduction of solid foods at the recommended age. The negotiations between mother and CFH nurse were referenced to good mother ideologies (Hays, 1996). However at times, mothers would actively challenge scientific knowledge and

related child rearing methods. Mothers resisted by calling on their own contextualised and child-specific knowledges in redefining good mothering practices.

Through their institutional position CFH nurses are a vehicle for social control (Perron et al., 2005: 541). There is little known about this powerful position is actually enacted within the private interaction between mother and CFH nurse, and particularly low-income mothers. A critical perspective is vital when marginalised groups are involved in such vulnerable positions where, as Wilson (2001: 299) states, they may be unable to negotiate effectively. My work in this project allows us to explore the in-situ negotiations around the constructions of mothering and the child health nurse role. I explore how processes of surveillance, normalisation, disciplinary power and resistance are played out as CFH nurses and low-income mothers talk, interact and respond to one another. By studying the co-creation of meaning that is achieved by negotiation, co-operation and resistance, I identify the interactive work that both reproduces and challenges mothering and CFH nursing ideologies. I explore how these processes reproduce and challenge ideologies of good mothering through how the low-income mothers and CFH nurses understand the sometimes conflicting dimensions of expertise and authority. In this thesis I argue that mothers and CFH nurses call on their own authoritative knowledges and that both negotiate, sometimes at length, to come to shared understandings over the meaning of good mothering.

Structure of the thesis

In the next chapter I use a Foucauldian conceptualisation of power to situate nursing within power networks that contribute to the regulation of mothers. I contrast humanistic and critical readings of CFH nurses' understanding of their work to argue that the relationship between mothers and CFH nurses is constituted through concepts of care, power and knowledge.

In chapter three I focus on the diverse and contested nature of good mother ideologies and good mothering practices. Low-income groups of mothers are frequently portrayed in opposition to good mother ideals. However there are means of resistance

available to mothers and I present the literature on how mothers both conform to and resist expectations in their relationships with child-health services and nurses. While the dominant scientific messages on good mothering were often acknowledged by low-income mothers they also resisted or reframed practices, behaviourally and/or conceptually, that did not fit with their own situation.

After contextualising the study I turn to the methodology and methods of this project in chapter four. I discuss the methodology, design and implementation of the methods, with a particular acknowledgement of the importance of my own reflexivity as a nurse and researcher.

Chapter five is the first of two findings chapters. In this chapter, I explore how mothers and CFH nurses understand the role of a CFH nurse. I argue that CFH nurses' expertise was valued by mothers and CFH nurses but was depicted as ambiguous, and problematised by nurses and mothers. CFH nurses were ambivalent about their professional expertise and authority, which they understood as conflicting with their ideal of caring for and empowering mothers. In contrast the mothers sought nurses primarily for their expertise, but generally used the nurses' knowledge in balance with their own contextual and child specific knowledge. At the same time their relationship with the CFH nurse influenced their response to her guidance. Mothers both accepted and contested the element of scientific motherhood to seek and follow expert guidance.

In chapter six I focus on the ways mothers and CFH nurses negotiate mothering practices. A bio-medical approach to mothering influenced the CFH nurses and mothers' actions and attitudes as they managed their conversations about mothering. Both CFH nurses and mothers used this approach to affirm good mothering (e.g. a baby gaining weight well and meeting developmental milestones). However mothers would resist this approach if it did not affirm their good mother identity. Negotiation was a key factor. In some interactions mother and nurse cooperate to claim a good-mother identity, in some instances ideals are enforced or negotiated. The good mother

ideal may also be rejected as mothers call on their own experiential and contextual knowledge to negotiate their own good mother identity.

In the concluding chapter I bring together the findings of this thesis relating them to Foucauldian concepts of power to reveal the interplay of care, power, knowledge and resistance within the interactions. I return to the aims of the research and argue that good mothering is a shared concept created through negotiation in the interaction between mother and CFH nurse. Finally I discuss the contribution of the thesis to the literature and directions for further research.

CHAPTER TWO

POWER, CARE AND KNOWLEDGE IN CHILD AND FAMILY HEALTH NURSING

INTRODUCTION

In this chapter I argue that child and family health (CFH) nurses, in their interactions with mothers, have a caring role that sits in tension with their institutional role. The institutional role positions CFH nurses as experts who direct and sanction parenting. But the nurse role is also grounded in caring, and this creates tensions in the CFH nurse-mother relationship. I use Foucault's concept of governmentality (Foucault, 1982: 221) to help explain how child and family health nursing has been established as a technology of government to guide and educate mothers in the socially sanctioned methods of rearing children. These methods are based on dominant scientific knowledges and evidence-based practices. At the same time CFH nurses are grounded in caring, which is understood by many nurses to be the essence of nursing (Hagell, 1989: 231). The complexity of care in nursing is reflected in Gordon's (2006: 104) description of nursing as 'a tapestry of care ...that includes emotional, physical, intellectual, domestic, technological, and medical activities'. I employ the work of Michel Foucault in developing a deeper understanding of power, care and knowledge in the relationships and interactions between CFH nurses and mothers.

I structure this chapter in five sections. First I introduce Foucault's concept of power. I discuss how power is constituted through knowledge and exercised relationally. Thus it is present in the CFH nurse-mother interaction. In the second section I draw on governmentality and bio-power to situate child health services and CFH nurses within the management of populations. In the third section I explore how disciplinary power and surveillance constitute techniques used to encourage the 'right' behaviours within the population, and argue that such techniques underpin the CFH nurse-mother interaction. In the fourth section I introduce pastoral power and argue this underlies the centrality of care in nursing, which is particularly reflected in the importance for

nurses of both client empowerment and the nurse-client relationship. Finally, I turn to the contested constructions of nursing and consider the role tensions that CFH nurses face, within their interactions with mothers, given their dual status as a carer and as an institutional representative.

KNOWLEDGE AND THE FORMATION AND EXERCISE OF POWER

Through his critical historical studies of social institutions Foucault sought to explain how power is created and exercised. Power is created through knowledge and the dominant form of knowledge within societies at any one time produces the capacity to exercise power. Particular knowledge is privileged, and this structures (thus constrains) the kinds of knowledges that can be or are used to shape prevailing ideas and social action (Foucault, 1982). Integral to understanding the exercise of power is the circulation and function of knowledge. Foucault positions power and knowledge together and this is central to an understanding of how power is exercised in contemporary societies. This entwined and dynamic conceptualisation of power-knowledge² is best encapsulated as follows:

Power produces knowledge ... power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (Foucault, 1977: 27).

Power and knowledge are always intermingled and professional knowledge is not immune to this interaction (Abbott and Sapsford, 1990: 148; Bloor and McIntosh, 1990: 163; Mulholland, 1995: 445; Powers, 2003: 230). Unlike some cultures where authoritative knowledge is consensual and shared in a horizontal manner, in Western societies knowledges exist in an hierarchical structure (Browner and Press, 1996; Miller, 2005: 29). The dominant knowledges are constructed as expert knowledge

² Foucault wrote the term 'power-knowledge' with a dash (not a slash) as it was not an either/or meaning (Gore, 1993: 51). See e.g. Foucault (1977: 27).

(Miller, 2005: 31), and it is the possession of a body of knowledge that enables professional groups to exercise power (Turner, 1995: 152). These dominant knowledges are considered legitimate and constructed as 'truth'.

Identifying the techniques of how knowledge is produced in a particular field is important because of the relation between knowledge and truth. Foucault (1990: 60) claims the production of truth 'is thoroughly imbued with relations of power'. He argues scientific knowledge is not objective truth but rather socially constructed truths supported by the dominant paradigms (Foucault, 1977: 28; 1980b: 112; Powers, 2003: 230). Thus the construction of truth occurs actively within interactions and social relationships.

Contemporary western societies privilege scientific knowledge as the dominant knowledge. The 'gold standard' of scientific medical research is the randomised controlled trial, i.e. replicable, generalizable experiments that randomise intervention and control groups. It is considered to be the most objective form of research (Grossman and Mackenzie, 2005; Kaptchuk, 2001). However, while the results may be rigorous, research funding and direction is based on existing paradigms and legitimated emphases and assumptions – for example more research on curative or drug trials than prevention or spiritual therapies. Scientific evidence influences what knowledge is believed to be true and is the most legitimate form of knowledge in determining policy and practice, in health and other spheres.

Health, nursing and regulatory bodies promote the use of evidence-based practice, as the 'gold standard for the provision of safe and compassionate health care' (Brown, Wickline et al., 2009: 372). This practice is informed by the evidence from scientific research rather than based on traditional knowledges such as practice wisdom. Professionals such as child and family health nurses are influenced by, and required to base their practice on, this 'evidence-based' knowledge and outcome-focused policies. Evidence-based practice frameworks determine the ethical and appropriate patterns of behaviour to which individuals, such as parents and CFH nurses, must conform (Andrews, 2006: 199; Jamrozik and Sweeney, 1996: 208; Miller, 2005: 29). This

privileging of particular behaviours and modes of care then shapes which behaviours CFH nurses encourage.

The exercise of power

Power, in Foucault's conception, is relational (Foucault, 1990: 95; Holmes and Gastaldo, 2002: 559; Lupton, 1997: 99). For Foucault (1990: 93) power is everywhere and exercised in every social relation. He describes power as:

[T]he multiplicity of force relations imminent in the sphere in which they operate and which constitute their own organization ... power ... is produced from one moment to the next ... in every relation from one point to another (Foucault, 1990: 92-93).

Power thus needs to be understood by examining the way that certain actions or ideas can modify others (Cooper, 1994: 437; Foucault, 1982: 221). As Foucault (1982: 221) states 'To govern, in this sense, is to structure the possible field of action of others'. In this understanding, the health professional is not a dominating possessor of power but rather one through who power passes in a complex field of power relations (Foucault, 1991c:247). This widens the consideration of the exercise of power beyond just varying degrees of domination of one over the other; a more common conceptualisation of power. There is conceptual room for the place of negotiation in the exercise of power.

Foucault emphasises the productive aspects of power. Power is not just a repressive force but is constructive (Holmes and Gastaldo, 2002: 558). Foucault highlights what Lupton (1997: 98) describes as the 'seductiveness' of the productive features of power:

What makes power hold good, what makes it accepted, is simply the fact it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole

social body, much more than as a negative instance whose function is repression (Foucault, 1980b: 119).

This productive aspect of power allows people to create – and therefore negotiate – new ways of understanding and speaking about what is considered to be true in particular societies (Gilbert, 1995: 867). Productive power is not a resource but rather is exercised by people with ‘the capacity to shape, facilitate and generate practices, processes, and social relations’ (Cooper, 1994: 436). Therefore both CFH nurse and mother have the capacity to impact on each other and affect each other’s practices – thus it is a two-way exchange of power that has a productive (produces a discourse) rather than simply repressive effect.

A feature of the relational aspect of power is that the power relationship is reciprocal, ‘the object also retains power towards its exerciser’ (Kuokkanen and Leino-Kilpi, 2000: 237). This provides the space for resistance and negotiation within interactions. Resistance is a crucial part of the way that power circulates and is exercised (Lupton, 1997: 102), exemplified in Foucault’s (1990: 95) statement that ‘where there is power, there is resistance’. In power relationships there are always multiple points of resistance which are present throughout the ‘power network’ (Foucault, 1990: 95).

The interaction between health professional and client brings into being the relationship between the subjects, mother and CFH nurse, and thus, as Lupton (1997: 99) points out, provides the basis for the relational exercise of power. The negotiations between CFH nurse and mother, which are the key focus of this research, are an exercise of power and resistance even though neither CFH nurses nor mothers may be explicitly aware of these dynamics.

GOVERNMENTALITY, BIO-POWER AND THE EMERGENCE OF CHILD AND FAMILY HEALTH NURSING

Child and family health nurses have a complex, and sometimes apparently conflicting role in supporting mothers, children and families. CFH nurses are described in some sociological and nursing literature as both ‘friend’ and ‘inspector’ (De la Cuesta, 1994;

Marcellus, 2005; Peckover, 2002; Wilson, 2003). Exploring the emergence of both child health services and child and family health nursing provides an understanding for the basis of this complexity. The Foucauldian concepts of governmentality and bio-power are useful here and enable an exploration of the nexus between government policy and the care provided by health professionals who work for the state. Child and family health nursing responds at the population level to concerns about the attainment of, for example, normative milestones, while simultaneously focusing on individual mothers to optimise their parenting capacities, and the health and wellbeing of their children (Fowler, 2000; Murphy, 2003; Peckover, 2002; Wilson, 2003). Thus, child and family health nursing sits within the twin 'poles' of bio-power in that it focuses at the level of populations *and* at the level of the individual.

Governmentality

The concept of governmentality points to the ways in which technologies of government (defined as calculated and strategic undertakings) are invented and assembled in an attempt to manage aspects of social and economic life. As Rose (1999: 52) says,

technologies of government are those technologies imbued with aspirations for the shaping of conduct in the hope of producing certain desired effects and averting certain undesired events.

Like Foucault, Rose is interested in the 'conduct of conduct' and the techniques that allow government to occur at a distance. Such technologies are connected through multiple sites of power. Paradoxically, what is also observed is that the further removed from the population the government is, the greater the need for population measures and calculations. Further, Rose states that such governments do 'not seek to govern through "society", but through the regulated choices of individual citizens' (Rose, 1993: 284).

Foucault (1982: 221) argues that the capacity for governing through a 'mode of action upon the action of others' emerged from the 17th century. State interventions shifted

from a focus on exercise of power through death (for example, wars) towards a focus on life. This meant that the bodies of individuals became sites for the exercise of power. It also represented a shift from 'sovereign power which is overt, visible and located in a monarchical structure' (Gore, 1993: 52) to disciplinary power – a less visible exercise of power focused on individuals' engagement with body practices. Disciplinary power (discussed later in this chapter) is incorporated in bio-power, a technology for managing populations.

Bio-power

Bio-power consists of a range of discourses, knowledges, technologies, practices and politics that are used to 'analyse, regulate and control' the behaviour of human bodies and populations (Danaher, Schirato et al., 2000: ix; Murphy, 2003: 435). The individual body is an object to be manipulated through disciplinary techniques in order to produce a productive 'docile body'. However bio-power is not a dominating power over groups and the disciplinary techniques do not guarantee control of people by the state (Gastaldo, 1997: 115). Bio-power is 'a subtle, constant and ubiquitous power over life', for example the expansion of the health system into private life (Gastaldo, 1997: 116). Populations are relied upon to take on responsibility and act on prevention and health promotion knowledge, and thus, govern themselves in line with expert knowledges.

Foucault argued that 'bio-power' encompassed two poles. The ability to generate information at the population level, largely through statistical calculations of life and death measures, meant that the first pole focused on the 'species body' resulting in a 'bio-politics of the population' (Foucault, 1990: 139). This enabled opportunities for regulation at the level of the population, such as the introduction of immunisation programs. The second pole, and a necessary corollary of population knowledge, was a focus on the potential of bodies within populations, for example the monitoring of a child's growth and development. At this level, power 'centred on the body as a machine' (Foucault, 1990: 139) where strategies to optimise individual capabilities and increase usefulness and docility through disciplined individual actions enabled

‘development of an anatomo-politics of the human body’ (Foucault, 1990: 139).

Foucault claims that:

[I]t was the taking charge of life, more than the threat of death, that gave power its access to the body ... life and its mechanisms [were transformed] into the realm of explicit calculations and made knowledge-power an agent of transformation of human life (Foucault, 1990: 143).

The knowledge from the twin poles of populations and individuals informs discourses and the power of discourses lies in their use to shape behaviour (McCabe and Holmes, 2009). People internalise these truths and act accordingly thus ‘power produces specific subjects’ (McCabe and Holmes, 2009: 1522). This has the effect of ensuring that the regulation of populations is maintained with minimal need for state intervention (Allen and Hardin, 2001: 168; Wilson, 2003: 285-286). The acceptance of dominant institutional discourses means that people take for granted self-regulation. The self, as a ‘discursive object’, can be worked on and reflected on; discourses and social practices shape how people see themselves (Allen and Hardin, 2001: 168), both as a person and, in the case of this study, as a nurse or mother (Allen and Hardin, 2001: 168). Working on and reflecting on the self occurs at two levels: at one level, individuals employ a ‘self monitoring, self reflection, and self analysis’ discourse, and at the second level, individuals engage with discourses relating to the content of that analysis – what one ‘should’ be like (Allen and Hardin, 2001: 168). Nurses are influenced by discourses about the characteristics that nurses should possess and exemplify, for example nurses should be kind and caring (Bradbury-Jones, Sambrook et al., 2008: 263; Walker, 1997: 8). Nurses who adopt these beliefs take them into the workplace and use them to guide their practice (Gilbert, 1995: 870) and this influences their interactions with others, including with mothers. It is through their interactions and relationships with mothers that CFH nurses have the capacity to exercise power. Child and family health nurses are strategically placed within the realms of governmentality and bio-power to direct and manage the behaviours of others, while undertaking self-monitoring.

Governmentality and bio-power, the managing of populations through attempts to manage aspects of social life, are reflected in the development of the early child health services for the purpose of improving the health of children.

The emergence and establishment of child health services

Concerns about population health and infant morbidity and mortality led to the establishment of child health services at the beginning of the 20th century. Child health services emerged around the Western world, particularly the British Empire, partly as a result of social movements concerned with improving the welfare of children (Mein Smith, 1997: 1; Ritson, 1997: 1). These movements were a response to the poverty and isolation of families from their extended family that had arisen out of industrialisation and urbanisation (Ritson, 1997: 1). The impacts of these changes were felt at a class level with poor individuals and families affected the most, but the implications were understood at the national level. Governments became involved with child welfare when concerns arose about the national and economic implications of poor infant health. The wars of the late 19th and early 20th century, including the Boer war and later the Great War (WW1), revealed the poor health of young men and the potential negative impact on conscription. Additionally, attention turned to the high infant mortality rate and declining birth rate (Brennan, 1998: 12; Mein Smith, 1997: 3). Infant survival was constructed as the 'building block' of a nation particularly in the British Empire (Mein Smith, 1997: 2). The concern of government with infant health at a population level reflects bio-power.

The concerns for infant health also directed attention to how to address these. In Australia, as in other Western countries, the high infant mortality rate and declining birth rate came under the scrutiny of politicians, the medical profession and philanthropists (Brennan, 1995: 21; Brennan, 1998: 12; Knapman, 1993). While charitable organisations and health officials were aware of the poor social conditions it was only after the pro-natalist movement of the time was encouraging women to have more babies that the state and federal governments became involved in addressing

the situation (Brennan, 1995: 22). Mothers and in particular the poor mothers, in disadvantaged areas became the focus of concerns. Despite poor public health measures at the time and an awareness of the link between poverty and ill-health, child and infant death was attributed to ignorance and inadequate child-rearing practices (Barnes, Courtney et al., 2003: 15; Mein Smith, 1997: 224). Thus, government-sponsored infant welfare services consisted of trained nurses who were to teach mothers in their homes in matters of hygiene and the importance of breastfeeding (Barnes et al., 2003: 15; Brennan, 1998). The 'training' of mothers in socially-sanctioned health behaviours and the move into the private sphere of the home reflects practices of bio-power (Gastaldo, 1997: 116) at a population and individual level.

The concept of knowledge-power is also evident in the establishment of child health services. Groups supporting the development of services for mothers and children, consisting of 'an emergent class of professionals, technocrats or experts', perceived the benefit of bringing the social world in line with scientific knowledge (Reiger, 1985: 3). Guided by the importance of science, professionals were arguing that mothering should be taught along 'rational, scientific principles' (Reiger, 1985: 128). The new professional experts came to control 'mothercraft' as a 'new domain of knowledge', with maternal ignorance a major premise (Reiger, 1985: 128-129). This resulted in women's knowledge, the accumulated knowledge from past generations being dismissed (Reiger, 1985: 139). As Brennan (1995: 27) explains the scientific approach to parenting was viewed as progressive and held hope at a time when infant deaths were still common. What was taught from the child health clinics was also promoted in newspapers and magazines (Reiger, 1985: 213). That middle-class mothers took on the modern scientific principles of childrearing with the most zeal resulted in the infant welfare services, which at first were directed to working class mothers, eventually becoming universal across all social strata (Reiger, 1985: 213).

Resistance, an integral part of the Foucauldian concept of power-knowledge, was also evident in the response by some mothers to the scientific messages of mothering. Reiger (1985: 217) makes the point that while many of the messages were heeded, such as four hourly feeding of babies, because science had 'proved' babies' digestive

systems needed this time, there was also evidence mothers rejected or modified the experts' messages. Many mothers brought their babies up in the same way their mothers had done, effectively 'thumbing the nose at too much modern nonsense out of books' (Reiger, 1985: 217).

Along with the imperative to improve the welfare of children, another major influence on the establishment of child health services was gender and the desire, by the feminist women's movement and infant welfare movements, to improve the position of women in society. In promoting the status of women as mothers these movements fought for social reforms to improve the conditions of mothers and children, particularly the poor (Mein Smith, 1997: 7). In trying to raise the status of women they also promoted motherhood as a career requiring training and skill (Brennan, 1995: 38). These womens' organisations supported calls for the provision of maternal and infant care services for mothers - which were virtually non-existent at the time (Ritson, 1997). Reiger describes how bourgeois women visited poor families, and led their 'sisters' in the call for these services (Reiger, 1985: 216) These voluntary visitors also led to a recognition of the conditions of deprivation poor families experienced, and were subsequently replaced by government-supported, professional infant welfare nurses, with their scientific messages about hygiene and childrearing (Reiger, 1985: 216). Just as these social changes put the spotlight on infant health and raised the status of women by promoting motherhood as a career in the home, a parallel movement was occurring to raise the status of nursing as a professional career for women outside the home.

The profession of child and family health nursing

In Australia the call to have nurses recognised as infant welfare professionals was part of the larger movement towards the professionalisation of nursing. Nursing registration, after a long battle, became a requirement and an early step towards the recognition of nursing as a profession in caring work, rather than as an occupational workforce to meet the needs of hospitals and the medical profession (Abel-Smith, 1960; Keleher, 1998: 54; Reverby, 1987: 2; Witz, 1992: 142). The aim was for nursing to

gain the legal status as a profession through state sponsored registration (Witz, 1992: 128).

Child and family health nursing was one of the earliest areas of nursing specialisation in a new style of health service; a health service that was free, available to all, voluntary for families, and based on principles of health education (Brennan, 1995: 42). Unlike the UK where Health Visitors initially were not trained nurses, in Australia most CFH nurses had their general nursing plus midwifery training before coming to this area of practice. From the 1920's the 'Infant Welfare Certificate', gained from mothercraft training in the hospital setting, was the third certificate required for working in this area, in addition to the general nursing certificate and midwifery certificate (Mein Smith, 1997: 209). The concept of power-knowledge is evident in these processes, as knowledge and education significantly increased CFH nurses' authority and status within the community and in their interactions with mothers.

Child and family health nursing (or 'infant welfare' as it was then referred to) became established as a separate speciality area of nursing and mirrored the ongoing professionalisation movement of general nursing at the time (Abel-Smith, 1960; Reverby, 1987; Witz, 1992: 136). Medical knowledge remained dominant over nursing, however, and this was evident in that the medical profession initiated and governed the development of the CFH nurse role (Keleher, 1998: 55). Medical doctors who had worked in similar public health activities overseas brought the principles of training in infant welfare nursing to Australia. For example, Dr William Armstrong was involved in the setting up of the service in Sydney (Keleher, 1998: 55). Dr Vera Scantlebury-Brown was the director of the Victorian baby health centres (Brennan, 1995: 27), while Dr Isabella Younger Ross and Dr Helen Mayo also established services in Victoria (Ritson, 1997: 44). Of particular influence was Dr Truby King who had instigated the Plunket infant welfare service in New Zealand (Ritson, 1997: 44). That nurses - with their medical scientific knowledge and training - and not expert mothers were employed to support and teach mothers, reflects the dominance of medical science in the government of mothers and children.

The establishment of child health services in Australia

The establishment of child health services occurred over similar periods throughout Australia, including Tasmania, with regional differences depending on the governments of the day (Mein Smith, 1997; Raftery, 1996). For instance the South Australian conservative governments believed in self-help and left the welfare work to the voluntary sector - with middle-class educated women taking up the cause forming infant welfare associations to support the services in their area (Mein Smith, 1997: 246). Labor dominated governments provided the service in their states (Mein Smith, 1997: 246). In Queensland the Labor government of the time established the service in 1918 believing nurses providing advice and guidance offered babies the greatest chance of survival (Barnes et al., 2003: 15). In NSW the (government) health department supported the service (O'Connor, 1989; Osborne, 2004). In Victoria local government, local groups of women and local councils all vied for control over infant welfare services (Reiger, 1985: 2; Ritson, 1997). Irrespective of jurisdictional differences in organisational responsibility, these services were supported as means of repopulating the Australian nation with future healthy (and white³) citizens following wars, a declining fertility rate, and a high infant mortality rate (Drummond and Marcellus, 2005: 9). These child health services were developed as 'technologies of government' (Rose, 1999: 52) as a means of influencing the individual behaviour of mothers in desired ways to have effects at a population level.

In Tasmania the Child Welfare Association emerged from a public meeting of the Women's Health Association in 1917 in response to calls to improve the nation's health and welfare by reducing the infant death rate (Waters, 2006). This women's association established and supported the baby health clinics which had a government employed nurse, volunteers and a doctor on a voluntary basis once a week (Waters, 2006). These services were eventually institutionalised.

³ The indigenous population were excluded from services and data collection systems, including the measurement of infant mortality rates (Drummond and Marcellus, 2005: 7; Madsen, 2007: 28; Mein Smith, 1997).

A mothercraft home established in Tasmania was a small hospital providing care and treatment for mothers and infants, including premature babies and those with feeding difficulties, providing advice on breastfeeding, and providing a training school in infant welfare (Kelly, 1977: 154; Madsen, 2007: 31). A Matron and a nursing Sister staffed the home and provided training in infant welfare for four student nurses at a time (Kelly, 1977: 154). The students who were registered nurses trained for four months, registered obstetric nurses had an eight months training and, later, untrained women had a two-year training course to be mothercraft nurses (Kelly, 1977; Waters, 2006). All paid the sizable fee of £15 (Kelly, 1977).

The mothercraft home was modelled on the Truby King Karitane Hospital in Dunedin (New Zealand) (Brennan, 1998: 11; Waters, 2006). The dominance of science was evident in King's work. He had an interest in animal husbandry and was particularly influenced by ideas of control and discipline (Madsen, 2007: 29). King adapted this approach as the foundation to his teachings on scientific principles and the regimented management of babies (Madsen, 2007: 29; Reiger, 1991a: 20; Ritson, 1997: 44). King's strong beliefs in scientific methods in the managing of child rearing took the form of training to conform to the principles of scientific motherhood. Mothers were taught a scientific mothering regime that encouraged regulation and discipline including routine bathing and sleeping times, four hourly feeding, early toilet training (from six weeks), and mothers were not to rock or play with their babies as this would promote 'self-indulgence' (Madsen, 2007: 30). As Ritson (1997: 44) states the 'ideals of the infant welfare movement had already been taken over by a disciplinarian'.

Due to the expansion and costs of the service the Department of Health later took over all child health services including the mothercraft hospital in Hobart (Tasmanian Numbered Acts, 1949; Waters, 2006). The Child Welfare association was renamed as the Child Health Association to avoid confusion with the government child welfare (child protection) department (Waters, 2006).

The disciplinary practices of governmentality were evident in the child and family health nurses' role at the time. The principal role of the CFH nurses was primarily one of training mothers to conform to the principles of scientific mothering. CFH nurses,

through home visits and centre visits, provided information and teaching on 'the importance of breastfeeding and household hygiene' (Brennan, 1998: 12). Activities included demonstrations and lectures on such topics as 'how to erect home steam tents, dress wounds, make foment, prepare formulae and cook for invalids' (Brennan, 1998: 13). That this was primarily women's work was reflected in the CFH nurses teaching of mothercraft in schools and to women's groups (Brennan, 1998: 13).

Early CFH nurses in Tasmania combined the training of mothers with advocating for social reform. Supported by the Child Health Association they lobbied for 'pure' milk supplies i.e. fresh, clean, full cream milk not watered down (Brennan, 1998: 13; Waters, 2006). Laura Richardson, the first child welfare nurse in Hobart, was particularly vocal and succeeded in obtaining clean milk supplies to the Hobart clinic for mothers to collect as needed. Launceston's first child welfare nurse, Myrtle Searle, lobbied against the damp, overcrowded, unhygienic housing conditions in the poorer parts of the town, and contributed to debates and the eventual establishment of public housing in Tasmania (Brennan, 1998: 13). They also distributed clothing, food and firewood to the poor (Brennan, 1998: 13).

Current child health services

The contemporary framing of child and family health nursing continues to reference the future benefit to the nation of a healthy population (Drummond and Marcellus, 2005: 8). Child health nursing remains situated within the twin poles of bio-power with the care of populations and individuals. Whereas previously the focus was on improving infant mortality and future physical health through teaching and improving mothering practices (Mein Smith, 1997), the current focus is on the importance of early childhood experiences on future health and wellbeing. Scientific knowledge from studies on human development remains dominant in influencing policies and practices of child rearing. Studies showing the impact of early experiences on infant brain development and long term development, learning and wellbeing have been used to endorse services for children under five years and their families (Shonkoff and Phillips, 2000; Shonkoff, 2010). Interventions early in life are considered in terms of their long

term cost effectiveness and the health, social and economic benefits later in life (Tasmanian Early Years Foundation).

Child health services have changed their model of care over the last century. The early developmental model of care with its focus on monitoring and surveillance of child development shifted to a wellness model in the 1970's with a primary health care philosophy, and focus on health promotion and illness prevention (Barnes et al., 2003: 15; Borrow, Munns et al., 2011: 72; Schmied, Donovan et al., 2011: 107; World Health Organisation, 1978). The primary health approach is informed by child development and attachment theories, recognition of the social determinants of health, and socio-ecological models still informed by dominant scientific knowledge of health and wellbeing (Schmied et al., 2011: 107).

The primary health care approach aligns with the principles of population health (Schmied et al., 2011: 107). In population health the focus is on early identification of those at risk and early intervention for better child health outcomes (Barnes et al., 2003: 15). A population health approach consists of universal services available to all combined with targeted and selected services to those assessed as needing extra support (Borrow et al., 2011: 72; Briggs, 2012: 4; Schmied et al., 2011: 109).

The place of child and family health nurses as agents of the state in promoting appropriate child rearing methods is reflected in their medico-scientific approach and the use of dominant scientific discourses in their work with clients. In Tasmania, child and family health nurses working from child health centres throughout the state offer nurse health assessments of child health, growth and development at regular ages between birth and five years (Department of Health and Human Services, 2014; Schmied et al., 2014). The child and family health nurses provide support to parents and information on parenting including nutrition, breastfeeding, sleep and settling, oral health, stages of child development, communication, play, postnatal depression, child safety, balancing work and family life, and practical parenting tips (Department of Health and Human Services, 2013). The information and advice is based on scientific, evidence-based literature and sources. For instance certain websites on parenting are recommended for parents in their baby's Personal Health Record (Department of

Health and Human Services, 2013: 21). These websites are run by recognised reliable scientific sources. One website is by the South Australian government department of Child and Youth Health (<http://cyh.sa.gov.au>). Another is the Raising Children Network (<http://raisingchildren.net.au>) which is supported by authoritative research organisations: the Murdoch Children's Research Institute, the Centre for Community Child Health at the Royal Children's Hospital in Melbourne, the Parenting Research Centre, and the Smart Population Foundation. CFH nurses also access these sites as a legitimate source of scientific, evidence-based information.

While much of the information is in response to mothers' questions or as 'anticipatory guidance' i.e. information on what to soon expect regarding their child's development, some of this information is required to be discussed as part of the child health assessment process (Department of Health and Human Services, 2013). Mothers receive information on key health topics such as safe sleeping, and the effects of smoking. Safe sleeping information from 'SIDS and kids' is promoted through a pamphlet provided with the Personal Health Record. CFH nurses are also required to raise the topics of sleeping and smoking with mothers through discussion as part of the Child Health Assessment at two, four and eight weeks. The SIDS information promotes babies be put to sleep on their back, in a safe sleeping environment including their own cot of Australian standards, with a firm mattress, and in the caregiver's room; that the baby be in a smoke free environment; and be breastfeed if possible (Sids and Kids) (www.sidsandkids.org). Smoking around children, second-hand smoke, is a risk factor for children's health (Winstanley and Ford, 2012: 4.9), and discussion of smoking behaviour, plus how to seek help to quit is part of a government strategy to reduce smoking. CFH nurses are required to record their discussion of smoking and sleeping via tick boxes on an assessment form completed at each assessment (Department of Health and Human Services, 2013).

At the eight week child health assessment it is policy for CFH nurses to offer mothers a screening test for postnatal depression. The Edinburgh postnatal depression scale questionnaire (Cox, Holden et al., 1987) is an objective tool used by professionals in their support of mothers. It is also a form of 'gentle' surveillance (Wilson, 2001; 2003: 285) by CFH nurses; a disciplinary technique that monitors the mental health of

mothers who may be referred to medical or support services such as counselling if there is evidence of depression.

Child and family health nurses also provide early intervention. They refer to appropriate services including the Parenting Centres; part of the Child Health and Parenting Service which provides short term intensive interventions for more complex issues such as postnatal depression, persistent sleep and settling issues, and breastfeeding problems. A two-year intensive home visiting program is also offered for young parents aged 15-19 years (Department of Health and Human Services, 2014). Families attend the centres for appointments or drop in without an appointment to open sessions. Home visits are also made, particularly for the first visits. Thus the child health service and its use by families has become a persistent feature of child-rearing in Australia.

The establishment of child health services and CFH nursing has had a continuously significant social influence on mothers and mothering. Founded on dominant scientific principles, these health services were, and continue to be, provided by CFH nurses to educate mothers in correct child rearing methods. In this way, how children are raised is managed at a population and at an individual level. This can be understood in terms of governmentality and bio-power. CFH nurses' use of technologies and practices which are part of bio-power becomes evident when considering the concepts of disciplinary power and surveillance.

TECHNOLOGIES OF DISCIPLINARY POWER AND SURVEILLANCE

Foucault (1991b) describes disciplinary technologies as strategies that are used to govern the 'right behaviour' of individuals and populations. These techniques are evident in the interactions between mothers and CFH nurses, as nurses act to shape maternal behaviours in particular ways. A key purpose of child health services is the surveillance of child populations for the prevention and early intervention into health problems (Wilson, 2001: 294). This surveillance work consists of the systematic

collection of data -the weighing and measuring of infants and assessing child development over set periods of time - the identification of those children not conforming to normative expectations, and the referral of these children and parents to further services either within child health or with other service providers (Perron et al., 2005: 541). These apparently benign health interventions are informed by dominant discourses of health and wellbeing. While scientifically validated, this mode of service has been challenged by sociologists who draw on Foucault to present a critical analysis of the health professionals' role in the surveillance and governing of populations.

Armstrong (1995) critiques what he has termed 'surveillance medicine', a new form of health care based on the surveillance of healthy populations which emerged in the twentieth century. He contends that child health services are a central apparatus in this surveillance. Unlike 'hospital medicine', the dominant model of Western medicine based on signs and symptoms and treating sick bodies, surveillance medicine is based on the risk of potential illness. The full development of the concept, Armstrong (1995: 395) argues, was built up around child health. This reflected the political focus at the time in terms of the link made between high infant mortality and child morbidity and mothers' lack of resources. Surveillance medicine aims to identify the potential risks of disease in both mind and body during growth and development (Armstrong, 1995: 396). Thus surveillance becomes a technology of governmentality; a means by which institutions and their representatives detect and guide individuals within populations towards 'normal' and 'right' behaviour and health milestones. Surveillance is central to technologies of disciplinary power.

Disciplinary power is the use of techniques that function overtly or discreetly in subtle coercions to 'train' docile bodies (Foucault, 1991a). A 'docile body' is one that can be 'subjected, used, transformed and improved' (Foucault, 1991a: 136). In the health context, disciplinary power provides guidelines on how people should 'understand, regulate and experience their bodies' (Lupton, 1997: 99). In the context of the mother-baby relationship, disciplinary power constitutes how mothers regulate their baby's body and development. Disciplinary power has a major influence on the governance of

both individuals and populations through forms of surveillance. These forms are the interrelated processes of 'hierarchical observation', 'normalising judgements' and 'the examination' (Bradbury-Jones et al., 2008; Foucault, 1991a; Gilbert, 1995: 868; Lupton, 1997: 99; Perron et al., 2005). They are the 'simple instruments' underlying the success of disciplinary power (Foucault, 1991a: 188).

'Hierarchical observation', the first form of surveillance, is a process of by which an individual perceives that their behaviour is constantly monitored, and behaves as if they are under constant observation (Perron et al., 2005: 539). Foucault described this surveillance as:

Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself. A superb formula: power exercised continuously and for what turns out to be a minimal cost (Foucault, 1980a: 155).

Drawing on the image of Bentham's (Bentham, 1843) panopticon structure - a prison where individuals would not know whether they were being observed or not - Foucault explains how individuals adopt a form of self-monitoring to become a 'docile body' (Foucault, 1977: 200). Its power lies in that individuals would not know when they were under surveillance therefore they adopt self-governing actions behaving as if they were under constant surveillance (Foucault, 1977: 200; Gilbert, 1995: 868). Today this surveillance, or 'hierarchical observation', is reflected in everyday life. For example mothers are aware family and friends as well as professionals can judge them on their mothering practices (Gilbert, 1995: 868). In the child health centre, surveillance practices can be overt such as with measuring and recording of the infant's growth, or subtle, through strategies such as CFH nurses' encouraging mothers to utilise specific services.

A prime site of surveillance is routine home visiting which allows CFH nurses to gather information about their clients, including information the CFH nurse may not

otherwise have become aware of unless the mother chose not to inform her. For instance CFH nurses in Wilson's (2001: 297) study were able to get a better picture of the private life and setting of the family including the relational dynamics between the mother and her partner when present. The CFH nurses believed this knowledge of the family was crucial to developing a better relationship with the mother than if they had not home-visited. Wilson (2001: 297) found surveillance was implicit. In Rollans and colleagues' (2013: 10) study, surveillance was also evident when, for example a CFH nurse would make observations of the environment such as checking the car in the driveway had the right baby seat.

Nurses would also learn about the family's private life by engaging in a 'discourse of the social' (Silverman, 1987: 191), that is engaging the mother in conversation. Peckover (2002: 372) describes techniques of talking and listening, asking questions and directive conversations and learning more over time as rapport builds between mother and CFH nurse. A friendly, non-coercive approach allows rapport to develop and allows assessments to be made of the mother and family by the CFH nurse with or without a formal assessment tool (Rollans et al., 2013). As Wilson (2001: 298) found, CFH nurses do not use the word surveillance but do talk of watching and observing. They understand their actions not in terms of surveillance but as practices conducted within an approach of respect and recognition of being in a privileged position of trust (Shepherd, 2005; Wilson, 2001: 297).

The second form of surveillance is 'normalising judgement' which, following comparison of the individual to particular norms and measures, classifies any deviation from the normal (Foucault, 1991b: 194; Gilbert, 1995: 868). Armstrong (1995) and Brosco (2001) argue that this creates a 'problematization of normality', which is the result of intense surveillance. This problematization and surveillance is epitomised in the height and weight growth charts used by CFH nurses (Armstrong, 1995: 396; Brosco, 2001). Such charts are predicated on the use of 'population data' to establish normality. Normal growth can only be understood in relation to the possibility that there is a category called abnormal growth. Armstrong (1995: 397) questions how the boundaries of what is normal for a child can be defined when measured against other children, arguing that 'abnormality was a relative phenomenon'. The growth charts

judge the child's body not against absolute physiological and pathological categories but against characteristics of a population considered normal (Armstrong, 1995: 397).

Normalising judgement is a form of reward/punishment with an implicit aim to change or 'correct' abnormal behaviours (Foucault, 1991b: 195; Perron et al., 2005: 539). This can be particularly powerful in the relationship between mother and professional nurse. For instance a mother may enjoy feelings of success as a mother when her baby gains in weight, at a visit with the CFH nurse. However, if her baby loses weight the mother is likely to experience negative feelings (punishment), possibly of failure as a mother, and feel the need (and be encouraged by the CFH nurse) to change behaviour to improve the situation. A negative judgement is also likely to result in ongoing surveillance, and could also be felt as a form of punishment.

Bradbury-Jones and colleagues (2008: 262) also point out there can be multi-directional forms of normalising judgements which are not just, for example, directed at mothers, but include nurses being judged by mothers, managers, and also themselves. This disciplinary technique can prompt self-monitoring or policing of oneself against normative standards (Bradbury-Jones et al., 2008: 262). Foucault has expressed this as 'technologies of the self' (Foucault, 1988). As Allen and Hardin (2001: 168) point out, people judge themselves and adjust their behaviour accordingly. 'Watching' oneself judgementally (i.e. normalising judgement) rather than descriptively, is the enactment of a discreet form of this disciplinary power (Allen and Hardin, 2001: 168; Bradbury-Jones et al., 2008: 262).

The third technology for encouraging the 'right' behaviour or 'training bodies' is the examination. This technique combines hierarchical observation and normalising judgement and is the 'social practice' by which the judgement is made (Bradbury-Jones et al., 2008: 263; Foucault, 1991b: 184; Gilbert, 1995: 868). Here the 'experts' make assessments, prescribe interventions and make evaluations using the objectifying discourses of the institution (Gilbert, 1995: 868). This pattern of social practices is followed, for instance when the baby is brought to the centre at the designated age for the Child Health Assessment conducted by the CFH nurse – the child is assessed

against normative growth measurements and developmental milestones, and confirmed as meeting normal healthy growth, or not. Examinations are an opportunity to observe the body, and this surveillance continues in the form of a popular appeal to patients to monitor themselves, and to confess their behaviour to 'responsible professionals' (Bloor and McIntosh, 1990: 160). The individual consequently identifies themselves within a certain discursive framework such as a 'good mother', or 'good nurse' (Gilbert, 1995: 868). Thus a 'gentle efficiency of total surveillance' (Foucault, 1995: 249) encourages families to attend child health services, and to comply with advice.

While technologies of power can be coercive a Foucauldian perspective also highlights the productive aspects of power (Cooper, 1994: 435; Perron et al., 2005: 536). From this perspective power is considered neutral: 'neither inherently oppressive nor liberatory, yet with the capacity to be both' (Cooper, 1994: 435). The productive aspects of power involve strategies that rather than being overtly coercive and acting on 'docile bodies' involve recruiting the active engagement of the client (Hayter, 2006: 34) - in the case of this study, the mother - in order to promote the health and development of the child. This active engagement entails the mother placing herself and her baby under surveillance. On the other hand, the voluntary nature of the use of the child health services means mothers can choose to see another CFH nurse if they wish to or not access the service at all. This suggests resistance forms a part of the mother-child and family health nurse relationship.

Surveillance and Resistance

Foucault (1990) argues resistance, like power, is present in all social interactions. The relational strategies that child and family health nurses use in their interactions with mothers are often intended to (covertly) minimise client resistance and maximise their compliance. In her interview study of New Zealand Plunket (child and family health) nurses, Wilson (2003: 290) problematised the CFH nurse-mother relationship as both friend and inspector, and suggested it was the monitoring and surveillance aspects of the role that caused tensions in their 'precarious' relationship. Surveillance was

legitimated by CFH nurses in their belief it was an objective and neutral instrument in a process of ensuring children's health (Wilson, 2003: 284). However a good relationship with the mother was required in order to undertake this surveillance. Therefore CFH nurses used a gentle, non-threatening, 'partnership' style of practice, avoiding a more directive approach, in order to develop an ongoing relationship with the mother. Wilson (2003: 285) defined this process as 'gentle surveillance', describing it as a technique to 'keep the mother coming'.

However, nurses display a reluctance to consider the concept of power in their practice. Peckover's (2002) Foucauldian analysis of health visiting practice in the UK revealed a tension between CFH nurses' caring role and their surveillance or 'policing' role (Peckover, 2002). There was a reluctance by the CFH nurses to understand their work in terms of conveying institutionalised values and social norms as this did not relate to the empowerment and non-hierarchical approaches they professed to use (Peckover, 2002: 375). They therefore did not acknowledge how they policed the family through their disciplinary practices; how they are used by the institution to shape clients' behaviour (Abbott and Sapsford, 1990: 148; Peckover, 2002: 375).

A critical view of the nurse-client relationship is also provided by Thompson (2008). She found the intensive role of the generalist family health nurse was 'enmeshed in practices of governmentality and bio-power' (Thompson, 2008: 76). Nurses in this role require a 'penetrative gaze', i.e. a highly intensive searching approach, which involves in-depth assessments, and providing educative and health promoting messages. In this way, nurses come to know their clients intimately and develop trusting relationships with them. Thompson (2008: 82) warns however, that this 'searching nursing gaze' has the potential to be deeper than the more superficial 'medical gaze'. The nurse comes to know far more about the client than the traditional focus on 'health and problems', as did the CFH nurses mentioned earlier in this chapter who learnt more about the families from observations during home visits. The intense level of surveillance conducted means not just the client but the wider family fall under the gaze and become well known to the nurse.

The relative intimacy of the nursing gaze and interaction can generate resistance and a backlash against health promotion work. As Thompson (2008: 82) pointed out, the clients in her study were not 'docile bodies' and while they sometimes welcomed high levels of intervention they could also contest, resist and redeploy information, intervention and education. Several clients, for instance, had declined the assessment, and others had withheld information the nurse had been aware of from living in a small community (Thompson, 2008: 81).

The key function of CFH nurses – the assessment and guidance of children's development and wellbeing – is underpinned by technologies of power such as discreet and overt surveillance, normalising judgements, and relational strategies. Much of the nursing literature, however, focuses on CFH nurses' interactions as a site for their 'caring work', and does not account for elements of power in these interactions. Care, much more than power, is a central discourse in nursing. I now use the Foucauldian concept of pastoral power, another key factor in governmentality, to provide a context for understanding the interactions between mothers and CFH nurses and also the significance and centrality of care in nursing.

PASTORAL POWER

Foucault (1982: 214) argues that institutions, particularly health care institutions, have taken on the pastoral function and institutional power of the church to care for and guide people. Foucault (1982) describes this function of health care as exercising a new form of pastoral power. Instead of looking after individuals throughout their life in this world for salvation in the next, health care institutions guide people for this world, with aims such as health, wellbeing, and safety (Dreyfus and Rabinow, 1982: 215). Abbott and Sapsford (1990: 134) describe pastoral power as 'advising, counselling and facilitating' and argue this is just as effective as coercive power to determine and guide appropriate behaviour. Two processes central to pastoral power are the development of a trusting nurse-client relationship and client empowerment (Holmes and Gastaldo, 2002; Thompson, 2008). These practices are fundamental to nursing and particularly child and family health nursing, given the centrality of the nurse-client relationship, a major theme in nursing literature (Bridges, Nicholson et al., 2013; Briggs, 2007; De la

Cuesta, 1994; Jonsdottir et al., 2004; Luker, Austin et al., 2000; Taylor, 1998). It is through relationships that child and family health nurses can conduct their caring work (De la Cuesta, 1994).

Developing a trusting relationship with the client, rather than attending only to child development concerns, provides CFH nurses with a strategy to get to know the client on a deeper level (Cody, 1999). CFH nurses see their listening and their emotional and psychological support as providing therapeutic benefits, for example helping the client to make meaning of their experiences (Cody, 1999: 121). From a Foucauldian perspective, building trusting relationships and processes of 'confession' are crucial elements of pastoral power (Holmes and Gastaldo, 2002: 562). Confession has now come to function within the norms of the science of care (Foucault, 1990: 65); where just as people once confessed to their priest and received absolution and healing; now it is normal for clients to discuss their problems with their counsellor, or therapist, or nurse. This revealing of oneself is a principal means by which nurses are able to gather information about their clients (Holmes and Gastaldo, 2002: 563) and influence clients' (healthy) actions or behaviours. Thus expectations and norms around confession are integral to the pastoral power of the nurse.

Nurses are reluctant to link their relationships with clients to the concept of power. For nurses these interactions are the site of their 'caring' work, arguably a more familiar and comfortable concept than power (Manojlovich, 2007; Rafael, 1996; Ryles, 1999). The centrality of care and relationships reflects a humanistic understanding in nursing (Paterson and Zderad, 1976: 3; 2008). A humanistic approach sees nursing as providing personalised care that recognises the uniqueness of all individuals (Davis, 2005: 126). It is understood as an approach where 'nurses consciously enter into an empathetic and (possibly mutual) therapeutic relationship with patients' (Traynor, 2009: 1563). The nurse provides individualised care with the aim of developing the human potential to the utmost and achieving wellbeing. Pearson (1991: 193) states that 'true caring is based on an attitude of nurturing – of helping another to grow'. Helping another self-actualise is caring in its most significant sense (Mayeroff, 1971). It is through relationships, seen as the 'common ground' of all nursing, that care is conducted.

Nursing academics argue that for child and family health nursing, care is grounded in interaction and relationship building (Cody, 1999; De la Cuesta, 1994). However there are many tensions and conflicting constructions in nursing that challenge such a relational approach.

Contested approaches to caring

There are two contrasting and interlinked approaches of care apparent in the literature relating to child and family health nurses' interactions and relationship building with clients. Firstly, there is a collaborative approach which reflects a humanistic style and which I relate to pastoral power. Secondly, a contrasting expert approach which I link to the concept of power-knowledge.

Collaborative approach

A collaborative approach, the more dominant approach currently promoted in the child and family health nursing literature, strives for a partnership between CFH nurse and client (Davis and Day, 2010: 80; Day, 2013; Roche et al., 2005: 510). The aims of the model are for the CFH nurse to engage with the family in a supportive relationship involving parents as partners, in a process that enables the parent to use their own skills and expertise in the process of finding solutions tailored to their needs (Davis and Day, 2010: 80). The process of professional partnership is viewed by nursing scholars as being at the relational core of nursing (Jonsdottir et al., 2004: 241). From this perspective, nurse and client work together through an 'open, caring, mutually responsive and non-directive' dialogue whereby all involved gain insight into the areas of health which are a concern and how to best address these (Jonsdottir et al., 2004: 241). The concept of pastoral power is reflected in this relational approach of engaging the client and coming to know the client. The partnership approach to relationship-building has been presented in child and family health nursing literature as a more appropriate model of relating to parents than the traditional expert model which is more directive and less collaborative (Davis and Day, 2010: 112-124).

Expert approach

Within the expert model the nurse is presented as having superior expertise to the parent and holding the power to control the interaction and decision-making (Davis and Day, 2010: 76). This understanding reflects the Foucauldian concept of knowledge-power, where dominant, scientific, knowledges are constructed as expert knowledge and the domain of the dominant professional groups, in this case CFH nurses, with the resultant dismissal of maternal knowledges (Miller, 2005: 31; Reiger, 1985: 139). This contrasts with the collaborative model that recognises the expertise of both mother and nurse. The construction of nurses as experts is evident in a group of qualitative empirical studies that examine the CFH nurse-mother interactions and the advice-giving practices of CFH nurses.

Findings from UK and Swedish studies show that unsolicited, standardised and otherwise unwelcome advice was common in CFH nurse-mother interactions. Heritage and Sefi (1992) examined the advice-giving practices of UK Health Visitors' first home visit to first-time mothers. The findings revealed that while some of the advice, which was predominantly related to the care of the baby such as when to bath and when to start solids, was informative for the mothers, 75% of the advice was unwanted (Heritage and Sefi, 1992: 391). Kendall's (1993) UK study of health visitors' interactions with mothers with a child under one year, also found advice giving was unsolicited in 95% of the cases (Kendall, 1993: 105). When mothers did request advice, CFH nurses responded by going into a stereotyped 'advice giving sequence' without first exploring the nature of the issue with the mother (Kendall, 1993: 105). Similarly, Baggens (2002: 361) found Swedish CFH nurses also offered standardised answers to parents' concerns. Baggens (2002: 351) conclusion, reflected in all the studies, was that such practices of advice giving did not empower mothers and acted to reinforce the CFH nurse as the expert.

A further key theme in the research was that CFH nurses believed in the truth of their own 'expert' knowledge and dismissed the 'popular' or lay knowledges of the mothers. Heritage and Sefi (1992) found that CFH nurses regarded their own knowledge and

expertise as superior to that of the mothers', and asserted their authority on this basis. This was particularly evident in instances where mothers would attempt to assert their own knowledge or competence (Heritage and Sefi, 1992: 412). Similarly, Kendall (1993: 105) found mothers' knowledge was generally not taken into account by the CFH nurses, nor was the mothers' knowledge sought, suggesting that the CFH nurses saw themselves as the authoritative experts in child rearing.

A further theme in these studies that demonstrates aspects of the expert model of care, was that child and family health nurses dominated the talk and the interactions (Baggens, 2001; Kendall, 1993: 105). CFH nurses in Baggens' (2001: 659) study controlled the interactions by following a professional agenda which included assessing health and development and detecting health problems. CFH nurses initiated the topics for discussion three to five times more frequently than mothers, thus constraining the conversation to the topics deemed important to the professional agenda, and deterring the mother from raising her own topics (Baggens, 2001: 664). The CFH nurses were in turn subject to their service program directives, the official health promotion program they were required to deliver (Baggens, 2001: 664).

A final theme found in the studies was advice-giving used as the child and family health nurses' 'ticket of entry' to deflect perceptions of surveillance and social control (Heritage and Sefi, 1992: 413). In the UK, where health visitors were mandated to visit all mothers with newborns, offering advice provided a purpose for the CFH nurses visits, particularly in cases where the visits or engagement with the service is unwanted by the mother. The CFH nurses generally initiated advice giving via a series of steps in which a problem was developed that required advice. The process involved an initial inquiry from the CFH nurse, such as 'Is the baby's [umbilical] cord dry?'; a response from the mother indicating a possible problem; a more focused inquiry into the problem by the CFH nurse; a detailed response from the mother; and finally advice giving by the CFH nurse (Heritage and Sefi, 1992: 379). The CFH nurses unsolicited exploration of the situation allowed her to tailor her advice in a way that supported rather than openly challenged the mother's actions thus the CFH nurse was able to appear of use to the mother (Heritage and Sefi, 1992: 380). However the advice-giving also implied that the mother was lacking in knowledge to some degree, and this

resulted in advice that was of indeterminate value to mother, or advice that was resented and resisted by the mother (Heritage and Sefi, 1992: 413).

Empowerment

The Foucauldian concept of power incorporates the ability to influence the behaviour of another (Cooper, 1994: 437; Foucault, 1982: 221). Expert power has been defined in nursing as 'the ability to influence others through the possession of knowledge or skills that are useful to others' (Kubisch, 1996 #485: 198). It is how this influence, or 'neutral' power is exercised within the interaction that determines whether it is liberatory or oppressive (Cooper, 1994: 435). Benner (1984: 209), in her seminal book *From Novice to Expert*, described how skilled and experienced nurses can empower their clients via expert power through the nurse-client relationship, but only, she stressed, when these relationships are based on 'mutual respect and genuine caring'. Such relationships are crucial to pastoral power and influence how nurses guide the behaviour of clients. A therapeutic relationship of mutual trust, respect and equality where clients are equal participants in the process facilitates the empowerment of clients including those in underprivileged groups (Kuokkanen and Leino-Kilpi, 2000: 237).

The empowerment approach in health care has become prominent following the Declaration of Alma-Ata in 1978 (Falk-Rafael, 2001: 1). This declaration, from an international conference on primary health care, heralded the view of health as a social justice issue – health was acknowledged as a fundamental right for all, and all had a right and duty to be involved with planning and implementing their health care (Aston, Meagher-Stewart et al., 2009: 24; Falk-Rafael, 2001: 1; World Health Organisation, 1978). Encouraging populations to take control over their own health is a feature of governmentality and the productive aspects of power. Empowerment became identified with health promotion, defined in the Ottawa Charter as the 'process of enabling people to increase control over, and to improve their health'; a key feature of a new public health movement (World Health Organisation, 1986). Across the health disciplines empowerment has become associated with enabling

people 'to gain some measure of power in their own lives', although how this occurs differs according to the discipline focus and setting (Falk-Rafael, 2001: 2).

Chandler's (1992: 65) definition of empower; 'to enable to act', reflects a nursing position which draws on the possibilities for empowerment. Zerwekh's (1992b: 102) definition of empowerment describes a nurse approach whereby parents are enabled 'to develop personal capacity and authority to take charge of everyday family life'. This focus melds well with the humanistic caring approach which views caring as helping the client grow towards their potential. Guiding clients in this way is a feature of pastoral power. Empowerment is described as essential to nurse practice when working with families (Aston, Meagher-Stewart et al., 2006; Cawley and McNamara, 2011; Houston and Cowley, 2002; Mitcheson and Cowley, 2003; Rao, 2012).

In line with a collaborative approach, empowerment is viewed as client-centred and is underpinned by the development of a trusting relationship. Negotiating health goals with the client, being a resource of knowledge, building client skills and capacity, and using a strengths-based approach have all been described as features of empowering practice (Falk-Rafael, 2001). They are also features of pastoral power in that they focus on guiding the client towards appropriate behaviours. The use of empowerment in nursing has been focused at the level of the individual rather than at a more radical level of population (social) change. This is due in part to the fact that power in the nursing context has remained largely unexplored.

Much of the nursing literature that examines empowerment fails to address the relationship between empowerment and power (Gilbert, 1995: 865). While readily accepting a positive concept of empowerment in their practice, nurses have expressed discomfort with the idea of power (Rafael, 1996: 3). Nurses engage much more readily with the 'intuitively attractive' concept of empowerment, which is closely linked to their conceptualisation of 'care' (Ryles, 1999: 600). Where power is considered within the nursing literature, it has been defined as 'control, influence, or domination' (Chandler, 1992: 65), and thus is conceptualised in direct opposition to care (Manojlovich, 2007: 2; Rafael, 1996). The interpretation of power as 'coercion and domination' (Kuokkanen and Leino-Kilpi, 2000: 236) also conflicts with nurses' beliefs

around empathic and therapeutic caring. The tension between adverse perceptions of power and humanist perceptions of care suggest the reason for nurses' discomfort and reluctance to engage with power.

Researchers contend that examining empowerment in nursing practice through a critical lens will reveal underlying dynamics of power (Bradbury-Jones et al., 2008: 258; Gilbert, 1995; Perron et al., 2005). Powers (2003) for example, critiques strategies of empowerment in nursing and argues that empowerment is used as a coercive strategy under the guise of choices offered to clients. The choices presented, however, tend to be limited to what the health professional believes are safe options, while alternative choices outside the dominant paradigm are not offered. Because they are undertaken for the 'good of the patient' such strategies may be seen as 'benign coercion' with little critique of the exercise of power. However, the essence of power is not so much about who has it or what it is, but how it is exercised (Kuokkanen and Leino-Kilpi, 2000: 237); in this case, how it is applied in nurse-mother interactions.

Attempts to empower clients may prove difficult for nurses as the existing unequal power relationship can operate to constrain fundamental requirements of empowerment such as open communication (Delmar, 2012; Kuokkanen and Leino-Kilpi, 2000: 238). For example, language can be used to exercise the nurses' power over, and control of their clients. Hewison (1995: 78-80) described several ways this can occur in interactions with clients in a nursing home: overt practice such as ordering a client to undertake an activity; persuasion such as amicably deterring a client from an undesirable behaviour; controlling the agenda which Hewison describes as using routine communications about what was expected to happen; and using terms of endearment which engendered a mother-child encounter.

Humanistic ideas and approaches to the conceptualisation of care in nursing pre-suppose that the nurse-client relationship is collaborative and enabling. A collaborative rather than expert approach is favoured as it fits with CFH nurses' conceptualisations of care. This approach centres on communication and client involvement in their own health care, which is constructed as empowerment. These ideals and approaches can

obscure strategies of persuasion or 'benign coercion' that are inherent in nurse-client conversations and the presentation of health care information and options. These strategies are central to the exercise of pastoral power.

CONTESTED CONSTRUCTIONS OF CARING, KNOWLEDGE AND STATUS

The complexity of care in nursing is reflected in Gordon's (2006: 104) description of nursing (presented in the above introduction) as 'a tapestry of care ...that includes emotional, physical, intellectual, domestic, technological, and medical activities' and her claim these dimensions often exist in opposition to each other rather than in harmony. The relationship between care, status, power and knowledge adds further to the complexity of the interplay of these dimensions within child and family health nursing. Contested constructions of nursing care and nursing knowledge also reveal tensions between nursing identity and practice.

Contested constructions of care

The nursing literature describes a tension whereby institutional (management) modes of care are privileged over the professional ethic of (relational) care. Within organisations the 'tasks' of caring, such as assessments or immunisations, are easier to define and manage and are emphasised over the emotional labour nurses provide (Phillips, 2007: 122). Physical care, including screening and health assessments of children, provides a framework for the organisation and management of care (James, 1992: 505). The relational elements of care, a major part of the nurses' work, do not feature strongly in the care management approach and the legitimacy of such care is not as evident within policy priorities (Phillips, 2007: 122). Health services, with their 'scientific' focus on 'doing' and physical interventions, prioritise physical labour over the more invisible, lower-status emotional labour (James, 1992: 503). Thus nurses can find their everyday practice results in conflict between the needs of the organisation and the best interests of the client (Grant, 2012: 13; Phillips, 2007: 122).

Studies involving child and family health nurses also reflect tensions when CFH nurses' ideas of what is important in caring conflict with institutional agendas. Cody (1999) identified two competing agendas of health visiting work in her account of British health visiting (child and family health nursing). The first was the recognised public policy aspects including the measurable tasks of child development screening and immunisation, the overt surveillance and population health measures of bio-power. The second agenda, reflecting health visitors' pastoral power, was their support of mothers through the provision of psychological support, particularly within an established relationship of trust. While health visitors were mandated to focus on the first agenda, it was the latter that could take up the majority of time, with the health visitors focus being on offering psychological support and non-directive counselling (Cody, 1999: 123).

Grant (2012), who found similar tensions, addressed child and family health nurses resistance and exercise of power in their caring. Providing care that is individualised to the client was important for the CFH nurses in Grant's (2012) Australian study of interactions with culturally diverse families. The CFH nurses in this study were frustrated when their view of the individual needs of their client conflicted with the organisation's view of how care should be delivered (Grant, 2012). They were particularly frustrated if they felt they were not listened to by the organisation (Grant, 2012: 14). However CFH nurses who had confidence in their caring role, i.e. CFH nurses who accepted their authority and embraced caring, compassion and empathic approaches, created room for a constructive, rather than a rebellious resistance (Grant, 2012: 14). This constructive resistance was evident on two occasions in the study. In one instance, a CFH nurse halted her structured needs-assessment, a dictate of the organisation, in response to her client's needs, and in another instance, a CFH nurse provided more visits to a client than was sanctioned by the service (Grant, 2012: 13). CFH nurses in these cases made decisions based on their professional ethic of care, and exercised power productively by empowering the mothers (Grant, 2012: 14). However, less 'expert' (Benner, 1984), for example less experienced, CFH nurses felt more conflicted in their decision making between the needs of the client and the

dictates of the service (Grant, 2012: 14). They felt this was a decision between being a 'good nurse' or a 'good employee' (Grant, 2012: 12).

Contested constructions of nursing knowledge

A further contested area of nursing and care is that of nursing knowledge. In its assertion of professional status, nursing has laid claim to its own body of knowledge (Chiarella, 2002: 192; Hall, 2005; Lawler, 1991: 35; Stevens and Crouch, 1998: 160; Watson, 2013: 243). Chiarella (2002: 201) contended that the nursing profession originally argued that this body of knowledge was the formalising of women's work, at a time when the rising status of women was becoming a prominent issue. Some decades later the argument had developed that nursing was a scientific discipline in line with medicine but with different content areas. This century the argument has shifted again to define nursing as a discipline based on nursing research, and focusing on the 'essence of nursing', the nurturing aspects, which has generated a unique body of nursing knowledge (Chiarella, 2002: 201). Nursing is therefore a profession where clinical nursing knowledge and expertise ought to have equal weight with medicine in clinical decision-making (Chiarella, 2002: 265).

Kulbok and Ervin (2012: 37) have stated that nursing knowledge is 'the product of interaction and interdependence of four domains – the discipline and science of nursing, the philosophy of nursing, the nursing profession, and nursing practice'. However these US nursing academics found that medical perspectives rather than nursing perspectives continue to have a major influence on nursing education and practice (Kulbok and Ervin, 2012: 39). The importance of pastoral power is reflected in the authors' focus on relational caring as they argue nursing knowledge stems not so much from empirico-analytic science, but from the lived experience of nurses involved in caring relationships with their clients (Hagell, 1989: 226). While nursing has a strong scientific base, nursing knowledge has been defined by nursing theorists as:

[K]nowledge of people (or people in groups) and health-illness experiences that are mediated by human care transactions. [Nursing knowledge] allows a close and systematic observation of one's own experience and seeks to disclose and

elucidate the lived world of human health-illness experience and the phenomena of human-to-human caring (Hagell, 1989: 231).

While nursing makes claim to a body of knowledge, Hagell (1989: 231) warns of the dominance of an empirico-analytic science that would risk the loss of the essence of nursing i.e. care. Hagell (1989: 231) claims that care cannot be conceptualised by science nor measured; it can only be experienced. As experience and emotional labour is sidelined in institutional modes of care, nursing knowledge would also remain subordinate to the dominant medico-scientific knowledge. Despite professionalisation, clinical nursing knowledge and expertise are yet to enjoy equal weight with medicine in clinical decision making (Chiarella, 2002: 265).

Gordon (2006) has challenged discourses which position nurses as holistic caregivers, particularly in contrast to doctors and the reductionist approach in medicine. Nursing professionals have been accused of introducing a new reductionism by constructions of medical and technical aspects of nursing practice that are highly contrasted with the emotional, relational and caring aspects (Gordon, 2006: 106). As Gordon (2006: 106) argues:

Rather than joining the body and mind, the physical and the emotional, the medical and technical into that tapestry I described, nurses constantly counterpose the technical and medical with the caring, emotional, and relational. This dichotomization is one of the distinguishing characteristics of nursing discourse in the late twentieth and early twenty-first centuries.

That nurses treat the body as well as the mind; that they do 'lifesaving, not simply soul-saving' work is a matter many nurses avoid acknowledging in their nursing identity (Gordon, 2006: 105). The reason for this avoidance, Gordon (2006: 116) postulates, is that nurses do not want to be associated with the 'tasks' related to the care of bodies. These 'tasks' limit nursing to 'mindless activities' that hold low status in the medical system (Gordon, 2006: 116). This denial, however, minimises the skills and investment in education that nurses require to carry out their role. The contested

nature of the discourses on nursing knowledge is reflected in debates on the status of nursing.

Contested constructions of nursing status

The status of nursing is also a contested area both within nursing and among other professions. Child and family health nursing is considered low status both within nursing and in relation to medicine in particular. In contrast to the predominantly technical nursing specialisations, child and family health nursing is among a smaller number of specialist groups, including community nursing. These community branches of nursing, which work from public health and primary health care paradigms, are considered marginalised areas of nursing (Keleher, 2000). As these paradigms privilege the promotion of health and prevention of illness they are contrasted unfavourably with the much higher profile illness paradigm which favours the diagnosis and treatment of illness (Keleher, 2000: 258-259). The holistic, client-centred approach sits in contrast to the more fragmented, but technical means of care (Zadoroznyj, 1998: 24) which better articulate with the dominant bio-medical discourses.

Many factors have contributed to the status of nursing, such as determinations about the relative autonomy and technical nature of the work. These comparisons are made using an indeterminate/technicality ratio that describes the level of autonomy and status a profession holds (Traynor, 2009). The relational, non-technical nursing care work reflects more the 'indeterminate' aspect of the work compared to the 'technical' aspect. A key feature of indeterminacy is tacit knowledge (Polanyi, 1967). This knowledge, which is not able to be put into words, is built on experience, competence and expertise, and influences a person's actions (Polanyi, 1967). Unlike technical skills, such knowledge cannot be taught but is gained from experience. Nursing as a lower status profession within healthcare is considered to have a high level of technicality. Child and family health nursing, however, was found by Belle and Willis (2013) to have a high level of indeterminacy. Yet child and family health nursing remains a low-status field within nursing (Keleher, 2000: 258).

In exploring the professional status and role of the nurse, Chiarella (2002: 17) identified five concurrent constructions or 'images' of the nurse in her study of how

nurses are portrayed both in a legal sense - through the courts system, and in society, for example through media. Some of these images are contradictory, some are more dominant at different times in history, but all, to some extent, are present in the lives of nurses (including CFH nurses) today (Chiarella, 2002: 17). The images include the nurse as ministering angel, the nurse as domestic worker, the nurse as doctor's handmaiden, the nurse as subordinate professional, and the nurse as autonomous professional. Three of these images, domestic worker, doctor's handmaiden and subordinate professional, are of non-nursing origin, mainly from doctors and health administrators, and present nurses as 'under control'. The other two images, ministering angel and autonomous professional, emerge from nursing literature and narratives as nurses 'in control' of nursing and nursing's image (Chiarella, 2002: 30). Chiarella (2002: 30) argues it is not nurses but the non-nurses who have had the power to depict the role and status of the nurse. Where the status of the nurse has been in question, as in cases of law, the images derived from non-nursing sources have usually prevailed (Chiarella, 2002: 30). How clients construct nurses and what clients expect from nurses is influenced by these images.

While nursing's body of knowledge relates to caring it is the dominant scientific knowledges that are called on by the health institution to be promoted to clients and to influence the behaviour of mothers. Nursing knowledge and care remain subordinate to medicine and the status of the nurse remains that of 'subordinate professional' –the autonomous nurse with responsibility remains subordinate to the autonomous doctor with power (Chiarella, 2002: 18).

CONCLUSION

I have argued that child and family health nursing sits in a context of health promotion that constitutes governmentality; where child and family health nurses manage the health behaviour of individuals and populations on behalf of institutional goals. This power is established via a body of expert knowledge and yet exercised relationally. Thus, child and family health nursing is underpinned by a humanistic conceptualisation of care that focuses on collaboration and guidance that constitutes pastoral power. Through their disciplinary technologies of surveillance and the regulations and

procedures of their discipline, CFH nurses are a vehicle for social control (Perron et al., 2005: 541). However, studies suggest that nurses themselves lack awareness of this power. Caring is a more dominant concept in nursing and the centrality of care is evidenced in the emphasis on the CFH nurse-mother relationship within an ethical framework of care. Employing the concept of pastoral power allows a more critical understanding of the relational nature of power in the CFH nurse-mother interaction.

Entwined with both care and power, scientific knowledge is a dominant discourse which underpins CFH nurses authority and practice. Scientific knowledge as the authoritative knowledge on child rearing is a central feature of CFH nurse practice, as seen in the prevalence of advice-giving in many interactions. Mothers' knowledge and expertise is largely subordinated to that of the dominant medico-scientific knowledge. Constructions of knowledge and the nursing role, however, are contested. The increasing autonomy of nursing through professionalisation, the indeterminate nature of nursing experience, which constitutes expertise, and popular images and portrayals of nursing contribute complexity to these constructions.

Studies of child and family health nursing challenge claims that child and family health nurses work in a partnership-style relationship with mothers. The existence of surveillance in child and family health work highlights negotiations of power that occur in the mother-CFH nurse relationship. The concern, Wilson (2001: 299) points out, is the impact on those more marginalised or vulnerable mothers, who may not feel in a position to negotiate effectively. That such mothers may resist the imposition of dominant ideas and practices is explored in the following chapter.

CHAPTER THREE

GOOD MOTHER IDEOLOGIES AND RESISTANCE IN THE CONSTRUCTION AND PRACTICES OF LOW-INCOME MOTHERING

INTRODUCTION

In this chapter I discuss ideological representations of the good mother that regulate mothers in our society (Goodwin and Huppatz, 2010a: 1). Good mother ideologies are complex and contested social constructions, but they are dominated by bio-medical and scientific discourses and have a powerful influence on mothers' child-raising behaviour. Low-income mothers are one of many groups of mothers whose practices and dispositions are compared unfavourably to elements of dominant good mother ideologies (Gillies, 2007: 1; Stapleton, 2010). This contributes to, and reflects their social and cultural marginalisation, and the surveillance to which their lives are subjected. The concept of 'scientific mothering' (Apple, 1995), described as mothers' submission to the knowledge of psychological and bio-medical experts on the raising of children, is of particular significance in the interactions between mothers and the child and family health nurses and emphasises a tension between the medico-scientific, rational approach and the relational approach of CFH nurses caring. Drawing on sociological and nursing literatures exploring mothering and nurse-mother relationships, and employing Foucauldian concepts of knowledge-power and pastoral power I argue that low-income mothers both value and resist scientific mothering. Mothers seek CFH nurses' knowledge and expertise and their support but at the same time resist challenges to their own experiential knowledge and expertise. These opportunities for resistance are evident in mothers' everyday lives and their interactions with child and family health nurses. These practices of resistance suggest that insight can be gained into alternative understandings of good mothering that remain under-represented in the literature.

I begin this chapter with a discussion on good mother ideologies in contemporary society, using perspectives from sociological, professional nursing and health literature. I follow this with the argument that good mothering ideologies are always contested, however low-income mothers while contesting negative portrayals remain marginalised in discourses of mothering. I then address a constitutive element of this ideology that is of particular relevance to this study; that of scientific motherhood and the related imperative that mothers have the guidance of experts in raising their children. Conformity and resistance to health messages is discussed with a focus on low-income mothers. Finally I turn to the relationships between mothers and child and family health nurses and present the complex and nuanced forms of resistance to authority and expertise that can occur in these interactions.

GOOD MOTHER IDEOLOGIES

The regulation of mothers in society is evidenced in the multiple ideologies of mothering that are historically, culturally and socially situated. The socially constructed elements of the good mother provide 'the ideals and standards women are expected to conform to and against which they are judged and judge themselves' (Goodwin and Huppatz, 2010a: 1). A burgeoning body of literature about motherhood reveals rather than a single coherent concept, multiple and nuanced ideas of what constitutes the good mother co-exist in contemporary western societies (Abrams and Curran, 2011; Butler et al., 2010; Christopher, 2012; de Souza, 2013; Elliott, Powell et al., 2013; Goodwin and Huppatz, 2010b; Johnston and Swanson, 2006; Maher, 2005; Maher and Saugeres, 2007; Manne, 2005; Marshall, Godfrey et al., 2007; Mollidore, 2013). Despite changes in women's social standing over the last three to four decades, such as the significant movement from stay-at-home mothers to large numbers of mothers moving into the workforce (Brown, Small et al., 1997: 185), some elements of the dominant good mother ideology have changed little, with mothers continuing to bear the prime responsibility for childrearing.

'Intensive mothering' best describes the dominant good mother ideology at this time (Arendell, 2000: 1192; Hays, 1996). Features of this ideology include mothers as primary carers for children; and that child rearing is 'child-centered, expert-guided, emotionally absorbing, labor-intensive, and financially expensive' (Hays, 1996: 54). Children are treasured beyond any considerations of money, efficiency or broader economics (Hays, 1996: 54). Mothers are also to perform physical care by keeping their children clean and providing adequate food and clothing (Wearing, 1984: 49). Children also need attention appropriate to their age of development in terms of cognitive stimulation and psychological nurturing (Hays, 1996: 54).

The responsibilities implied by good mother ideologies incorporate physical care but extend beyond practice to disposition. A good mother puts her children first because she is, first and foremost, a mother. In terms of disposition, she is loving calm, relaxed and patient, does not scream or yell or continually smack her children; she exercises self-control even in challenging circumstances (Brown et al., 1997: 197; Lupton, 2000: 60; Lupton and Fenwick, 2001: 1011). An infant's needs must always come before the mother's and any privations, such as loss of sleep, must be dealt with, with equanimity (Lupton and Fenwick, 2001: 1011). These expectations can be linked to the idealisation of an intensely emotional relationship between a mother and her children, which Douglas and Michaels (2004) refer to as 'new momism'. This, they explain, is an unrealistic expectation that to be 'truly fulfilled' a woman must become a mother and be totally devoted intellectually, psychologically, emotionally, and physically to her child at all times (Douglas and Michaels, 2004: 4).

Mothers are also expected to be responsible for the total safety of their children. Situated within the current neo-liberal risk culture, or personal responsibility culture, mothers must 'eliminate all risk to children at any cost' (Wolf, 2011: xvi-xvii). This expectation reflects the ethics of individual responsibility and the good citizen as one who takes care of themselves (Petersen and Lupton, 1996; Wolf, 2011: xvi). 'Total motherhood' is a moral imperative where the child's environment must be risk free, as anything less is perilous (Wolf, 2007: 615). These imperatives take precedence over any of the woman's 'wants' (Wolf, 2007: 615).

Scientific discourses are central to good mothering practices, and reflect the dominance of scientific knowledge. The mothers in Brown and colleagues' (1997: 196) study believed the good mother needs to stimulate and encourage children's emotional development throughout infancy and childhood. Such beliefs reflect an acceptance of the psychological and child development literature which reinforce the ideas that a mother's active involvement and guidance is most important for the child's development, and that the mother must be with her child for the first three to six years (Fowler, 2000: 118; Wearing, 1984: 61). Child-rearing manuals, 'experts', the market, and media reinforce expectations that mothers are expected to expend a great deal of cognitive, emotional, physical and financial resources on the child (Hays, 1996; Pocock, 2003: 81).

Dominant constructions of good mothering are unachievable. Mothers recognise the impossibility of meeting the ideals but they nevertheless feel the pressure to be a good mother (Arendell, 2000: 1196; Brown et al., 1997: 198). The mothers in Wearing's (1984: 54) and Oakley's (1979: 143) studies committed the 'cardinal sin' of losing one's temper and being angry with their child, as patience and not losing her temper were considered key attributes of the good mother (Brown et al., 1997: 198). Almost all mothers experienced a sense of guilt for not living up to the ideal (Wearing, 1984: 52) even though, in Wearing's study, no participant could identify a woman who conformed to the good mother ideal.

In her study of both low-income and middle class working mothers Arendell (1999) makes several key points regarding the impact of motherhood ideologies on women. First, she argues motherhood ideologies shape women's actions and sense of self even when resisting such ideals (Arendell, 1999: 3). Mothering ideology is the background for both mothering behaviours and judgement of mothering (Arendell, 1999: 3). Arendell (1999: 14) also found mothers denigrated themselves and others at the same time. Mothers' discussion of their strengths was accompanied by critical comments such as 'if only I was ... 'more organised' or 'more patient' or 'less stressed' (Arendell, 1999: 12). Mothers justified and defended their choices by comparing themselves to other mothers in similar circumstances instead of, Arendell emphasises, with reference

to social factors such as work and social policies, or lack of support from partners (Arendell, 1999: 14). In the process of defining their mothering against dominant discourses mothers contribute to their own policing against the norms - mostly without reflection (Arendell, 1999: 21).

The judging of oneself against the (idealised) norm and adjusting one's behaviour accordingly, or feeling guilty when not meeting the norm, reflects the hidden power of discourses on the self such as self-monitoring (Allen and Hardin, 2001: 168), as discussed in Chapter Two. Mothers engage in self-governing behaviours, for example, when attending child health centres, or when they conform to societal expectations to have their children immunised, or breastfeed their baby even when ambivalent about this (Lupton, 2011). The practices expected of the dominant ideal of the good mother are oriented toward maximising the physical and psychosocial development of her children. However while certain elements of the good mother ideology are persistent, they are also contested. I present these re-negotiated constructions of motherhood in the next section.

GOOD MOTHER IDEOLOGIES AND CLASS

Good mother ideologies can have the effect of excluding particular mothers, and can marginalise alternative motherhoods. Arendell (1999: 4) claims that this exclusion occurs on the basis of discourses that position difference and non-conformance to ideological norms as deviant behaviour. Aimed at mothers who do not meet the social mores they act to stigmatise and punish mothers. However these discourses are not applied consistently across class or racial groups (Arendell, 1999: 4). For instance middle-class mothers not dependent on welfare can be full time mothers whereas low-income mothers cannot and must be part-time workers to be a good mother (Arendell, 1999: 5; Blaxland, 2010). Processes of mother-blame are a key strategy of these discourses, which operate to hold mothers to account for, among other things, their child's health and development (Arendell, 1999: 7).

Good mother ideologies are, however, contested. Mothers can reinterpret their behaviour choices as conforming to dominant ideals, and ideologies can shift to incorporate emergent practices. The capacity to challenge, incorporate and reinterpret good mother ideologies varies according to social position and is not available in the same ways to all mothers. Mothers who are marginalised due to their social position or the circumstances under which they are mothering are particularly vulnerable to processes of exclusion rather than reinterpretation.

Representations of low-income mothers frequently portray this group from a deficit perspective. Social scientists argue that working-class mothers, who do not conform to middle-class standards of parenting, are 'vilified and blamed' by media and politicians alike (Butler et al., 2010; Cutcher and Milroy, 2010: 166; Gillies, 2007: 1). The negative portrayal of low-income mothers is emphasised in Gillies' (2007) book 'Marginalised Mothers', which is based on her qualitative interview research with low-income mothers in the UK. The author argues that popular discourses, including television and newspapers, portray mothers who are poor and marginalised as a particular type of mother. She is 'irresponsible, immature, immoral, and a potential threat to the security and stability of society as a whole' (Gillies, 2007: 1). Such negative portrayals of low-income mothers are intensified when combined with young age.

Young motherhood, coupled with low income is particularly problematised. The intersection of class and age presents a substantial obstacle to the good mother ideologies reflected in discourses and government policies, particularly for teenage and single mothers (Breheny and Stephens, 2007; 2009; McDermott and Graham, 2005; Stapleton, 2010; Verduzco Baker, 2011). Graham and McDermott (2006: 30) argue that quantitative data is frequently used to generate predictions of teenage motherhood as the epitome of social exclusion. Factors including lack of qualifications, early school-leaving, and family poverty combined with teenage motherhood describe a negative trajectory for young mothers. The focus of quantitative research on evidence of poor health and socio-economic outcomes, particularly when related with early motherhood, have contributed to discourses which situate young mothering

outside good mother ideologies (Deal and Holt, 1998; Francesconi, 2008; Jaffee, Caspi et al., 2001; Kaplan, Goodman et al., 2004).

For many low-income mothers, their structural position does present a significant constraint to their ability to mother, particularly within dominant mothering ideologies (Butler et al., 2010; Graham and McDermott, 2006; Stapleton, 2010). Constraining factors such as poverty, lack of appropriate support, poor housing and limited transport options combine to limit opportunities for low-income mothers to change their circumstances (Graham and McDermott, 2006: 28). Many of the mothers in Stapleton's (2010) study who had traumatic childhoods were less resilient than their counterparts from supportive families. They were undermined and disempowered by their parenting experience (Stapleton, 2010: 205). Mothers in both Graham and McDermott (2006: 28) and Stapleton's (2010: 195) studies experienced poor quality estate housing, lacked networks of friends and family, and had few opportunities to develop relationships or undertake employment or education that could change their circumstances. Parenting responsibilities and challenges were immobilising rather than enabling for most mothers in these situations (Stapleton, 2010: 195). It is the mothers themselves rather than the structural barriers however that tend to be the focus of many policies and discourses.

Low-income mothers as marginalised mothers in health policies and discourses

Social science authors highlight how low-income mothers are overwhelmingly marginalised and problematised in policies and health discourses with young mothers in particular positioned as both a social problem and a social threat (Breheny and Stephens, 2007: 112; Butler et al., 2010: 5; McDermott and Graham, 2005: 60; Phoenix, 1991: 86; Porr, Drummond et al., 2012; Romagnoli and Wall, 2012; Stapleton, 2010). Much of the scientific medical, health and policy literatures present young and low-income mothers from a health deficit perspective, primarily as 'at-risk' of poor health and socioeconomic outcomes, or as a member of a 'deviant' group (Butler et al., 2010: 5; McDermott and Graham, 2005; Phoenix, 1991; Stapleton, 2010). Statistics

focusing on negative health outcomes, such as poor antenatal care, low birth weights, low immunisation rates, and low attendance at health clinics, pervade the professional literature (Breheny and Stephens, 2007: 113; Hanna, 2001; Olds, 2006). Breheny (2007: 113) argues positive views of adolescent mothers tend to be interpreted and dismissed as 'youthful idealism' with the professional focus remaining on negative understandings of statistics of social exclusion and disadvantage. Low-income mothers in particular are the focus of health and welfare policies and literature.

Health policies and programs, including child health services, targeted to disadvantaged groups reflect the principles of scientific mothering, where experts guide families (through working with mothers) in the standards that support conformity to middle-class norms (Gillies, 2005a: 70). Gillies (2005a: 70) highlights the emphasis in UK family policies on the need for all parents to have access to 'support, advice and guidance' to enable effective parenting. Parenting education programs and support services including child health services are targeted in low-income areas. For some mothers involved with child protection services the parenting classes are mandated. These policies reflect state attempts to control and regulate child-rearing practices (Gillies, 2005b: 835). Romagnoli and Wall (2012) describe similar policies and approaches in Canada. There, state programs focus on promoting intensive mothering practices targeted to low-income mothers. The approaches are underpinned by the science on brain development and the impact of parenting in the early years on later cognitive development (McCain and Mustard, 1999; Romagnoli and Wall, 2012; Shonkoff and Phillips, 2000).

Home visiting programs by nurses operate as a mechanism of state surveillance, as discussed in chapter two. There is a prolific body of professional scientific literature claiming the positive effects of structured programs of home visiting by CFH nurses to targeted groups, such as teenage mothers and first time mothers in disadvantaged and poor circumstances (Cowley, Kemp et al., 2012; Eckenrode, Campa et al., 2010; Kemp, Harris et al., 2011; Olds, 2006: 21; Olds, Kitzman et al., 2010; Quinlivan et al., 2003; Sawyer et al., 2013). Many of these programs, such as those based on David Olds' US research are highly intensive, involve regular home visits from prenatal stages until the

child is two years old or longer, and aim to improve parental behaviours and the child's environmental conditions in the crucial early years of life (Kemp, Harris et al., 2013; Olds, 2006: 9). Nurses use a structured education program providing information and advice on parenting and childrearing. In Tasmania the Child Health and Parenting Service has a home visiting program targeted to teenage mothers which is in addition to the less intensive universal service available to all families (Department of Health and Human Services, 2013). These home visiting programs result in an intense surveillance of families through the development of a trusting relationship between nurse and mother. As discussed in chapter two, trusting relationships are a key site of pastoral power and in the case of these programs allow an ongoing 'gentle surveillance' (Wilson, 2001: 298).

Low-income mothers 'doing' good motherhood

The negative portrayals of marginalised mothers are contested in findings from qualitative, sociological research studies that have explored the experiences of low-income mothers themselves (Butler et al., 2010; Foster, 2009; Gillies, 2007).

Qualitative studies have challenged the negative representations revealing both resistance and conformity to dominant good mother ideologies (Butler et al., 2010; Gillies, 2007). Several themes emerge from these studies with a key theme being the positive reflection by mothers on early motherhood as a rite of passage. Low-income mothers undergo diverse motherhood experiences, and understand and construct these in particular ways.

All the mothers in Verduzco Baker's (2011: 77) study discussed their awareness of and resistance to the stigma and presumptions made about them. Low-income and teenage mothers' resistance to their portrayal as problematic and deviant mothers is reflected in a number of qualitative research findings. Stapleton's (2010: 204) UK study found that for many teenage mothers, becoming a mother was considered positively, as a 'rite of passage' and a normal event, compared to having a child when older; these constructions are juxtaposed to the portrayal of young motherhood as a deviant or 'at risk' event. Similarly, Gillies (2007: 119) found for many working-class mothers mothering and raising their children, particularly as lone parents, reflected progress

and achievement. Coping alone as a young single mother is a powerful sign of personal growth, self-determination and evidence of strength of character (Gillies, 2007: 120). This determination and resilience was demonstrated by one mother who left her abusive partner to establish a better life for herself and two children as a single parent (Gillies, 2007: 142).

The teenage mothers in Mollidore's (2013) study also constructed positive identities for themselves based on their own experiences. Motherhood was seen as a time of learning and personal growth where the young mothers felt empowered to improve their parenting (as a sign of good mothering) by seeking out and following professional advice (Mollidore, 2013: 114). They were active and knowledgeable agents in their own life, and countered professional stigmatisation by refusing their advice and reconstructing professionals and their advice, rather than themselves and their parenting practices, as a problem (Mollidore, 2013: 114). They actively chose their own supports including family supports. The young mothers emphasised their maternal instinct, presenting themselves as good mothers rather than teenage mothers (Mollidore, 2013: 115). Finally Mollidore (2013: 115) found the mothers created positive identities by judging the failings of other mothers thus gaining status for themselves. Despite all the mothers in the study constructing teenage motherhood as problematic in general they presented their own understanding of motherhood as not necessarily a problem but an enjoyable, although challenging experience (Mollidore, 2013: 116).

Graham and McDermott (2006: 26), in their review of qualitative studies of teenage parenting in the UK show that motherhood is a positive pathway for many young women striving for valued adult identities. Many young mothers found their future in motherhood, as it was a role where they could develop their self-esteem and achieve social respect. This was preferable to the opportunities offered by formal participation in society through education, which in their case would primarily lead to insecure and low paid jobs (Graham and McDermott, 2006: 26). These sentiments were reflected in Butler's (2010: 5) Australian study which demonstrated that young mothers found motherhood a 'valued and worthwhile endeavour' and a source of achievement and pride.

Countering the dominant portrayal of low-income mothers as 'feckless and incapable of parenting', Foster's (2009) UK participatory action research showed that mothers produced representations of themselves (in self-shot video logs) as 'strong, intelligent, capable and feisty' parents. The mothers' portrayals of their family lives, including bad language, allowing risky play by children, and extended family living arrangements, challenged 'respectable' middle-class images of motherhood, as the mothers revelled in a more 'raucous, chaotic family life' (Foster, 2009: 243-244). The videos demonstrated how the 'intense love and raw emotion' involved in childrearing, which is expressed in different ways according to culture and class, has the potential to expand the acceptable limits of mainstream representations of good mothering (Foster, 2009: 243-244). These possibilities and constraints of motherhood are deeply impacted by family background and support.

Stapleton (2010: 204) found that young mothers from a loving and supportive background were better able to meet the demands of mothering than those brought up in traumatic households. They could cope with the challenges parenting brought, such as sleepless nights, having little time for themselves, and the constant hard work of caring for a baby, and found being a mother an 'affirming and empowering' experience (Stapleton, 2010: 205). These young mothers had the support of their families; they had stable housing and many remained living in their family home. Thus for many low-income mothers, motherhood is a positive experience that creates the possibility of a positive maternal identity and a sense of adult achievement.

Despite structural constraints that impact on who they 'are' as mothers (e.g. their position as poor, unsupported, often depressed) it is through what they 'do' that low-income mothers rate themselves. In the process of creating good mother identities for themselves, low-income mothers adopt the elements of intensive mothering that are within their reach, such as putting their children first, being self-sacrificing and providing love and attention (Abrams and Curran, 2011; Elliott et al., 2013: 1; Gillies, 2007: 142; Verduzco Baker, 2011 vii-viii). Young low-income mothers in Verduzco Baker's (2011 vii-viii) US study argued that their 'love and self-sacrifice' is enough to demonstrate they are good mothers. Elliott and colleagues' (2013) US study demonstrated that low-income mothers embraced intensive mothering at the cost of

their physical and emotional well-being. For example many of the mothers sacrificed their own education so they could be present with their children, protect their children and fight for their rights particularly in the school system (Elliott et al., 2013: 15). Rather than providing music lessons and extra tutoring, low-income mothers engaged in intensive mothering by 'being there' to try and make their children safe from effects of poverty such as homelessness, abuse and violence (Elliott et al., 2013: 15). For the low-income mothers in Landy and colleagues' (2009: 201) study their children were their primary concern and always 'came first'. This was despite their significant struggles in their first few weeks in transitioning to mothering with poor social support and the extra burden of poverty and stigmatisation through public eyes (Landy et al., 2009: 201).

The lack of alternative images of a good mother conceals the work and other appropriate parenting rationalities of low-income mothers (Verduzco Baker, 2011 vii-viii). Low-income mothers are often blamed for their difficulties while structural barriers remain unrecognised (Verduzco Baker, 2011 viii). The powerlessness of low-income mothers to be recognised as good mothers is highlighted by Verduzco Baker (2011: 82) when she demonstrates how 'bad' motherhood is determined by stable social structures such as age, race and class. Therefore despite resistance and alternative constructions of mothering, low-income mothers remain 'bad mothers'. This emphasises the difficulty marginalised mothers have in reinterpreting their identity as good mothers.

The mothers in these qualitative studies demonstrated conformity to many elements of good mother ideologies. The mothers prioritised caring for their children above their own interests (Gillies, 2007: 142). They enjoyed being with their children, and motherhood was seen as a rite of passage (Stapleton, 2010: 195). However, as Verduzco Baker (2011: 82) argues, their structural position ensures that they are only recognised as good mothers by those who know them – family, friends and sometimes caseworkers who have come to know them over time. The impacts of social position i.e. of being working-class and not middle-class, is also evident in parenting styles.

Parenting approaches

There are differences in how low-income mothers and middle/upper-income mothers parent but, as Hayes (1996: 86) argues, their underlying assumptions are the same and reflect intensive mothering ideologies. Hayes (1996: 86) argues that low-income mothers and middle-income mothers share the view that their children's needs come first and it is their responsibility to do what is best for their children, as they see it. For instance, Hayes (1996: 86) found discipline styles of low-income mothers tended to favour rules and having obedient children, whereas middle-income mothers favoured choices and negotiation with their children. These different approaches have the same aim in promoting the future success of their children. Middle class mothers' approaches promoted the development of self-esteem, self-motivation, self-reliance and a sense of independence, which are characteristics needed to succeed in the future as professionals or corporate managers (Hays, 1996: 94). For low-income families disciplining children to obey and respect adults taught qualities that would help them as employees in future labour markets where they were more likely to find employment (Hays, 1996: 95). Here, views of raising children to be responsible adults are accepted across class groups but are interpreted and enacted differently by mothers depending on their social position.

In constructing maternal identity, both middle-class and low-income mothers contest dominant ideals of good mothering. However, the structural position of low-income mothers limits their ability, compared to middle-class mothers, to resist these mothering ideals and reframe their identity. Emerging evidence from social research shows that low-income mothers' perspectives of good mothering are attempts to counter negative stereotypes. Researchers highlight the adoption of elements of intensive good mothering as reflected in low-income mothers' beliefs in love, self-sacrifice and being there for their children (Verduzco Baker, 2011). However, unlike mothers on middle incomes, who are able to more easily reinterpret dominant ideals of good mothering, the more vulnerable low-income mothers continue to be excluded as good mothers due to their structural position of low-income, age and often race. The negative standing of low-income mothers tends to persist in the health and

professional literature, as I present next. In the following section I turn to an element of the dominant good mother ideologies that is particularly relevant to the interactions between mothers and CFHNs, that of 'scientific mothering' (Apple, 1995).

SCIENTIFIC MOTHERING WITHIN GOOD MOTHER IDEOLOGIES

Mothering ideologies delegate primary responsibility for children to mothers, and within the framing of scientific motherhood, mothers are at the same time dependent on experts to exercise that responsibility appropriately (Murphy, 2003: 437). Apple (1995: 161) has defined 'scientific motherhood' as 'the insistence that mothers require expert scientific and medical advice to raise their children healthfully'. The concept refers to the expectation that mothers will not only seek and heed expert advice (Apple, 1995; Brennan, 1998; Hays, 1996: 54; Johnston and Swanson, 2004: 498; Miller, 2007: 339; Reiger, 1991b), they will be supervised by health professionals (Hausman, 2004: 280). The implication is that mothers are not competent to raise their children without the supervision and expertise of others (Apple, 1995: 178; Petersen and Lupton, 1996: 153; Wilson, 2003: 286). Gillies (2007: 2) argues parenting has been reframed; from a loving and caring role, to a job requiring certain skills which mothers must learn from qualified professionals. The power of expert knowledge is a key feature of scientific mothering.

The concept of power-knowledge provides an insight into the way in which dominant discourses determine which knowledge is considered truth, and which is silenced (Foucault, 1977). Knowledge which is based in experience and meaning is discredited and thus repressed within dominant bio-medical discourses (Gilbert, 1995: 869; Miller, 2005: 43). Foucault (1980c: 82) describes these 'popular', but subjugated knowledges as belonging to those in the lower hierarchies, and as knowledges that 'have been disqualified as inadequate to their task ... located ... beneath the required level of cognition or scientificity'. The power of scientific motherhood therefore has the effect of dismissing the practical and experiential knowledge of mothers. It is the knowledge of scientific experts that is the authoritative and legitimate knowledge. Within this

paradigm mothers are expected to turn to professionals, who hold scientific, expert, authoritative knowledge; in this case, child and family health nurses.

Breastfeeding: an example of scientific mothering

Scientific mothering is well illustrated in the example of breastfeeding. The medical benefits, to child and mother, of breastfeeding is actively promoted in biomedical and health promotional discourses, that is, the dominant forms of power-knowledge (Bartick, 2013; Bartlett, 2004: 341; Ip, Chung et al., 2007; Oakley, 1979: 165; Schmied and Lupton, 2001: 235). The National Health and Medical Research Council (NHMRC) (2013) provides Australian health professionals with guidelines for feeding infants based on reviews of quantitative studies. These guidelines exclusively list medical reasons for breastfeeding, such as protection for the baby against several diseases including diabetes, coeliac disease, inflammatory bowel disease, cardiovascular disease such as high blood pressure and obesity. Benefits for the mother are also medical in nature and include reducing the risk of breast and ovarian cancer and type two diabetes for women who experience gestational diabetes (diabetes while pregnant) (NHMRC, 2013: 3).

Breastfeeding is promoted in a similarly scientific manner internationally. For instance the World Health Organisation (WHO) provides statements based on scientific research and reviews, which guide governments and health care providers (see for instance the WHO and UNICEF (1981; 2009) Baby Friendly Hospital Initiative and similar statements). In the United States the message from the authoritative paediatrics academy (2012) is virtually the same as the Australian NHMRC and WHO guidelines in that it focuses on the prevention of disease and the positioning of professionals as experts who can support mothers.

The national and international health bodies provide quite specific instructions on optimal infant feeding methods. The NHMRC guidelines, as with the American and WHO statements, promote exclusive breastfeeding for the first six months of life, with introduction of foods about six months, and continued breastfeeding for at least the first twelve months of life. However the statistics reveal differences between feeding

practice and these recommendations. While 90% of Australian infants are breastfed initially, only 25% are breastfed at twelve months and 65% of babies have been introduced to solid foods by 25 weeks, the median age being four and a half months (NHMRC, 2013: 8). However despite the significant difference between the policy and the reality, the message remains that an essential practice of the good mother is to breastfeed her baby on the basis that this is 'best for baby' (Lupton, 2000: 54; Murphy, 1999; Schmied and Lupton, 2001: 238; Wolf, 2007: 617).

Studies that have reviewed quantitative data have revealed socio-economic status is a consistent indicator of breastfeeding rates. Mothers in low socio-economic areas are less likely to commence, and to continue, breastfeeding than those mothers who are in higher income groups. This has been found to be the case in Australia (Amir and Donath, 2008; Donath and Amir, 2000) and overseas (Callen and Pinelli, 2004; Department of Health, 2009). Mothers who are older, well educated, with higher family incomes are more likely to breastfeed and for longer than those less educated, young, and with lower incomes (Callen and Pinelli, 2004). Donath and Amir (2000) found differences in Australian states also based on socioeconomic status, with Tasmania having lower breastfeeding rates than more wealthy states such as Western Australia. An exception is the Northern Territory, which has a high rate of socio-economic disadvantage yet a high breastfeeding rate (Donath and Amir, 2000: 167). The authors point to other factors, particularly cultural factors, which can influence breastfeeding (Donath and Amir, 2000: 167). In a later paper, the authors list factors that impede breastfeeding (Amir and Donath, 2008: 256). These reasons include less family support, less ability to seek support with problems, and less flexibility with work arrangements. Feeding in public is also a problem for many mothers and the fact their peers and social group are less likely to breastfeed is a constraining factor (Amir and Donath, 2008: 256). That social, cultural and financial factors impact mothers' choices still is not reflected in the dominant health messages around breastfeeding.

Scientific discourses privilege a particular understanding of empirical facts but do not have a monopoly on 'the truth' (Foucault, 1977: 28; 1980b: 112), as truth is often determined on the basis of pre-existing assumptions. Sociologists and anthropologists illustrate the often inconsistent or weak evidence base that informs expert definitions

of appropriate mothering practices. For instance, Weisner and Gallimore (1977) challenge norms and ideals around exclusive maternal caregiving, arguing that non-parental caregiving, particularly by siblings, is significant in many societies. McKenna and colleagues (2007) challenge the safe sleep message of not co-sleeping with babies due to the risk of Sudden Infant Death Syndrome. They argue co-sleeping is a normal and important part of human development. Wolf (2011: xii) cites evidence that shows very little health differences between breastfed and formula fed infants in the vast majority of cases. Lee and Furedi (2005: 6) call for 'objective' information to be provided to mothers on both bottle and formula feeding, as a routine part of child care (Lee and Furedi, 2005: 6). Medical scientists, however, challenge the claim that the benefits of breastfeeding are overstated, and produce evidence to the contrary (Bartick, 2013; Ip et al., 2007). For example the authors suggest there is a causal relationship between breastfeeding and reduced accounts of breast cancer in mothers who breastfed as evidence in support of breastfeeding (Bartick, 2013; Ip et al., 2007). Here, the assumptions of scientific and bio-medical discourses of health shape evidence and truth in breastfeeding messages.

Sociologists and anthropologists have argued this scientific discourse is not just a benign health message about the benefits of breastfeeding but a moral discourse on good mothering (Knaak, 2010; Lee, 2008). Not to breastfeed is presented in medical literature as a risk to both the health of the infant and to the mother (American Academy of Pediatrics, 2012: e837; Australian Breastfeeding Association, 2014; NHMRC, 2012: 14). In this increasingly 'risk (aware) society' (Beck, 1999) mothers adopt moral and social responsibility to manage risk in their families (Knaak, 2010; Lee, 2008). In conforming to these expectations mothers are expected to turn to the health professionals for information and assistance. Breastfeeding has become a specialist area under the control of medical experts (Bartlett, 2004: 341; Oakley, 1979: 165; Schmied and Lupton, 2001: 235; Van Esterik, 1989). The health professional has become the recognised expert on infant feeding with the resultant devaluation of women's knowledge and experience.

The scientific 'breast is best' argument can have little to do with the embodied experience of breastfeeding for mothers (Hausman, 2004: 279; Maushart, 1997: 202). For instance, in Schmied and Lupton's (2001) qualitative study all the middle-class, first-time mothers, interviewed regarding their breastfeeding experiences, expected to breastfeed yet half found breastfeeding to be difficult. These mothers were surprised and distressed, and felt a sense of failure and loss for not breastfeeding. They had a sense that they were bad mothers (Schmied and Lupton, 2001: 246). These reactions highlight how medical discourses focus on the technical and moral dimensions of breastfeeding, but not on the reality of mothering practices.

In attempts to counter low breastfeeding rates moral arguments are combined with risk discourses whereby breastfeeding is promoted as the best for baby and formula milk is portrayed as a risk to the health of babies (American Academy of Pediatrics, 2005; Bartick, 2013). However authors such as Lee and Furedi (2005: 6) and Knaak (2010) criticise such approaches as having a negative impact on the maternal identity of mothers who do not breastfeed. Hausman (2013: 341) points out that using biomedical evidence to manipulate or problematise mothers is of questionable benefit, particularly in the context of a culture that makes breastfeeding difficult (e.g. the often inflexible work arrangements especially for low-income mothers). Such practices reinforce the dominance of medico-scientific knowledge above other knowledges, such as maternal experiential knowledge, and emphasise risk discourses over alternative constructions.

Debates around alcohol consumption while breastfeeding or pregnant is another example of health messages within scientific-medical discourses that emphasise risk. The evidence is not clear on how much if any alcohol is safe; excessive alcohol intake is known to be harmful to the developing foetus but it is much less clear if low to moderate intake has any effect (NHMRC, 2009; O'Leary, Heuzenroeder et al., 2007; Sayal, Draper et al., 2013). However, the health messages that professionals, including child and family health nurses, give are from NHMRC (2009) guidelines; namely that avoiding alcohol while pregnant and while breastfeeding is the safest option. Resistance to the non-drinking message is apparent in the significant number of mothers who drink, including while pregnant. One Australian study revealed a third of

all mothers consumed alcohol – at least one drink occasionally while a significant number had 2-3 drinks a session or one a day (Hutchinson, Moore et al., 2013). Australian studies reveal that the women who drink while pregnant or breastfeeding are more likely to be older, well educated, and of a higher socio-economic status (Giglia, Binns et al., 2008; Hutchinson et al., 2013).

Health researches present education strategies as the answer to a lack of compliance with health messages (Hutchinson et al., 2013). The authors suggest more public health campaigns ‘to educate pregnant women’ on the national safe guidelines for alcohol consumption (Hutchinson et al., 2013: 475). This attitude reinforces scientific motherhood in that it encourages mothers to follow the health messages from health experts regarding their mothering practices. This approach also implies that any health and development problems can be attributed to mothers’ failing to follow expert, health promoting advice (Lupton, 2011: 638).

Mothers’ conformity and resistance to scientific knowledge

Foucauldian approaches to power, as discussed in chapter two, incorporate the potential for both resistance and self-governance. The relational nature of the exercise of power means resistance is always present (Foucault, 1990: 95). Interactions remain a site of negotiation and resistance. The power of dominant discourses, however, is also evidenced in the self-governing behaviours people adopt, such as conforming to normative behaviour. Mothers’ resistance to expert knowledge is both behavioural and discursive, and shaped by their social position; particularly class.

Expert information becomes part of the mother’s process of self-governance, and behaviours ‘for the good of the baby’ begin before birth (Holmes and Gastaldo, 2002: 559; Lupton, 2011; Murphy, 2003). Murphy (2003: 455) found most women, when pregnant, endorsed expert scientific messages, such as the imperative to breastfeed, and in so doing subordinated themselves to the dictates of expert discourses. Similarly Lupton (2011: 641) found women undertook health promoting actions although there was a marked class difference. Women with higher levels of education and income,

and living in affluent suburbs were more vigilant in following health messages such as taking recommended vitamins, exercising during pregnancy, and reducing or avoiding alcohol, in the desire to promote the health of their unborn child (Lupton, 2011: 642). However, working class mothers with low incomes and low levels of education, while agreeing with the messages of reducing alcohol and cigarette consumption for the good of their babies, continued to smoke and drink alcohol although many cut back during pregnancy (Lupton, 2011: 643).

Quantitative studies highlight the social patterns of breastfeeding but they do not capture the meanings mothers attribute to it, and how they use these meanings to resist scientific knowledge. Maternal decision-making is influenced by social and cultural factors. Infant nutrition, including breastfeeding, is a central topic in CFH nurse-mother conversations. Murphy and colleagues (1998) emphasise that broader agendas compete alongside health concerns to impact infant feeding (under two-year olds). For instance, non- nutritional aspects of food play a major part in decision-making but are not prominent in professional literature. While mothers recognise the nutritional aspects of food these are often subordinated to conflicting demands of the tasks at hand resulting in practices that do not follow health advice. Mothers in the study, although they admitted such practices are against health recommendations, would use a sweet or salty snack to occupy the child and allow them to safely prepare a meal, or would introduce solid food early to encourage their growth. Mothers admitted the snack was the best choice in a difficult situation, or that by ignoring recommended ages to introduce foods they would encourage the child to the next developmental stage. Not recognising and taking into account these symbolic and practical roles of food means educational messages, such as those nurses provide mothers on their children's nutrition, will not necessarily impact mothering practices (Murphy et al., 1998).

Resistance to health messages is also seen in some mothers' decisions around breastfeeding as reflected in the Australian statistics discussed earlier that do not align with health guidelines. These are similar to rates in many Western countries where the majority of babies are not exclusively breastfed including in the UK (Lee and Furedi,

2005; Marshall et al., 2007), Ireland (Tarrant et al., 2013) and the US (Guttman and Zimmerman, 2000). As with mothers in Schmied and Lupton's (2001) Australian study of first-time mothers, many mothers intend to breastfeed and believe the message that breastfeeding is best for their baby. However once babies are born significant numbers do not breastfeed as they had intended and a majority cease prior to the recommended twelve months. For many mothers, while they believe the health message that 'breast is best', the message is subordinated to more pragmatic matters such as the demands of the moment and individual and family contexts, such as returning to work and the inability to continue breastfeeding (Marshall et al., 2007: 2158; Murphy et al., 1998; Shaw, Wallace et al., 2003). A smaller number of mothers resist outright the call to breastfeed, never intending to follow this message.

Studies involving low-income mothers reveal different understandings and adherence to the biomedical health messages on breastfeeding. While the message that breast milk has superior nutrition and protective factors to formula milk was accepted by low-income mothers in Guttman and Zimmerman's (2000: 1468) study, they did not believe the message that breastfeeding held health benefits for the mother. This can be understood in light of many mothers' embodied experience of breastfeeding which is found to be not only hard work but can be emotionally and physically draining. For example the majority of mothers in Schmied and Lupton's (2001: 237) study, which had a sample of mothers from different classes, found breastfeeding to be a negative experience, such as the constant physical demands of breastfeeding, the loss of a sense of self and agency as their lives were put on hold to meet the demands of being there for their baby, and for some, the sometimes 'excruciating' pain of breastfeeding.

Breastfeeding is also resisted as an indication of good mothering if not reflected in the baby's behaviour. Mothers and other family and friends will contest breastfeeding as good mothering if the baby is unsettled or not gaining weight. Mothers who continue to breastfeed in the absence of observable signs the baby is settled and thriving, except for periodic reasons such as a 'growth spurt' or being in a different environment, risks being judged 'unsuccessful' or 'poor mothers' by those around them (Marshall et al., 2007: 2158). Breastfeeding as a sign of good mothering is also resisted by groups where bottle feeding, not breastfeeding, is the cultural norm within

their social networks (Marshall et al., 2007: 2157). In low-income groups it may be rare to have a friend breastfeed her baby or even observe someone breastfeeding. At such times mothers who breastfeed can call on support from 'allies' including health professionals and other mothers who have breastfed their children in order to support their practice as good mothering (Marshall et al., 2007: 2157).

Murphy (1999: 200) found in her interviews with first-time mothers that most of those intending to formula feed would provide an account for their decision to defend and legitimise what they knew was not the recommended good mother practice. Murphy (1999) described elaborate processes mothers used for justification of their decision. While one mother explained she was unable to breastfeed for physical reasons, the other mothers resisted the message through personal choice however used several means of justification to counter the possible judgement of 'bad mother'. They challenged the assumption that breast is best by arguing formula milk was not harmful and was adequate or superior to breast milk (Murphy, 1999: 196). The mothers highlighted breastfeeding as a risky practice as the baby may not get enough milk (Murphy, 1999: 196), and for one woman bottle-feeding, not breastfeeding, was the 'natural' way in her community; breastfeeding was risky due to lack of experience in her network (Murphy, 1999: 195). The mothers also challenged professionals' authority to define what was good mothering practices; by arguing they would know better what was best for their own child. When professionals, such as child and family health nurses, would also give advice to mothers' friends or family the mothers accused the professionals of interference (Murphy, 1999: 197). Family and friends were turned to as the experts who knew them better rather than the professionals (Murphy, 1999: 196).

Justification for bottle-feeding was also made in relation to 'higher loyalties', which is, it would present advantages for others, or suit other priorities. Firstly, it was considered advantageous for the father who could be more involved with his baby (Murphy, 1999: 198). Secondly, bottle-feeding would prevent upsetting other people by avoiding the 'offensive' act of breastfeeding in public, and of being embarrassed themselves (Murphy, 1999: 198). It was rare for mothers to state their own needs as the reason for bottle-feeding. For instance one young mother explained her decision in

relation to her double role of mother and young person with her need to be able to go out and not be tied down (Murphy, 1999: 199). This decision not to breastfeed required much explanation to avoid judgement as a 'bad mother' who did not follow the dominant expert health messages.

The discourses attached to scientific mothering have a powerful effect on good mother identities. Both moral arguments and risk arguments are used in health discourses to influence mothering practices. Most mothers, including low-income mothers, are aware of the dominant scientific health messages influencing parenting practices, such as breastfeeding as a good mother practice. However they do not simply accept this knowledge. They adapt, appropriate and reject elements of scientific mothering and other dominant good mothering ideals. They do so in interaction with others. I now turn to the interactions between CFH nurses and mothers, which are an important site of resistance and negotiation of scientific mothering.

NEGOTIATION AND RESISTANCE IN CHILD AND FAMILY HEALTH NURSE-MOTHER INTERACTIONS

Interactions with child and family health nurses are a standard practice of nearly all mothers with new babies. The interactions are a key site of negotiation around mothering practices and identities. In seeking the knowledge and expertise of the CFH nurse, mothers place themselves under the pastoral power of the nurses. Pastoral power, as discussed in chapter two, involves developing a relationship in which the mother is able to confide, or 'confess', to the nurse and become more known, which allows the nurse more power in determining and guiding appropriate behaviours (Abbott and Sapsford, 1990: 134; Holmes and Gastaldo, 2002). Mothers receive emotional support when CFH nurses use a caring, empathic approach. Such a response makes it more likely mothers will listen to the nurse and follow her advice. It also encourages the mother to return, which allows ongoing 'gentle surveillance', and CFH nurse approaches are those that 'keep the mothers coming' (Wilson, 2003). Mothers may comply or resist these practices, through behavioural resistance (refusal to comply with a recommendation) and conceptual resistance (rejection of the discourse

underpinning the recommendation) (Armstrong and Murphy, 2012). Mothers use both levels in their resistance to CFH nurses' expertise and authority.

Seeking knowledge and care

The fact that nearly all mothers initially access voluntary (opt-in) child health services, suggests this is a normal 'good mothering' practice even though, as Mayall (1990: 314) found, attendance rates drop after the first few months when attendance is not such a priority. Research shows that mothers value the advice CFH nurses give them, particularly in the first few months, provided this is given in the context of a respectful and kind exchange. This self-regulatory practice by mothers to seek knowledge and care places them under the gentle surveillance and pastoral power of the nurses.

Mothers report that it is important to be able to access CFH nurses not just at the stages recommended by the health services but when they needed to have their parenting or child development concerns addressed (Bowns, Crofts et al., 2000; Fagerskiold et al., 2003: 165). Mothers expressed dissatisfaction if they could not access the service when needed to for parenting concerns (Russell and Drennan, 2007: 26). Goldfeld and colleagues (2003: 252) have suggested parental need for information and support at a time when parenting is known to be stressful is the reason for visits to the child health centres, as most visits by parents in their study were unrelated to illness. Mothers, in several studies, regarded CFH nurses as an important resource for knowledge and advice (Mayall, 1990; Tammentie, Paavilainen et al., 2009; Tarkka et al., 2002). In Fagerskiold and colleagues' (2003: 164-165) study, mothers expected the nurses to provide 'sound advice' defined as helpful information based on the nurses' experience and knowledge. Mothers also wanted practical interventions, which involved more than advice, such as arranging appointments with other health professionals or demonstrating baby massage to relieve 'colic' (Fagerskiold et al., 2003: 165). This reflects good mothering practices of seeking information and guidance from professional experts.

McCallum and colleagues (2011) found there is an increased use of the child health service which is not related to socio-economic status; when infants have unsettled behaviours. Goldfeld and colleagues (2003) also found use of maternal and child health services by first-time mothers in Victoria was not affected by socio-economic status.

They found an increased use in the first six months of the child's life compared with the second six months. The visits were most commonly for routine visits and satisfaction rates with the service were high at 94%. A difference in attendance rates at child health centres was found between low and middle-income groups in Fagerskiold and colleagues' (2003: 162) study. Participants who were university-educated attended the child health centres fewer times than the less educated mothers. While no rationale was provided for this there are several reasons that could be suggested. It may well have been the more educated mothers were able to access information from other sources, such as the internet, when needed, were more confident in their own knowledge, were not willing to place themselves under surveillance, or had a range of other social resources to assist them when they needed help.

Very similar findings on what mothers wanted in their interactions with CFH nurses have been presented in several studies across a number of Western countries, for example the Scandinavian countries of Sweden (Fagerskiold et al., 2003) and Finland (Tammentie et al., 2009; Tarkka et al., 2002), and the UK (Bowns et al., 2000; Mayall, 1990; Russell and Drennan, 2007). Both low-income and middle-class mothers, in the studies discussed below, had the same needs in their interactions with nurses. Bowns and colleagues' (2000) participants were 'low-risk' mothers, and Tammentie and colleagues' (2009) nine participants had postnatal depression; all the other studies had a cross section of middle and low-income mothers. A major finding in the studies revealed mothers' accessed nurses for their expert knowledge and experience in the area of child health (Fagerskiold et al., 2003; Mayall, 1990: 316; Tarkka et al., 2002). Accessing nurses as experts in their field had a reassuring effect on mothers. Being told their child was doing well by someone they recognised as expert in the area of child health and development was heartening for mothers (Mayall, 1990: 314). Mothers were able to feel reassured when nurses had the knowledge and experience to interpret and allay the mother's uncertainty (Fagerskiold et al., 2003: 165).

Another key finding was that mothers expected caring and respectful interactions (Fagerskiold et al., 2003; Tammentie et al., 2009; Tarkka et al., 2002). Tarkka and

colleagues (2002) also found mothers expected their nurses to be competent and knowledgeable, qualities also valued by mothers in Russell and Drennan's (2007: 22) study. Mothers wanted information in response to their own needs, as well as that of their child (Mayall, 1990: 315). The need for appropriate and adequate advice that addressed the concerns of the mother was also confirmed by mothers in Bowns and colleagues' (2000: 809) study.

Relationships between mothers and CFH nurses are fundamental to mothers' assessment of nurses' support (Fagerskiold et al., 2003). All the studies, except Bowns (2000) which focused on 'low risk' mothers, had samples of participants from different socioeconomic groups, and class was not shown to be a factor in these findings. Across the studies, mothers wanted trusting and empathic relationships with their nurse (Fagerskiold et al., 2003; Mayall, 1990; Tammentie et al., 2009; Tarkka et al., 2002). Finnish mothers wanted a nurse they could connect with, (the nurse's personality was crucial), and who would work with them holistically as a unique family (Tammentie et al., 2009). Tarkka and colleagues (2002: 103) had similar findings in their study with first-time mothers who wanted empathetic nurses they could talk to in confidence, and care that was individualised and family-centred. Mothers wanted the nurse to understand from the mother's perspective her experiences of mothering and thus 'share the realm of motherhood' (Fagerskiold et al., 2003: 163). This sympathetic understanding, the researchers found, was just as important if not more so than a solution to a problem (Fagerskiold et al., 2003: 163), suggesting that while expertise is valued so are the relationships that constitute pastoral power. Such findings suggest the imperative of scientific mothering, to seek and follow expert advice, creates a context in which pastoral power can be exercised in the mother-nurse interaction.

Child and family health nurses' emotional accessibility to the mother that is, an ability to relate to the mother and see from her perspective, allowing her to interpret the mother's signals accurately and provide support, was of key importance to the mothers (Fagerskiold et al., 2003: 165). This emotional connection also reflects the concept of pastoral power in the interaction. It was nurses' time and willingness to listen (Russell and Drennan, 2007: 22), her ability to be a good listener and to trust the mother that prompted the mothers to appreciate the more technical role of the nurse

(Fagerskiold et al., 2003: 165). These included the mothers asking for and receiving advice, which they followed, and accepting practical interventions such as referrals to other health professionals (Fagerskiold et al., 2003: 164).

Mothers characterised interactions with CFH nurses as unsupportive or uncaring when they felt nurses did not listen or trust them. Nurses' communication skills were paramount. Fagerskiold and colleagues (2003: 165) found that a lack of emotional connection - not being able to interpret each other's signals was a significant factor in encounters the mothers considered unsupportive. Lack of support was equated with uncaring encounters which were considered unprofessional by the mothers and which the researchers agreed were due to the nurse's 'difficulties in interpreting a mother's signals... unwillingness or indifference' (Fagerskiold et al., 2003: 165). This was particularly so when the nurse and mother did not know each other, when it was the mother's first baby, and she was not sure what to expect from the service, or when the nurse was busy seeing many people (Fagerskiold et al., 2003: 165).

How the information was delivered was important. Mothers appreciated a discussion as between equals which recognised the mother's skills and knowledge of her own family, rather than an interventionist approach where unsolicited advice was given with the implication the mother was ignorant and lacked parenting skills (Mayall, 1990: 315). This reflects a preference for the collaborative, partnership approach (discussed in chapter two) and the importance of relationship between nurse and mother, key features of pastoral power.

Mayall (1990: 314) found, in her UK study, attendance was not so important after the first few months and attendance generally declined overall as children got older. Mothers would attend not so much for the benefit of their child but for their own benefit - for confirmation their child was doing well. Mothers knew the nurses wanted them to attend, as overseeing the child population was recognised as a function of the service. Therefore as Mayall (1990: 314) claims, a sense of responsibility and compliance influenced mothers to bring their children to the centre – as long as opening hours were convenient. Mothers adopting this self-regulating practice place

themselves and their children under the 'gentle' surveillance (Wilson, 2001; 2003) of experts. While not welcoming it, mothers also expected nurses, as part of the state's protection of children, to have a surveillance role of them to monitor the safety of children (Mayall, 1990: 314). Mayall (1990: 314) argues this focus by parents on the surveillance role of nurses had become more prominent since the publicity on child abuse cases in the media.

Mothers value visits and interactions with child and family health nurses on several levels. They construct the visits as within normal 'good mothering' practices, and value emotional support, and respectful advice. This is particularly so in the first few months, and particularly for first-time mothers. The partnership approach of CFH nurses ethos of care, coupled with the importance mother's place on partnership demonstrates the salience of pastoral power and gentle surveillance.

Resistance to expertise and authority

Child and family health nurses and mothers are in complex power relations that incorporate the possibility of dominance and resistance (Foucault, 1982: 209). Resistance, like power, is diffuse yet present in all social interactions (Armstrong and Murphy, 2012: 325; Foucault, 1990: 95; Goodwin and Huppatz, 2010a: 3). Armstrong and Murphy (2012: 322) conceptualise the relationship between resistance and power as:

'a complex network with multiple points of potential difference or divergence bringing possibilities for disruption to the discursive flow. ... Rather than a one-dimensional conceptualization, we need to conceive of this process in terms of a web of potential points of resistance which may ultimately result in individuals adopting very different stances or positions.' (Armstrong and Murphy, 2012: 322-323).

Understanding strategies of resistance is critical to examining the exercise of power, as it is only through such strategies that the exercise of power, often rendered invisible

through uncontested negotiations, becomes visible. As Foucault argues, we should take 'the forms of resistance against different forms of power as a starting point' when analysing how power is exercised (Foucault, 1982: 211). The analysis of interactions between professionals and clients requires exploration beyond the superficial level of acceptance or rejection of advice or recommendations to ascertain the subtle and nuanced strategies of resistance (Armstrong and Murphy, 2012: 314). Rejection or acceptance may in fact be a strategy employed to mask the opposite case.

Behavioural resistance

In their examination of how those subject to public health discourses resisted these 'regimes of power and knowledge', Armstrong and Murphy (2012: 314) make a distinction between resistance at the behavioural level (e.g. refusal to comply with a recommended action) and resistance at the conceptual level (i.e. rejection of the discourse informing the recommendation).

Examples of behavioural level resistance were evident in Bloor and McIntosh's (1990: 175) study of interactions between working-class mothers in Glasgow and health visitors. Mothers used methods of escape or avoidance, such as not attending arranged appointments or not answering the door and pretending to be out when the worker called (Bloor and McIntosh, 1990: 175). Similarly, in Peckover's (2002: 374) qualitative study of UK health visitors and mothers who had experienced domestic violence, the mothers described hiding and not opening the door due to their fear of the nurse's authority.

Another form of behavioural resistance has been described by Heritage and Sefi (1992) in relation to advice giving by nurses. The authors describe how first time mothers both actively or passively resisted health visitors' frequent and unsolicited advice that was proffered at the first home visit (a visit that nurses in that study were mandated to make). In contrast to the above findings of studies where mothers seek CFH nurses for their expert advice when they need it or have a problem and desire sympathetic interactions, unsolicited advice brings a different reaction. This resistance was defined

by the authors in two ways: one was 'unmarked acknowledgement', a form of passive resistance, where mothers receipt the advice, e.g. with a 'yeh' or 'mm', but do not comment on it or adopt it (Heritage and Sefi, 1992: 395). The second form of resistance was 'competence assertions' where the mother indicates resistance by claiming she already knows about the substance of the advice or is already acting on it (Heritage and Sefi, 1992: 402). This acts to counter any suggestion of the mother's incompetence (Heritage and Sefi, 1992: 409). Such reactions also demonstrate resistance to the concept of scientific mothering and the belief that professionals hold the 'truth'.

Bloor and McIntosh (1990: 176) found by far the most common technique of resistance was concealment, which was particularly effective as it avoided control without confronting. Mothers are strategic in how much they reveal to their CFH nurses. Maternal practices that mothers realised could draw negative responses from the workers, such as early introduction of solid foods, were not mentioned and information given to workers was manipulated so that CFH nurses were told what they wanted to hear (Bloor and McIntosh, 1990: 176). Similarly, in a study of New Zealand Plunket nurses, the nurses stated they were quite sure mothers did not always tell them the truth and would conceal facts they knew the nurses did not want to hear, such as starting the baby early on solids (Wilson, 2003: 288).

Peckover's (2002) study also demonstrated concealment as a strategy of resistance mothers employed against the disciplinary practices of the nurses. The mothers in this study had all experienced domestic violence and been recruited through voluntary community organisations (Peckover, 2002: 371). They saw the health visitors (CFH nurses) as from 'a different world' and not able to understand their lives which the author relates to the inherent middle-class discourses of the profession (Peckover, 2002: 374). As one mother described, the health visitors are often married, doing a job they like, have a husband also working, do not know what it is like to live on the breadline so cannot understand what it is like for them (Peckover, 2002: 374). At the same time if they do not have children the health visitor is going by the 'textbook', which is not acceptable to the mother (Peckover, 2002: 374). Peckover (2002: 374)

found all the mothers avoided disclosing domestic violence to the health visitors. This reflects the ambiguity mothers' face, in wanting to seek help but fearing the consequences of seeking it: either having their children removed or not being believed. Mothers also held back from divulging 'everything' about how depressed they may be feeling especially if a trusting relationship had not been developed (Peckover, 2002: 374). Thus, disciplinary practices and social positioning shapes resistance in these CFH nurse-mother interactions.

Non-cooperation is a further category of resistance at a behavioural level (Bloor and McIntosh (1990: 174). Non-cooperation was a covert non-compliance practice by mothers who would indicate compliance then ignore health advice they did not agree with, without confronting the worker (Bloor and McIntosh, 1990: 174). For example, as one mother said, she would agree with the nurse during a visit, but then revert to her own practices afterwards, because 'she's no' here every day to check' (Bloor and McIntosh, 1990: 174). While resisting the nurse's advice at times, as Armstrong and Murphy's (2012: 320) understanding suggests, this rejecting behaviour may not indicate a disagreement with the nurses' position of authority, and also does not preclude the possibility that the mother may follow other advice.

Behavioural level resistance to health messages was also evident in Murphy's (2003) longitudinal study of a class representative sample of mothers, focused on the antenatal period and for two years after birth. Mothers offered bottles of formula to breastfed babies (a practice not recommended and interfering with exclusive breastfeeding) to help the baby sleep through the night and thus help them with the constant demands of child caring (Murphy, 2003: 442). The mothers also introduced solid foods earlier than the recommended time to reduce the number of feeds and as a means of encouraging their babies' progress (Murphy, 2003: 442). Such behaviours were legitimated by the mothers in a form of counter discourse the author termed a 'rhetorical strategy of resistance' (Murphy, 2003: 443). The mothers do not necessarily deny expert knowledge, or resist conceptually, but 'redefine' and 'relocate' this knowledge (Murphy, 2003: 443). Thus they reframed expertise and in the process subordinated nurse's 'technical' and categorical knowledge (Murphy, 2003: 453) to their own practical knowledge and expertise. These choices do not end the 'quiet

coercion' and 'normalising judgements' of disciplinary power (Murphy, 2003: 442). Mothers explained, sometimes at length, their justification for their departure from the recommended advice of the expert medical discourses (Murphy, 2003: 442).

Conceptual resistance

Resistance also occurs at the conceptual level, although studies of this level of resistance are less evident in the literature, which may be the result of researchers considering only the behaviours as acceptance or rejection of health discourses and advice. Looking beyond behavioural responses to mothers' more ideological, experiential and practical reactions, such as those described by Bloor and Macintosh, allows a more nuanced understanding of how discourses are accepted or rejected at a conceptual level. An example of conceptual level rejection of the discourses recommending an action is provided by Armstrong and Murphy (2012: 320) who show that a mother rejected the need to give up smoking in a subsequent pregnancy after her first baby was born at a good weight (nine pound) and scored high on the APGAR assessment scale at birth. The mother rejects the concept that smoking is bad for her baby's health, as it does not follow her own experience (Armstrong and Murphy, 2012: 320). A further example of resistance at a conceptual level, described by the authors, is that of parents choosing not to immunise their children due to their own reasons, which they legitimate against that of 'official doctrine' (Armstrong and Murphy, 2012: 320). The parents challenged the biomedical, expert view by developing dissenting views to the aetiology of the disease, and a different assessment of the risks involved (Armstrong and Murphy, 2012: 321). Bloor and McIntosh (1990: 172) used the term 'individual ideological dissent' to describe this covert resistance by mothers to resist the idea that health visitors 'expert' knowledge was superior to lay knowledge. Many mothers also challenged the legitimacy of health visitors' 'book knowledge' as they believed mothering was experiential, and learnt from other (lay) mothers. Mothers sought advice from experienced mothers above that of the health visitors.

Murphy (2003) describes a range of responses to expert discourses on infant feeding by the mothers in her study, as they struggled to manage the physical demands of child caring. At one extreme was an example of both conceptual and behavioural rejection of professional expertise; a mother made her own decision about how to feed her baby rejecting totally the idea of seeking and following professional advice and knowledge, and considered her own experiential knowledge to be superior to 'book knowledge' and established development goals (Murphy, 2003: 447). At the other extreme, one mother accepted totally the idea of the expertise of the professional's knowledge, seeking and following advice on each step of the weaning process, thus reflecting both conceptual and behavioural docility to expert knowledge in her progress (Murphy, 2003: 447-8). Murphy found most mothers in her study fell between these two extremes as the mothers came to measure expert knowledge against their progressive experiential knowledge (Murphy, 2003: 449). The mothers' class status made no difference in the findings of the study. Initially in the antenatal stage, the mothers as 'novices' followed the ideology of scientific motherhood seeking information from the health professionals (Murphy, 2003: 443). However as they later became more confident in their mothering and feeding practices, the mothers although influenced by the technical, scientific information became guided more by their own practical knowledge thus challenging the scientific motherhood rationality.

Mothers, particularly low-income mothers, exercise agency in resisting normative behavioural expectations of motherhood, many of which are implicated in the child and family health nurse-mother interaction. Mothers validate their own experiences and knowledge, and often parent within their personal capacities and limitations, rather than within established guidelines. In considering resistance to power, however, Armstrong and Murphy (2012) warn against a simplistic applauding of resistance to power without taking a critical view of the consequences of such actions. The overall purpose of health interventions - the benefit to the population in treating disease and preventing illness - must be recognised and considered and not simply dismissed as oppressive forms of power (Armstrong and Murphy, 2012: 324).

CONCLUSION

Good mother ideologies have a powerful impact on definitions of mothering at the social and individual level. These ideologies are referenced to middle class values and practices that, in combination with other discursive constructions of class and family, create normative and deviant mothers. Mothers contest these practices and orientations of good mothering by using forms of conceptual or behavioural resistance, in which they reinterpret their behaviours to conform to good mothering. However the possibilities and successes of such challenges are referenced to social positioning. Thus, low-income mothers can struggle to construct a mothering identity that is legitimated.

Scientific mothering incorporates the medico-scientific knowledges of the prevailing health discourse into good mothering practices, and is an important element of ideologies of good mothering. Scientific mothering is the seeking and following of expert knowledges and guidance on child rearing and is thus central to this study. Scientific knowledge related to mothering and child rearing practices is central to child and family health nurse–mother interactions. While mothers value CFH nurses’ knowledge, information and support (Mayall, 1990: 316; Russell and Drennan, 2007: 24), mothers’ active resistance to these dominant, expert-guided, medico-scientific discourses has also been noted (Bloor and McIntosh, 1990: 171; Peckover, 2002). Mothers consider and often value the scientific messages but take broader contextual factors, such as personal and family expertise, and emotional and practical capacity, into account and call on their own experiential knowledges when making mothering decisions. The relationship and communication style of the CFH nurse shapes how mothers feel about the interaction, and can facilitate the exercise of pastoral power.

Exploring the interaction and relationship between child and family health nurses and low-income mothers will provide an understanding of how mothering practices are actively negotiated by this group of mothers, and how this contrasts with the consistent portrayal in the literature of their mothering as problematic.

CHAPTER FOUR

METHODOLOGY

INTRODUCTION

My discussion and analysis draws on data generated through twelve observations of interactions between CFH nurses and mothers (with fathers sometimes present), twelve in-depth interviews with CFH nurses, and thirteen in-depth interviews with mothers. In this chapter I reflect upon the project methodology, design and implementation. I begin by outlining my use of an interpretivist and constructionist methodology and then move to a discussion of the methods detailing my observation strategies and in-depth interviewing techniques. I then describe the research participants and sampling strategies, and give details of the analysis process. Given my choice of methodology, I reflect throughout the chapter on the impact of my position as a nurse-researcher.

METHODOLOGY

Adopting constructionism and interpretivism

In keeping with my focus on how mothers and CFH nurses negotiate meaning I chose a constructionist approach to knowledge. Constructionism emphasises the process of making meaning through interactions (Crotty, 1998). Meaning making is a social process, 'contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context' (Crotty, 1998: 42-44). Thus, meaning is constructed through contextualised encounters between people. As social actors, we create and continually modify our understanding of the world through interaction with others. These meanings are informed by the interplay of our social, historical and cultural

backgrounds (Schwandt, 2003: 305). Thus, different people will assemble different meanings from the same phenomena (Gray, 2004).

An interpretivist approach is a window to understanding the meanings and motives underlying any social action (Holstein and Gubrium, 2005; Schwandt, 2003). Because we are embedded in our life-world we cannot stand outside it to gain an objective view (Angen, 2000: 385). Reality, from an interpretivist perspective, is constructed intersubjectively (understandings between people) and intrasubjectively (within a persons' own understandings) (Angen, 2000: 385). An interpretivist approach, therefore, allows an understanding of the meaning and motives underlying social action (Holstein and Gubrium, 2005). In using the interpretivist approach in this project I looked for 'culturally derived and historically situated interpretations of the social life-world' (Crotty, 1998: 67). Interpretivism is concerned with how reality is experienced in our everyday life; our interpretations are temporal and situational therefore always open to negotiation (Angen, 2000: 385). Context is inseparable from understanding (Angen, 2000: 385). From this perspective, the researcher and their values cannot be separated from the research process (Angen, 2000: 385). A continuous process of evaluation of their influence on the research process is required by the researcher to increase the integrity of qualitative research (Finlay, 2002: 531). Reflexivity, as discussed below, is crucial.

There are competing conceptualisations of the process of interpretive understanding. Some qualitative researchers argue for the possibility – and desirability – of researchers understanding the life-world of social actors in an objective manner (see Schwandt 2003: 298). In these traditions, the interpreter stands over and against (i.e. objectifies) what is to be interpreted and thus remains both unaffected by the interpretive process and external to it (Schwandt, 2003: 300). The interpreter can therefore reconstruct the original meaning of the action (Schwandt, 2003: 298). Not surprisingly then the interpretive process (Denzin, 2002) in understanding the 'phenomena', the lives and problems of the subjects, often provides interpretations which differ from those of the subjects. Denzin (2002: 364) claims this is due to the researcher having been in a position to see things that the subjects are not able to see.

This approach, however, does not account for the co-construction of meaning that occurs between the researcher and the participants.

My work is informed by philosophical hermeneutics, which challenges the possibility of the 'uninvolved' researcher (Schwandt, 2003: 300). The philosophical hermeneutic argument is that 'understanding is not ... a procedure - or rule-governed undertaking; rather it is a very condition of being human. Understanding *is* interpretation' (Schwandt, 2003: 301). Rather than recognising, tracking and setting aside one's prejudices and biases, understanding requires the interpreter to engage with their biases that always accompany them (Schwandt, 2003: 301). This allows the interpreter to reflect and gain understanding, not only of what is being researched but also, of their own self. Schwandt (2003: 302) states that understanding requires participation, conversation and dialogue. Understanding is produced in such dialogue, not reproduced in analysis by the interpreter (Schwandt, 2003: 302). As such meaning is mutually negotiated in the process of interpretation, it is not 'discovered' and there can never be one 'correct' interpretation (Schwandt, 2003: 302). Understanding is experiential – it is 'lived' or 'existential' (Schwandt, 2003: 303).

Reflexivity

Taking into account the social world of the researcher as well as the researched is crucial in the co-construction of knowledge. Reflexivity is an essential part of interpretive approaches. In this thesis, I adopt Finlay's (2002: 532) definition of reflexivity as 'thoughtful, conscious self-awareness ... [it is a process of] continual evaluation of subjective responses, intersubjective dynamics, and the research process itself' (Finlay, 2002: 532).

As co-constructors of knowledge in the research process and not just passive reporters of 'fact' and 'truth', researchers are called to an ongoing self-awareness of their place and impact on all stages of the research process (Finlay, 2002: 531; Hertz, 1996: 5; McCorkel and Myers, 2003: 199). This requires me to make explicit my multiple social positioning (e.g. gender, age, race, and class) in relation to the people I am researching

(Doucet, 1998: 52). However, a deeper level of engagement that moves beyond a discursive accounting of these positions is needed in order to address the possible impacts on the research (Doucet, 1998: 52). The interdependence and interconnectedness of the researcher, the method, and the data (Mauthner and Doucet, 2003: 414) make this a difficult and complex task (Rose, 1997). There is no certainty to reflexivity, it can only ever be a partial process (Finlay, 2002: 543). I cannot say with any certainty how much my own background, including past experiences, personal assumptions, and behaviours have shaped the data collection and analysis (Bishop and Shepherd, 2011: 1290) – however, I do discuss key processes and incidents which offer insight into the impact of my social position.

I am a white, middle-class, married woman who is a nurse and a mother. I have thus been involved with motherhood, parenting, and families professionally and personally all of my adult life. My past experiences and current position have not been marked by marginalization or social disadvantage. Rather, my social position has enabled me to more easily conform to the dominant good-mother ideal. I have worked for 40 years as a nurse, and for the last 20 I have worked as a CFH nurse, primarily with people of low socio-economic background. Throughout my nursing career I have valued the humanistic ideals of care that are important elements of the nursing identity.

While undertaking this project, a number of relational and contextual issues arose for me. These issues are common to similar situations where experienced nurses undertake research, and thus occupy the role of both practicing nurse and novice postgraduate researcher (Cartwright and Limandri, 1997; Colbourne and Sque, 2004; Ritchie, 2009). As will be discussed further in this chapter, tensions between my nursing and research role occurred in interviews with mothers, while different issues arose with nurses as a result of my researcher-colleague position.

While perhaps only in part, I practiced reflexivity in order to incorporate the powerful benefits of reflexive research which are to: examine the impact of the position, perspective, and presence of the researcher; promote rich insight through examining personal responses and interpersonal dynamics; empower others by opening up a

more radical consciousness; evaluate the research process, method, and outcomes; and enable public scrutiny of the integrity of the research through offering a methodological log of research decisions (Finlay, 2002: 532).

METHODS

In this project I focus on understanding what is happening in the interaction between nurse and mother. To do so I designed a mixed-methods study, combining observation with interview. My observations provided me with a picture of how mothers and CFH nurses spoke and behaved toward each other, while the interviews allowed me to discuss these representations with the participants. Using these methods together contextualised and provided different perspectives on a key site of meaning making for mothers and nurses. The approach assisted me to place behaviours and speech into context, and to better understand actions by talking about them with participants (Atkinson and Coffey, 2002: 802; Hansen, 2006: 101).

Observations

After a pilot study, for which I observed one interaction between a CFH nurse and a mother, I completed observations of twelve interactions. Three CFH nurses were observed in interaction with mothers on three separate occasions, a fourth nurse was observed twice, and the fifth nurse was observed once. Of the eleven families involved, two attended interactions twice. Nine attended once which included one interaction where two parents came in together, with their four children. I observed one home visit and all other interactions took place at a Child Health Centre. Interactions lasted between twenty-two minutes and seventy-two minutes with the average time forty-five minutes.

I used audio-recording and systematic observations of the interactions between the nurses and mothers (and fathers if present) to create a record of the interactions. I initially considered video-recording, particularly as a means of access to behavioural

detail (Peräkylä, 2006), but it was too intrusive in the confined space of the child-health consulting rooms and likely to produce much more self-conscious performances by the participants.

Audio recording the interaction provided an accurate record of what was said, and provided a basis for more intensive analysis of the 'conversation' later. This meant during the interactions I was more active in observing what was happening and there was more interaction between myself and the participants than if I had been involved with operating a video camera.

Using Spradley's (1980: 82) matrix for observation as a guide, (see Appendix 8), I systematically took notes on each five minute period during the observation. I had a reminder to note what was happening, who was doing what and other factors including objects used by the participants and the use of space. I started a stopwatch simultaneously with the audio-recorder and noted these times on the matrix. This allowed the actions to be matched up with the audio later during the transcription process. As there was little time to write more than this during the interaction, I would write more detailed observations and reflections immediately after the session ended. These notes included things that had struck me more noticeably, the impressions I had, how I had felt about the interaction including my part in it. This provided valuable information for me to work with when analysing the data, to place each interaction, and interview, in context.

From the observations I obtained valuable data that would not have been available had I simply audio-recorded the interaction. Observing the interactions allowed me to take notice of the unspoken communication between nurse and family. This included where participants' attention was directed, and the tenor of the interaction. I was able to notice how comfortable the participants were with each other, how much the participants' body language corresponded with what was spoken, and the use and impact of the physical space.

By observing the surroundings I could see the institutional culture evident at the centre, such as the presence of toys or choice of posters displayed, and how this shaped interactions. For example one nurse would take down a breastfeeding poster, which depicted correct feeding techniques, off the wall directly in front of her to teach the mother from this.

Interaction with the participants

While the observer position is often measured on a continuum from participant to non-participant (Hansen, 2006: 78; Liangputtong and Ezzy, 2005: 110), Angrosino (2008: 165) suggests observation is better considered more in the context of interaction between researcher and the participants. This perspective acknowledges that each person has an impact on any situation with others, whether it is direct or indirect, and whether they are conscious of it or not (Angrosino, 2008: 165). I can offer a more useful insight into interactions when, as researcher, I am able to include and analyse how the participants interacted with me, as well as each other.

After introductions, usually made by the CFH nurse, I tried to sit to the side and in the background where I could observe how the CFH nurse, the mother, and the father when present, interacted. I did not want to intrude on the interaction but it soon became apparent I could not pretend I was not there. While the main interaction was between the parent/s and CFH nurse, I was included at varying times often by a glance from the mother as she was talking, or on occasions by the CFH nurse when she included me as a fellow nurse for a 'second opinion'.

On a couple of occasions, my multiple roles, as a nurse, researcher and woman meant I needed to make choices about my place in the interaction. In one visit, I felt a dilemma as to where to sit. The mother sat on the mat with her baby. The CFH nurse came and sat with her and I felt that was where I wanted to sit also. But being 'the researcher' I was not sure if I should. On the other hand, I was another woman and this mother wanted to talk about her situation, 'women's talk'. As I had to take notes, I sat on my chair facing the mother, not too far away. While the interaction progressed well I felt the, to me, 'artificial' role of researcher prevailed over my desire for what I felt were

more authentic interactions of three women being together. I was also quite involved in relating to toddlers who would perhaps come up to me with a toy while their mother was engaged with the nurse and a younger sibling. When the father was present he usually took on this role with the toddler.

The CFH nurses all said my presence did not impact on the interaction; except for two visits. The first was when the CFH nurse said, if I had not been present, she would have further explored the mother's relationship regarding her partner. She had not seen the woman for several months and at the last visit they had discussed concerns the mother had about her relationship. The other was when the CFH nurse felt on particular mother had spoken more than usual about broader matters of parenting and raising children specifically due to the fact this was research about parenting.

I felt an ease and familiarity during the observations, which is an important reflection on the data generated and collected. After the initial anxious feelings about how the observations and interviews would work out – where to put the recorder, would it work, will they turn up - I was quite comfortable. In fact I reflected I was too comfortable with the settings. After the first observations I recognized my feelings and thoughts (my familiarity with the rhythm of the consultations; moments of boredom; of thinking 'that is what I do or do not do', 'that was a nice way the nurse responded', 'that is something I can try in my practice') were the result of seeing through the lens of my own CFH nurse role. When reviewing the audio and notes of the interaction, I was sometimes unable to find anything from the interaction I needed to explore with the participant. In the same way, after my first interview with a mother I had written in my journal 'it was not unlike a home visit to a client'.

This sense of feeling familiar with the data I collected was, at the time, disconcerting for me as I felt I was missing an insight which I was unable to identify. Recognizing and acknowledging that I was observing and reading the data as a CFH nurse then allowed me to look at it from a different perspective. Reflexivity was an important process in this context. By the end of the data collection period I was viewing the interactions very differently and what had seemed normal in the early interactions now stood out

to me as needing further follow-up in the interviews. I now had many questions to ask about each interaction.

Interviews

I interviewed each of the parents and nurses either the same day or within a few days of each interaction, including the repeated interactions. I conducted a total of twelve interviews with nurses and thirteen interviews with mothers⁴, and carried out smaller and more informal follow-up interviews with one of the mothers, and with two of the nurses. The interviews with parents ranged from five minutes to two hours fifteen minutes in length with the average being fifty eight minutes. The interviews with nurses ranged from fifteen minutes to seventy minutes and averaged forty minutes.

I used in-depth interviews with open-ended questions to build a picture of participants' experiences and understandings around nursing and parenting practices (See Appendices 5 and 6). Exploring these stories of experiences and incidents to the fullest served as a resource for developing a deep and rich understanding (Van Manen, 1997: 68) of what being a CFH nurse or parent means, what is important in these roles, and what parents want and need in their interactions with CFH nurses – and vice versa.

My interviews with CFH nurses focused on three areas (see Appendix 5). First I asked questions about the interaction. This included the participants' thoughts about how the interaction generally, if it was successful and why, what the CFH nurse felt was the most important aspect from a nursing or personal perspective, and what was important for the mother. I also included questions I had about the visit. The second area of focus was child and family health nursing in general I asked participants to describe the child health role from their own perspective and in terms of 'expertise', and also to discuss some 'good' and 'difficult' interactions, and to talk about the nature of the nurse-client relationship. The third focus was on parenting. This included questions about what the nurse thought was important in bringing up children, what

⁴ Where both parents were present at the visit with the nurse, separate interviews were offered to allow both parents to talk freely. This happened on two occasions. In the other two cases both parents were present together for the interview.

advice or training she thought mothers and fathers wanted from a CFH nurse, and any thoughts on what most helped mothers and fathers.

The interviews with mothers (and two fathers – here, only the perspective of mothers will be addressed) explored three similar areas (see Appendix 6). The first topic focused on being a mother. Questions included what life was like before and after having a child, what was important for her in raising children, and what had been a good time and a challenging time in her parenting. The second area covered the child health service. These questions focused on mothers' interpretations of the child and family health nursing role, and what value she gave the nurses' information. Thirdly, I directed the focus onto the visit that I had observed, and I asked for thoughts and feelings about the visit more broadly. I also asked any further questions I had about the visit. At the end of each interview with both CFH nurses and mothers, I asked the participants if they would like to add anything – and most did. The schedules and interview processes were piloted with a CFH nurse, one mother and one father before the data collection began.

Interviewing is a social encounter and as such is a complex and unique interaction which can shape the nature of the knowledge that is generated (Fontana and Frey, 2008). The interviews were active processes that lead to a 'contextually bound and mutually created story' (Fontana and Frey, 2008: 116). The perception of the interviewer as an invisible, neutral being with no impact on the research outcomes is a myth (Fontana and Frey, 2008: 116). I was an active participant in a negotiated encounter, which was shaped by the mother, the CFH nurse and me. As a CFH nurse (and as a mother, and also as a researcher), my own tendency to take and hold a position was unavoidable because I was located both historically and contextually, with conscious and unconscious motives, desires, biases and feelings (Fontana and Frey, 2008: 116).

Interviewing and dual roles of researcher and nurse

Over thirty years ago, Oakley (1981) challenged the traditional interviewing techniques of maintaining distance and objectivity, by acknowledging the reality of the

relationship that can develop – particularly between females - between the interviewer and interviewee, particularly over repeated interviews. A more personal-style or casual tone for research involvement, where people get to know and trust each other can lead to more honest disclosure and result in better understandings. In keeping with this philosophy, all of the interviews I conducted in this study were carried out in a conversational manner.

Being a nurse and a researcher presented dilemmas for research rigor (Bell and Nutt, 2002: 70). During interviews with the mothers two situations in particular arose. The first was when a participant would ask my opinion while discussing some child health issue. In these situations I was careful to answer or discuss the issue while maintaining my role as the researcher, albeit one knowledgeable in the area. I was careful not to enter into a 'consultation' or counselling role or take over the role of the CFH nurse. It seemed to me that to ignore or deflect such questions or discussions would be insincere, as I felt this approach was being dishonest by omission. These requests from mothers also provided an opportunity for me to reciprocate, in a relationship where the participant was very much more the giver than I was.

Some situations arose that, due to my role as a researcher and also as a qualified nurse, were not so easy to determine how to respond. An 'ethic of care' approach, i.e. attending to how best to work with this specific dilemma in this particular context (Edwards and Mauthner, 2002: 27), directed my actions at times when I was unsure of my role. A major criterion in any encounter (for a researcher and a nurse) is 'to do no harm'. Such an instance occurred in one interview with Jenni, a mother who discussed a situation and decision she had to make that was affecting her life deeply. I later wrote in my journal:

I was aware that I was thinking 'what exactly is my role here'. Listening was the main purpose; however she was also indicating that she needed help in where to go with this. I did say to talk to her CFH nurse about places to go ... but I sensed some hesitation and maybe she did not want to do this with her nurse.

... I ethically needed to follow up as a researcher to ensure that this research process did no harm.

My response may have been shaped by my professional values of care in nursing. I felt a need to provide help in a practical way and, after discussion with my supervisor, a follow up phone call and provision of the information seemed an appropriate response. When I phoned, Jenni said it had been helpful to talk with me, and that she had not talked about this to anyone before. She was aware where she could get help if needed.

The second area of tension I found as a nurse doing research was a more difficult situation. This was where, as an experienced CFH nurse, I was able to see a problem when the mother did not. I faced the dilemma of whether or not to intervene. For example, I had observed Carolyn's interaction with a CFH nurse the week prior, and the visit was regarding breastfeeding and poor weight gain of her newborn baby. When I was interviewing Carolyn she was breastfeeding her baby, and I could see straight away the problem with how the baby was feeding. Carolyn was not concerned and to her the baby appeared contented. My dilemma was whether to raise the problem as I saw it and discuss some suggestions on what to do, which may have been a bit different to the advice of the CFH nurse, or to say nothing.

At the time I decided not to interfere. I spent some time silently reasoning whether to say anything or not. CFH nurse's visit the day before had obviously not raised any major concern about the baby's progress. I knew the nurse to be very skilled in supporting breastfeeding, and I was able to assume the baby had probably gained at least the minimum amount of weight to not warrant more active intervention. The dilemma persisted after the interview process. I had written in my journal 'maybe I should have swapped roles – as it is important to get the feeding right at the beginning'.

In the end, I acted on my judgement as a researcher. Even though I could see a problem that could be addressed differently, intervening ran the risk of doing more

harm than good. It could have hurt the relationships between Carolyn and her nurse, between Carolyn and me, and between the nurse and me. But perhaps more importantly it could have affected Carolyn's self-confidence in her ability to breastfeed, which is an important element in successful breastfeeding. For some time after however, I questioned if I had made the right choice. I find there is not an easy answer to this type of dilemma. Other nurse researchers have also found tensions between their two roles and that recognising this was an important factor in resolving it (Colbourne and Sque, 2004: 303). For example, Ritchie (2009: 23) found she learnt to weave in and out of the two roles which were carried out in tandem.

Interviewing nurses as an insider/outsider

Interviewing colleagues is a distinct type of social interaction (Platt, 1981: 89) occurring in the context of an ongoing relationship and from the position of an insider. This situation will affect the dynamics of the interview (McEvoy, 2001: 57). An insider can bring a deeper insight into the social world under study and provide valuable interpretation and understanding to the meanings colleagues bring (McEvoy, 2001: 50; McNair, Taft et al., 2008: 73). Thus, the experiences I shared with the CFH nurses had the potential to act as a catalyst to deeper levels of discussion (McEvoy, 2001: 52).

However, in the interview stage of my research with CFH nurses I found it difficult to manage my role as researcher and my position as a nurse-colleague. Although I developed a schedule to guide my questioning, I would pursue current nursing-work issues, particularly those I considered a concern to the profession. Sometimes I used the opportunity of the interview to raise the issues myself. I reasoned that these were important issues and therefore relevant to the research. Looking back on those interviews the questions were clearly not relevant to the study. The more interviews I conducted the more I would become aware of when I was going off on such a tangent and was able stop myself or postpone such discussion till a later time after the interview.

The nurses also found my dual role a dilemma at times. Because the interview was a rare opportunity for nurses to speak reflectively about their practice, and yet was also a research project, participants' experienced a tension if they thought they were off the topic. Nurse Carol describes her awareness of this tension when she wanted my assistance with a problem: 'It's hard for you. I should ask you this when we're not doing the interview'. I then found myself responding as a colleague, or perhaps responding to the need of the person I was with, by acknowledging her need to talk and agreeing to talk after the interview, which we did. If I had not been a colleague this admission of difficulty and request for help may not have been made. We did follow this up after the interview. This highlights the responsibility and reciprocity demanded in conducting ethical research.

Field notes

I took field notes and kept a journal throughout the project. This included recording initial thoughts for analysis as well as self-observations i.e. my own reactions about what is seen and heard (Kellehear, 1993: 133). Detailed accounts of the research process, including entering the field, the arrangement of interactions and interviews, and interactions with the participants, were kept.

SAMPLE

Sampling and recruitment strategies

Because I am a CFH nurse, access to the field was relatively straightforward, and I undertook a convenience sampling approach. I met with the Director of Nursing and the Nurse Unit Manager in the region in which I worked (chosen for ease of access) to introduce and explain the project. These women acted as gatekeepers in the formal process of gaining access to CFH nurses (Hansen, 2006: 85; Liamputtong and Ezzy, 2005: 168). My approach defined and legitimized the project as post-graduate research as distinct to a more common service project. It allowed me to present myself in the role of researcher rather than colleague, although these two roles remained entwined throughout the research process with the nurses.

With the agreement of the regional Director of Nursing and the Nurse Unit Manager I introduced the project to CFH nurses at a monthly team meeting. All but two of thirty nurses eligible to take part, were present. This included a number of part time and relief staff. As with the managers, nurses appeared very interested and there was discussion and positive feedback about the project. Before the meeting ended three nurses had volunteered to take part. On the day of the initial meeting all nurses received an information package about the project which included an information sheet and invitation/consent to take part (See Appendices 1 and 2), plus a consent form and information/invitation sheet for the nurses to pass along to parents (see Appendices 3 and 4). The packages were also put in the absent nurses' pigeon-holes for when they returned to work.

As low-income parents are the focus of the study, only families with a Centrelink Health Care Card were eligible to participate, as these cards are only available to those on incomes below a set limit. Up to three families per nurse were recruited from among the participating nurses' clients. There was no response to my initial strategy of putting up posters and information sheets in the waiting rooms and consultation rooms at participating nurses' centres (see Appendix 9). I found a more effective approach was to attend 'open sessions' held at child health centres. I was able to meet parents while they were waiting to see the nurse and introduce the project to them, offering them the flyer and information sheet (see Appendices 3 and 9).

Most of the parent participants were recruited by the nurses themselves. Some had families in mind they thought would be suitable for the research after hearing me talk about the project. Personal contact has been found by others to be the most effective way to recruit disadvantaged groups (Cannon, Higginbotham et al., 1988: 454). Nurses approached clients with the information package, and recruited them for the project, and secured their permission to have me contact them. My contact details were in the information package for parents to contact me at any time although no potential participants did this. The original study design also included interviews with fathers who attended appointments with CFH nurses,

either individually or with their partners. However, after experiencing ongoing difficulties in recruiting men, I chose to focus my analytic attention on mothers only.

Saturation

It was initially difficult to gauge how many nurses would be needed for the project. The number of participants to include in a qualitative study is best guided by the principle of saturation point (Mason, 2010; Morse, 2000). Saturation point comes when additional data brings no new understandings (Bowen, 2008: 140; Liamputtong and Ezzy, 2005: 86; Mason, 2010: 1). I reached saturation within this study and concluded collecting data when similar patterns continued to occur with no new themes emerging from the data. Patterns related to key themes of analysis in the thesis including how CFH nurses imparted advice, what mothers were seeking in the interactions, how conformity and deviance to good mothering ideals were managed by nurses and mothers.

Morse (2000) has identified five factors taken into account when considering the concept of saturation and determining saturation, and thus sample size, in a study (Mason, 2010: 10; Morse, 2000).. The first is the scope of the study. The broader the scope of the study the longer saturation takes (Morse, 2000: 3). Keeping the study focused on the topic once analysis commences is important in avoiding the need to collect more and more data and undertake unnecessary data analysis which will not add to the findings overall. Guest and colleagues (2006) for example in their study of women's sexual health, found from their 60 interviews with women in two African countries saturation was reached after 12 interviews from women in one country. Elements of the basic metathemes were evident after just six interviews. Morse (2000: 3) argues more data does not mean richer data and risks a more superficial analysis. I found conducting interviews following the interactions produced data focused on the topic i.e. the interactions, relationship between mother and nurse, and mothering. Themes emerged from the in-depth data and were not added to by the thirteenth interview with mothers. Hence further recruitment was not sought.

The nature of the topic is another factor when considering saturation (Morse, 2000: 3). The clearer the topic being studied the fewer participants will be required and the sooner saturation is reached, in comparison to a topic that is more intriguing but difficult to grasp and difficult for participants to talk on (Morse, 2000: 4). A small study with modest claims will be quicker to reach saturation than a broader descriptive or exploratory study (Guest et al., 2006: 79; Mason, 2010: 2). Although my study topic was looking below the surface at taken for granted assumptions, the relevant focus on mothering and nursing made it easier for participants to talk and I received valuable data that was rich in information and descriptions of experiences aiding my analysis, and reaching saturation.

It is this quality of the data that is a further important factor in the process of reaching saturation (Morse, 2000: 4). Morse has described quality data as being focused 'on target' and 'rich and experiential' (Morse, 2000: 4). Several factors affect the information received in interviews: participants who are articulate and reflective, who have time, who are experienced in the subject and are willing to share experiences contribute to the quality of the data (Morse, 2000: 4). Fewer participants are needed when the quality of the data is high. Certainly in my study both mothers and nurses were willing, articulate and reflective generally. This was a topic that held meaning for them and the nurses in particular had thought a lot about it. The data from both the interviews and the observations was very valuable in the way I was able to gain insights into the topic.

The study design also impacts on saturation (Morse, 2000: 4). Some methods produce more data than others and therefore need fewer participants. For example longitudinal studies or mixed method studies may produce more interviews and thus more data than single interview method alone (Mason, 2010; Morse, 2000: 4). My mixed methods approach provided two types of triangulation that strengthened the data, i.e. 'data source triangulation' by using multiple groups for participants, and 'methods triangulation' using multiple research methodologies involving observations and interviews (Liamputtong and Ezzy, 2005: 41). Using multiple methods provided different perspectives and several types of data on the same issue with a resulting saturation reached with fewer participants than I had initially intended.

Homogeneity is also a factor impacting on saturation (Guest et al., 2006; Mason, 2010; Sandelowski, 1995). Compared to a study with a heterogeneous focus, which would require larger numbers to reach saturation, Guest and colleagues (2006: 76) argue that the more similar the participants are in their experiences relating to the research area the quicker saturation is likely to be reached. Sandelowski (1995: 182) also points to the benefit of homogeneity due to the lower numbers needed, as a strategy in managing studies when resources are limited. In my study the nurses are a sample of a very homogenous population. In Tasmania the child and family health nurses are all female, white, middle-class, educated women, who are all experienced nurses particularly in the field of child health, and are focused on the ethical care of, children, mothers, and their families. The population the sample of mothers were drawn from were low-income mothers holding a health care card, with children under five years, and attending child health centres.

As Morse (2000: 3) has stated even after considering all the factors above it is still difficult to estimate the numbers required for a research project and advises overestimating rather than underestimating in order to help planning of the project. My initial intention had been to have a larger sample of both nurses and mothers in the study, i.e. ten nurses and twenty to thirty mothers. These numbers reflect Mason's (2010) findings on the number of participants in PhD interview studies. He found a statistically significant proportion of studies used samples in multiples of ten (Mason, 2010: 1). His conclusion was that defending sample sizes and not saturation was guiding students and supervisors in their data collection (Mason, 2010: 10). In this study I was able to be guided by saturation rather than recruiting the nominated number of participants. I found saturation was reached with fewer participants than originally proposed and stopped data collection at this point rather than continue for the sake of having larger numbers.

As my research progressed I found saturation was reached after twelve observed and recorded interactions between mothers and nurses, and the associated interviews, which had taken place over a period of two years. My methods produced substantial amounts of data with each interaction. A single interaction resulted in at least three

transcripts of data: the interaction averaging 45 minutes, an interview with the mother averaging 58 minutes, and an interview with the nurse averaging 40 minutes. In some cases further follow up interviews with nurse or parent were also conducted. After the first round of nine observations with three of the nurses I then approached two more nurses who had continued to show an interest in the study. The sixteen participants, nurses and mothers, in my sample reflect similar numbers in other studies in this area where sample sizes have ranged from one to nineteen (Aston et al., 2006; Byrd, 1997; Clancy, 2012; Espezel and Canam, 2003; Fowler, 2000; Fredriksen, Lyberg et al., 2012; Gillies, 2007; Grant and Luxford, 2011; Hanna, 2001; Knott and Latter, 1999; Machin, Machin et al., 2011; Rautio, 2012; Tammentie et al., 2009; Wilson, 2001). Byrd (1997) based her study of nurse home visiting on in –depth observations and interviews with one nurse. Gillies (2007: 10) had one interview each with five working class mothers. Similarly, Wilson (2001) had five nurses and conducted a single interview with each. Data collection was ceased in studies when patterns in the interactions had emerged (Clancy, 2012) and data was no longer adding to the category concepts (Machin et al., 2011: 1528). While in my study, having a larger sample would have produced more data, I had reached saturation after observing twelve interactions and conducted the subsequent interviews with the five nurses and eleven mothers.

Sample characteristics; child and family health nurses

The five CFH nurses who participated in this study were all experienced registered nurses with further qualifications in child and family health nursing. All were also midwives. Four of the nurses had been working in this area of nursing for more than 10 years and one had less than 10 years' experience at the time of data collection. The CFH nurses had a diversity of experience, and were from both urban and rural child health centres.

The nurses who participated in the study were:

Lyn: a nurse for over 25 years, and with substantial experience in child and family health nursing

Joy: another experienced nurse for over 30 years, with over 25 years of experience in child and family health nursing. Joy had a special interest in, and supports, breastfeeding.

Diane: has over 15 years in child and family health nursing and has a special interest in working with fathers and young parents.

Eileen: with over 10 years of experience in child and family health nursing describes herself as a keen advocate for her clients.

Trish: An experienced nurse before coming to work in child and family health nursing less than 10 years ago also has a special interest in breastfeeding.

Sample characteristics; mothers

Eleven mothers took part in the research. The mothers all had at least one child less than five years old, the age group towards which the child health service is directed. The mothers were current but not necessarily consistent users of the service. The mothers' ages ranged from 17 to 37 years. Of the eleven mothers, eight were living in de-facto relationships, one was married, one was single, and one lived apart from her current partner. Three mothers had one child only. The other eight had two or more children – these were all blended families. I have included parent profiles to provide some context to the mothers' interactions with the nurses, and their comments in the interviews. I have not included identifying personal or socio-demographic details of the mothers or their children, to protect their anonymity.

Emma: Emma was in her late 20s and mother of four children: baby Brodie, and three children aged 10 and under. Craig was Emma's partner and father of the two younger children; they were fighting a lot at the time of the study. Emma's parents abused her and when she was fifteen she 'just couldn't handle it anymore', and moved out of home. She lived on the streets until she was sixteen and used drugs and alcohol quite heavily. When Emma found out she was pregnant she 'was like wow! OK this isn't

going to be a good for my baby' and she 'gave it all up'. Emma has known nurse Eileen for four years. At the time of the study she was visiting every fortnight to have her baby weighed to reassure herself she was feeding him enough breast milk; breastfeeding was very important to her. Emma has completed a Certificate III at TAFE, is a stay at home mother and is on a government transfer income, and is also supported by her partner's wage.

Jenni: Jenni attended an appointment with baby Logan and Cameron (aged under five years old). Her older child was at school. Jenni had brought both children for their age appropriate health assessments. Jenni is married to Ahmad, who is father to the two youngest. Jenni was comfortable with 'old fashioned values' where, as mother, she would be staying at home to care for the children until the youngest went to school, while Ahmad was seeking work. Jenni had known nurse Eileen for over three years. Jenni has a TAFE education, is a stay at home mother and is on a government transfer income.

Rachel: Rachel was in her early 20s and mother to Amelia (who is school aged) and Tom (under three years old). Rachel had come to the open session with her friend Melissa, to see nurse Lyn. This was the first time in some months Rachel had attended to get Tom weighed at the request of the dietician. Tom had feeding difficulties and was developmentally delayed. Rachel lived with Tom's father. Rachel experienced psychological and social difficulties as a teenager. Amelia was born when Rachel was a teenager and living in a physically and emotionally abusive relationship; Rachel left the relationships when Amelia was several months old. Rachel remembers struggling to mother Amelia, and regrets this. Rachel had known nurse Lyn for six years since Amelia's birth. Lyn had been a frequent visitor and support to Rachel when she was in the abusive relationship and living in a rural area. Rachael did not complete year 12, is a stay at home mother and is on a government transfer income.

Melissa: Melissa was in her early twenties and mother to school aged Gareth and recently born Simon. The family came to the open session to have Simon weighed to check his progress. Melissa became pregnant in her mid-teens, and remembered this

encouraged her 'settle down and wake up' to herself. Melissa lived with Simon's father. Melissa had been seeing Lyn for the five years since Gareth was born. Melissa did not complete Year 10, is a stay at home mother and is on a government transfer income, and is also supported by her partners' wage.

Kylie: Kylie (late 20s) attended an open session with her de facto partner and newborn Nicholas, and Corey and Chloe (both aged under 10 years). Her partner Steven is the biological father of Corey and Nicholas. Kylie wanted Lyn to weigh baby Nicholas and talk about his sleeping. Kylie had known Lyn for five years and had attended regularly attended the centre or received centre or home visits for all of her children. Kylie has completed year 12, is a stay at home mother and is on a government transfer income, and is also supported by her partner's wage.

Tanya: Tanya is a single mother in her mid-to-late 30s. She attended an appointment with her twins, for their age-related child health assessment; her older child was at school. Tanya was a victim of childhood sexual abuse and had abused drugs and alcohol in her teenage years. One of her twins had required a major operation, approximately one year prior to the visit. Tanya and nurse Joy had known each other for seven years. Tanya has completed year 12, has casual work and is on a government transfer income.

Carolyn: Carolyn was aged in her early – mid 30s. She was mother to five children. Her previous partner had physically abused her, and she lived near her new partner, who was the father of newborn baby, Jade. Carolyn attended the centre because Jade was being breastfed and had not been gaining weight. This was the only the second time Carolyn had seen Joy. Carolyn has completed a TAFE course, is a stay at home mother and is on a government transfer income.

Angela: Angela, in her early 20s, attended an hour long appointment with her partner and baby Bradley (aged under 1 year), who had been born prematurely and required early surgery. Both parents had attended the centre regularly since Bradley had been discharged from hospital, and were visiting monthly at the time of the interview.

Angela and her partner also often phoned Lyn for reassurance and guidance. Angela has completed a Certificate III, is a stay at home mother and is on a government transfer income.

Sharon: Sharon was in her mid-30s and mother of Thomas (aged a little over 18 months old). Sharon lived in a de facto relationship with Thomas' father. She attended the health centre for the recommended age appropriate health assessments, and saw CFH nurse Joy since the birth of her son. Sharon has completed a Diploma at TAFE, is a stay at home mother and is supported by her partner's wage.

Donna: Donna (mid-twenties) and her de facto partner Clive attended two visits with nurse Trish during this research. The couple had attended the centre monthly with their first baby, Ella, and the second visit, which I observed, was with their new baby, Peta. The first interaction focused on Ella's age-related progression and the second interaction focused on a health assessment of the newborn. Donna has completed year 12, is a stay at home mother and is on a government transfer income, and is also supported by her partner's wages.

Alissa: Alissa (late teens), and her partner Kade, had been visited by CFH nurse Diane, in home visits since the birth of Ethan (aged under 12 months). The young couple lived with Kade's family. Alissa is completing year 12, is student and is on a government transfer income.

ETHICAL ISSUES

I received ethical clearance from the University of Tasmania Social Science Human Research Ethics Committee, which is a combined University of Tasmania and Department of Health and Human Services committee (ethics reference number: H0009264), for this research. My project followed all the required procedures but the study design raised particular ethical issues in protecting the anonymity of the participants.

Anonymity was a particular issue for nurses, as they are a close-knit group in a regional setting, and discussed the research, and the (nurse) participants among colleagues. I had emphasised to individual participants that I would not be disclosing who took part, or what they said and did to anyone apart from my university supervisors – and in those situations I did not share any real names. I informed the participants that no identifying information would be used in the thesis report or any resulting papers. I removed any identifying data, including recognisable turns of phrase and particular professional or personal experiences.

The research design, in terms of the interview process involving both the parents, and their assigned CFH nurse, raised the issue of internal confidentiality. I addressed the potential for the relationship between the two parents, or the nurse and parent to be affected by what the other may say in the interviews by ensuring the participants were aware that what they said in their interview would not be discussed with their partner, nurse or any of the other participants. I removed all identifying data from descriptions of the mothers who participated in the study. I also emphasised to participants that their participation in this research project would not affect the care they received from their CFH nurse.

There was also the possibility that issues may have arisen in the interviews that caused distress for the nurses. The participants were able to pause or stop their interview at any time. All the CFH nurses were DHHS employees, so a confidential, independent, cost free counselling was available through this workplace, and made available if a nurse wished to discuss the issue further. This information was written in the information package given to all nurses. At times nurses did discuss difficult and emotional issues, however the interviews seemed to provide an appropriate opportunity for the nurses to explore and reflect on these matters and they found it to be a positive experience.

I was concerned that mothers might be distressed when talking about the sometimes sensitive topics of parenting. As with the nurses, I listened attentively and sensitively to the parent and they were aware they could pause or stop the interview if they become distressed. I had explained this before the interview started. If parents needed to discuss

issues further I could give them the number of the Parenting Centre in their region to receive counselling. There was also a 24 hour parenting line phone number I was able to provide if needed. However, none of the mothers requested that additional support.

I was also concerned that my presence during the consultations between CFH nurses and mothers would inhibit the discussion between the parent and nurse. Therefore prior to the observation of the interactions the parents and nurses were encouraged to voice any concerns that my presence was making them uncomfortable and I would leave immediately. I also looked for signs that the participants were becoming uncomfortable but not voicing their concerns. I assured parents that any choice to stop taking part would have no effect on them, the nurse or the service they receive from the nurse. I did not carry out observations if other parties, e.g. nursing students, needed to be present. None of my concerns appeared to be realised.

ANALYSIS

I coded and categorised observational data, emphasising the pattern of interactions and negotiated nature of the responses on specific issues relating to motherhood, and child-raising. Non-verbal responses were also important information. Comments were added to the matching places in transcripts of the interactions where applicable and coded. Such negotiated interactions can be very subtle and nuanced, for example, apparently trivial pauses, body movements or overlaps can be crucial for reliably interpreting data (Silverman, 2001). Similarities and differences across the interactions were identified.

The interview data were analysed using an inductive, thematic approach (Hansen, 2006: 149). My analysis was aimed towards identifying beliefs about parenting and nursing. In order to explore the recurrent meanings and ideas that emerged from the interviews, analysis involved first an open-reading of each transcript to understand the participant's expression and meaning in the broadest context. The data management

program NVivo data management software was used to assist with undertaking line-by-line coding of each transcript, and finally, categorizing data according to emerging patterns and themes (Richards, 2005). Coding began at the completion of the first interview, with all data being updated as new codes or themes appeared. I sought to identify similarities and differences within and across the CFH nurses and mothers groups.

Synthesis of the data from two sets of interviews (CFH nurses and mothers) as well as the observations was a challenging task. I kept a field diary that contained reflections and comments written after observations and interviews and this informed initial ideas about the similarities and differences (Liamputtong and Ezzy, 2005: 273) in the datasets. I created a case for each interaction which contained themes derived from the observations and both interviews. Informed by the initial analysis of the separate components of the case, each case was examined closely to explore what was revealed about the shaping of a good mother identity. This required attention to themes that appeared consistently across observations and interviews, as well as accounting for those themes that were evident primarily or exclusively in one of the case components. I then looked across all the cases to explore similarities and differences, in order to bring together the key themes that are reported in the findings Chapters five and six.

My long term experience working as a CFH nurses shaped my analytic strategy. I initially used a positive, strengths-based nursing approach as the lens through which I read and interpreted the nurses' behaviour and language. Thus, in my early analysis efforts I emphasized the importance and benefit of developing trusting nurse-client relationships. This focus reflected my novice researcher position and the challenge of conducting research with an insider perspective. My hesitance and reluctance to recognise and acknowledge issues of power reflected the discomfort nurses can experience with this topic (Peckover, 2002: 375; Rafael, 1996:3).

Viewing child and family health nursing practice from a different perspective also meant my own nursing practice was challenged, and included in reinterpretations. Using a Foucauldian approach and gaining the valuable insights from my non-nurse

supervisors helped me to achieve this more critical perspective. As will be seen in the following chapters, I gradually move towards this a more critical perspective by addressing the issues of power and authority that underlie the interactions between mothers and CFH nurses, and which have become a major focus of the thesis.

CONCLUSION

I have used a constructionist and interpretivist approach as a means to develop an understanding of how mothers and CFH nurses negotiated meaning around mothering within their interactions. The mixed method of observation followed by interview has been a strength of this research. The data generated by these methods was valuable in that it contained multiple views of the same phenomena, which added depth to the interpretive analysis process. My insider position as nurse-researcher has been discussed throughout, and this reflexive process has enabled the findings to reflect something of the difficulty CFH nurses have with the concept of power.

CHAPTER FIVE

EXPERTISE AND AUTHORITY IN THE MOTHER AND CHILD AND FAMILY HEALTH NURSE RELATIONSHIP

INTRODUCTION

In this chapter I focus on child and family health nurses' and mothers' understanding of their relationships with each other. I found that child and family health nurses minimise their professional expertise and authority over mothers and claim a relational framework of caring. The mothers, on the other hand, visit the CFH nurses precisely for their knowledge and expertise to gain reassurance of their child's progress and, by implication, their good mothering. These differing understandings reveal a tension between expert knowledge and pastoral power in the definition and conduct of the relationship, and the possibility for both child and family health nurses and mothers to resist the ideals of scientific motherhood. My analysis suggests that child and family health nurses and mothers manage their interactions and relationships with each other in ways that minimise the possibility of negative judgements on the mothers' mothering. The nature of these child and family health nurse-mother interactions has significant implications for health care delivery and constructions of mothering.

In this chapter, I define child and family health nurses' expertise as a specialist body of knowledge held by CFH nurses due to their advanced training, which combines with their experience in this area of nursing. This definition also reflects those used in existing studies, for example McHugh and Lake (2010: 278) who define expertise as 'a hybrid of practical and theoretical knowledge'. See also Benner and colleagues (2009), and Dreyfus and Dreyfus (2009). From a Foucauldian perspective of power-knowledge (Foucault, 1977: 27), medico-scientific knowledge, the basis of CFH nurses' knowledge,

is dominant in our society and privileged over knowledges, thus enabling the professional group to exercise power (Miller, 2005: 31; Turner, 1995: 152).

I define mothers' expertise as the personal, situated and specific knowledge about what is appropriate or possible in their particular context and with their particular child. This arises out of my analysis of mothers' understandings of their knowledge, and existing work (Arendell, 2000; Fowler, 2000). From a Foucauldian understanding of knowledge-power mothers' experiential knowledge or 'popular' knowledge is 'inadequate' and subjugated to that of the dominant medico-scientific knowledges (Foucault, 1980c: 82; Gilbert, 1995: 869; Miller, 2005: 43). Yet this does not prove to always be the case here at the micro-level of interactions.

Calling on the work of Perron and colleagues (2005: 543), I define authority as both the professional legitimacy accorded to CFH nurses due to their expertise and knowledge, and the legitimacy accorded due to their social mandate of care-giving in their position as agents of the state supporting the health and wellbeing of children and their families. This perspective reflects CFH nurses' position within governmentality and bio-power, and pastoral power, in their role to support and influence mothers.

In the first of two sections in this chapter I present the findings on CFH nurses' conceptualisation of their relationships with mothers. I note the centrality, in CFH nurses' accounts of their practice, of care. I then present nurses' troubled relationship with power and expertise, focusing on three sub-themes. Firstly, I describe the ambiguous position of expertise within their relationships with mothers, when CFH nurses consider the coercive influence that their professional knowledge and power can have on mothers' behaviours. Secondly, I discuss the relationship, or link between expertise and intervention that occurs when CFH nurses strategically call on their knowledge and skills to impose a medico-scientific approach to mothering. Thirdly, I explore the paradox of expertise and professional identity. CFH nurses want their expertise acknowledged but are wary of the impact this has on their relationship with mothers, given the centrality of care to their professional identity.

In the second section of this chapter I analyse the mothers' accounts of their relationships with the CFH nurses. I discuss this by exploring two themes. The first is mothers' understandings of CFH nurses' expertise. In discussing this theme I examine five sub-themes. Firstly I describe how mothers recognised and accessed CFH nurses as a resource, in that these CFH nurses hold professional expertise particularly related to child development. Secondly, I describe the way in which mothers valued the child and family health nurses' own personal experience, and yet the importance of this knowledge was ambiguous, or was marginal to the encounter, as there is no professional model to legitimate this knowledge as a resource. Thirdly, I explain how the mothers' recognition of expertise did not always equate to acceptance of CFH nurses' authority. This was because mothers actively contextualise the CFH nurses' knowledge within the range of information available to them, particularly that of family and friends, and within their own circumstances. Fourthly, I describe how mothers found CFH nurses' knowledge a helpful resource when the CFH nurses acknowledged the mothers' agency and information was not imposed. Finally, I present how mothers used CFH nurses' expertise and authority strategically in order to manage the expectations of others.

The second major theme in this section of mothers' accounts of their relationships with the CFH nurses is that mothers valued the CFH nurse as 'someone to talk to'. While this relational aspect was appreciated the CFH nurses' technical expertise remained of primary importance for the mothers and is discussed in three sub-themes. Firstly, some mothers, particularly if they were socially isolated, valued the opportunity to talk to another adult. Secondly, it was helpful for some mothers to have someone who knew them and their situation. This was particularly the case for mothers who had children with complex needs; they did not have to repeat their story and appreciated the nurse knowing their child. The third and final sub-theme was that some mothers, particularly those in difficult circumstances, were able to disclose personal troubles to the CFH nurse, because they had become someone they trusted.

HOW CFH NURSES UNDERSTAND THEIR RELATIONSHIPS WITH MOTHERS

There were tensions between child and family health nurses' emphasis on caring for and empowering mothers and the importance of expertise and authority in their practice and professional identity. CFH nurses did not want to appear as the expert at the expense of diminishing a mother's confidence in her own parenting, but they strategically called on scientific discourses to guide and persuade mother's parenting decisions. They were strategic about what they addressed, and employed subtle coercion in giving advice which imposed elements consistent with scientific mothering. In accordance with Foucault's concept of pastoral power, I suggest that developing relationships was an important means for CFH nurses to support mothers but was also means of maintaining a gentle surveillance, a surveillance hidden under the 'guise of friendship' (Wilson, 2001: 298). As evidence of this, the child and family health nurses also expressed concern about the lack of recognition of their expertise and authority by mothers and other professionals.

The ethic of care within relationships with mothers

In their interviews, child and family health nurses emphasised care as central to their practice. Care for mothers in their mothering role was the core of their relationship with mothers. This care focus echoes the humanistic approach described in nursing (Watson, 1999) and professional discourses of the importance of providing support through developing good nurse-client relationships (Peckover, 2002: 374). Child and family health nurses also acknowledged the autonomy and expertise of mothers, and validated their experience.

CFH nurses described several aspects of supporting mothers' development not only as a mother in her parenting role but also as an individual. Their comments reflected the humanistic conceptualisation of caring as developing the human potential (Paterson and Zderad, 1976: 93; Traynor, 2009: 1563). CFH nurses' statements suggested they

aimed to empower mothers by encouraging them to recognise and develop confidence in their own knowledge and abilities as mothers.

The importance of being supportive, in CFH nurses' understandings of their role, is illustrated in the interview with Diane, who emphasised the distribution, and mobilisation of resources for mothers:

Diane The main role I see is ... as a support. And to really facilitate parents being able to access resources – be that their own families' resources or the services' resources or their own inner resources that is going to help them, you know, parent as well as they can. And in doing that I guess it's sharing information, and really building their confidence, to help them acknowledge the strengths they have.

Similarly, Eileen described the CFH nurses' role in terms that de-centred expertise and authority, and instead emphasised the CFH nurse role as enabling a mother's own growth in knowledge and expertise.

Eileen I think our role is very much a support. I think as an explorer, opening new frontiers, and allowing ourselves to be used as resources. ... And having the capacity to listen, interpret and help them with their own pathways and empowering and strengthening their parenting position. I think that's really important.

Both Diane's and Eileen's comments are mother-centred and emphasise care and the facilitation of mothers' needs and desires rather than nurses' medical expertise or authority. In so doing, the nurses repositioned and de-centred their own expertise. They described their attempts to build mothers' confidence and 'own inner resources' and strengths. Within this aim is an implication that nurses understand mothers to be the expert on their own children.

The idea of being an explorer and opening new frontiers was reflected in an interaction between mother Emma and Eileen. Emma has four children, with six month old Brodie her youngest. She was economically and socially marginalised through her teenage years and remains disadvantaged. Eileen encouraged Emma in her aspirations beyond her mothering role, supporting her idea of university education. In the course of the visit the conversation had turned to playgroups and activities Emma could take part in. Emma had described her enjoyment of a young mother's group she had previously been part of when Eileen brought up a possible 'new frontier':

Eileen Ohh yes, that's, that's a wonderful organisation [young mother's group].

Now that could be a stepping stone. I don't know if you've considered that, Emma, in terms of further education ...

Emma I really wanted to do social work at uni. ... I mean my big plan was when I turned 30 start uni. ... But I've pretty much been told that with the twins the way they are it's just not an option.

Emma described how care responsibilities had halted her plans for further study and referred to the judgements of unspecified others in doing so. However, Eileen continued to encourage Emma, saying:

Eileen I'd encourage you to ring the School of Social Work and just explain it and lay it on the table what the situation is, you know, how possible it is. ... But again, it's that balance, and you'd be the best one to know. ... You're very goal orientated ... So that could be really something to look at.

The interaction reflected a tension noted by Baggens (2002) that when 'empowering' clients, child and family health nurses exist in a tension between enablers and experts. Within a humanistic framing, Eileen's planning can be interpreted as emphasising Emma's empowerment, valuing the possibility for a growth in human potential. However, despite her statement that Emma would be 'the best one to know' Eileen dominated the envisaging of Emma's future. She did not enable Emma by providing

space for Emma to find her own solutions, so much as acted as an expert in defining both Emma ('you're very goal oriented') and the possible (and implicitly, most effective) pathways for moving forward. Eileen's immediate focus was on changing Emma's situation in ways that reflected dominant middle class valuing of achievement, education and socio-cultural positioning.

CFH nurses' emphasis on caring for mothers and a de-centring of medical expertise is also evident in Lyn's comments.

Lyn It's probably the more subtle things that make a difference to somebody in the longer term. Maybe we just listen to somebody one day or um, you know, give somebody a bit of positive praise that they haven't heard for a while. That kind of thing probably makes more difference in the overall picture of things. ... [It's] soul-saving.

Lyn presented listening and affirming, not treatment, as making the real difference to a clients' life, and described this as 'soul saving'. This position supports Gordon's (2006: 109) argument that nurses emphasise the caring aspects of their work over their medical knowledge and technical skills, thus separating rather than combining these equally important aspects of nursing. Lyn's description is typical of most of the CFH nurses' responses, which highlight the way in which the core focus of their work shifts from mothers' and children's physical wellbeing, to their social wellbeing and cultural position.

Most CFH nurses described supporting mothers as an important end in itself. However Joy made a more explicit connection between supporting mothers and the wellbeing of babies – the formal clients of the service. Talking in the context of supporting mothers' networks in rural areas, she says:

Joy [It's about] being aware of people being isolated, even if they're not isolated but maybe they're not surrounded by people that are that

supportive. So, to give them the support so that they can give the child the support, and nourish them and nurture them.

In common with the other CFH nurses, Joy positioned caring as central to her practice and aims. It is also clear in the interactions that CFH nurses are focused on the physical wellbeing of children.

Nurses' representations of their care for mothers did not reference their formally and professionally acknowledged skills in terms of medico-scientific care. They positioned themselves as resources for the practical and emotional support of mothers, and described this orientation in ways that linked their services to mothers' empowerment. In so doing, they marginalised the impact of their professional expertise and authority on their relationships with mothers. The relative unimportance of their knowledge to mothers' child raising practices suggests the CFH nurses are not fully accepting of scientific motherhood which demands mothers seek advice and direction from experts on the raising of their children.

Expertise and power: a troubled relationship

Because of their emphasis on care, CFH nurses had to manage the tension between authority and care, and the risks this tension posed to their representation of themselves as being supportive of their clients. The CFH nurses described their professional expertise and their authority in ways that suggested they were sources of ambiguity and contention. This tension was particularly evident in two areas: in developing and maintaining a supportive relationship with the mother; and when CFH nurses wanted their expertise and authority to be recognised by clients and other professionals.

Expertise within relationships with mothers

Child and family health nurses described a discomfort with displaying their professional expertise. At the same time, the service focus on babies often

foregrounded nurses' knowledge and skills. Indeed, for many child and family health nurses and mothers, the CFH nurse-client relationship is initiated via a highly visible, accepted and valued practice of child health nursing: weighing the baby. Lyn invoked the iconic nature of the scales in acknowledging the role of nurse-expert.

Lyn In a lot of instances [clients] still see us as standing behind scales. But, then I think they build on that from their experiences from that very first visit. That hopefully you set up a respectful, trustful relationship and they can see that you are actually there as a support person, that they feel comfortable, that they can ring, drop in and ask about stuff if they're having any problems with it.

Rather than a focus on her technical expertise (standing behind the scales) Lyn emphasised the relational elements of care that are, for the CFH nurses in this study, positioned as the most important element of their job. However there is some ambiguity as Lyn's comments also suggest CFH nurses recognise and welcome mothers seeking their expertise, where they can ring, or drop in and ask about baby issues not 'soul saving' issues. This ambiguity reveals CFH nurses may experience a possible tension in their role between how they experience the role and how mothers see them. As Lyn implied – and as data discussed later in this chapter indicate – mothers focus on having their child's progress assessed, and assessment draws upon nurses' medico-technical expertise.

Child and family health nurses discussed how they worked to move interactions beyond assessing the baby's progress, despite this being the reason most families visited the service. They presented this shift as a delicate negotiation of the implications of their knowledge and expertise. They were concerned that mothers might perceive nursing skills and position as threatening – as indeed a position of power. As Trish acknowledges, this is particularly true of low-income mothers, saying:

Trish Initially I think they were probably a bit wary of me, or she was especially, because I think she probably looked at me as an authoritative

figure but they don't now, not at all. ... Sometimes I find, especially those from lower socio-economic groups do find you as an authoritative sort of figure.

Trish presented her authority as a problem to be overcome in her relationship with mothers. She suggested the mother in question no longer sees her in terms of authority, and presented this as a positive change. Trish's statements suggest she conceptualises her authority as arising out of the intersection of professional knowledge and class privilege. Trish's comments also imply that her efforts at changing the interpersonal dynamics between her and her clients can effectively trump differences in structural position.

The way in which the child and family health nurses would engage with clients was of a particular tenor of interaction that suggested the possibility of mitigating authority and power. CFH nurses worked to establish rapport through creating a relaxed and informal environment. As an indicative example, when Donna brought their new six week old baby to the centre for her second visit Trish responded with enthusiasm:

Trish Oh my God, she's grown!

Donna There you go [handing baby Ella to Trish who lifts the baby up above her head]

Trish [to baby] Hello, what are you looking at? [to mother] She's so much like her sister!

Trish's initial exclamation indicated her excitement to see a new baby, an excitement that undermines any presumption of an impersonal professional engagement. By comparing baby Ella to her older sister, Trish emphasised her long-term relationship with the family. Trish does not impose formalised processes focused on the baby's physical or cognitive development rather the interactions reflect Clancy's (2012: 2555) description of 'ease and a personal professional approach'. Clancy (2012: 2560) describes 'familiarity and pleasantness' as characteristics of CFH nurse-mother encounters and these were obvious in the above interaction. She also describes

interactions conducted in a format of 'politeness, ease and pleasantness' where sensitive issues were discussed in a straightforward manner and without concerns being glossed over (Clancy, 2012: 2561). Clients are not deterred by CFH nurses' expertise and authority and CFH nurses did not impose their authority (Clancy, 2012: 2561). This description is reflected in the observations of encounters in this study.

The CFH nurses also presented interactions, such as the one above, as evidence of their supportive, mother-centred approach:

Trish Our relationship has changed over the time. It's not so much a professional relationship, not like an expert telling them what to do. It's more like friends; a professional friendship really isn't it? They know my name and use it. ... They don't seem to look to me for an OK to do something – they're comfortable in their parenting.

In linking a 'professional relationship' with 'an expert telling them what to do' Trish recognised the possibility of a power differential arising from her medical knowledge. However, she de-centred the relevance of authority and expertise through claiming that the couple's parenting reflected their own knowledge and confidence. Trish differentiated a professional friendship from both a personal one and the formal hierarchical expert professional-client relationship. Her comments suggest a professional friendship, while maintaining a professional-client boundary, is a more equal and intimate connection where familiarity has a valuable place. She thus reinforced the message that child health nursing is a supportive, relationship based practice.

Lyn's comments suggested her professional authority and expertise did not sit comfortably with her valuing of a supportive and empowering practice (Aston et al., 2006: 64; Gilbert, 1995). Lyn described expertise as having negative undertones of power:

Lyn [We are] very much there to, as I said, enhance the skills they already have and not to be set up on a pedestal as some sort of expert. ... An expert to me has connotations of a power play and even though you'd have to expect there is power difference there ... it's just being directive and blurting out information and [the client] taking that information and going away with it. And hopefully that's not how we work, you know more collaboratively with the client around working out what's going to work for them. ... I think we have a really solid strong body of knowledge and experience that we can share with clients. But expert is not the word I would use.

Lyn drew a distinction between an expert, who was someone using their knowledge to direct someone's actions, and her ideal of child and family health nurses using their knowledge as a resource to build collaborative and problem-solving relationships. Lyn acknowledged that 'you'd have to expect there is power difference there' (in the relationship between nurses and parents) but moved to reject any behaviours that might make power differences manifest in specific interactions. In essence, Lyn rejected a directive 'expert' model of care in contrast to the preferred 'partnership' model of care (Davis, Day et al., 2002). Lyn acknowledged the existence and usefulness of her knowledge but presented this as separate from power (which she presented as a question of the use of knowledge).

Trish on the other hand, acknowledged her authority and knowledge but described it as a troubling issue. She drew on her own experience as a mother to reflect upon the impact of expertise in not only determining the health of a baby but informing mothering identity:

Trish We need to be aware of how much power we have. Of the effect of what we say can have on a client where we can unknowingly hurt people. When I had my first baby I was told she was underweight: 'hasn't gained much weight this week' she said. I knew everything else was all right but she was the child and family health nurse. She held

authority. When I had my second baby I made sure she was above her birth weight before I went to the centre. Now I don't use graphs, unless a client asks, because of the negative effect it may have.

Trish made explicit the power of the CFH nurse's judgement over that of the mother's and how detrimental any perceived negative judgement can be to the mother. The nurse's negative judgement of her own baby's progress, and the implication Trish was not a 'good mother', was used by Trish to explain her motivation to minimise any negative impact she may have on a mother. Trish described graphs – an indicator of CFH nurses' expertise and a manifestation of the key surveillance techniques of hierarchical observation, normalising judgements and the examination (Foucault, 1991a) – as potentially unconstructive for mothers, rather than useful tools for protecting babies' wellbeing.

Echoing Lyn's comments Trish acknowledged the power that can arise from a nurse's structural and institutional position, but rejected its legitimate use in professional relationships.

Trish And sometimes I find I'll ask questions or delve a bit more, because I feel like I'm in control a bit more, because they are- which is awful - but because they are that lower socio-economic group. Sometimes you think you do have quite a lot of power? (questioning voice) And it is easier ... I think for those people to feel pressured or to be pressured, because you feel more confident. I dunno. I think sometimes you think well I know better because I'm better educated. Only I think you have to be really careful not to come at it from that point of view [said in a very serious tone].

Trish acknowledged her expert knowledge power that is associated with her knowledge and role. Her approach reflected the findings of previous studies, which note nurses' reluctance to talk about power (Gilbert, 1995; Holmes and Gastaldo,

2002; Perron et al., 2005). Rather than defining power as primarily a potential resource for protecting the wellbeing of children or advising mothers in effective mothering practices, Trish implied that nurses' power could be source of unwelcome and unhelpful pressure on parents. She framed her sense of control over wielding this power as resting on a good relationship with parents that needed careful management and a reflexivity that problematised any taken for granted claiming and use of power. Like Lyn, Trish presented power as something to be managed via a caring or partnership approach to interacting with clients, rather than as a dynamic that arises out of their differing structural positions.

Child and family health nurses recognised positive aspects of their own expertise in terms of both a body of specialist knowledge and their personal experience. Their comments provide some indication of the ambiguity rather than absence of expertise in the child and family health nurse practice. Eileen acknowledged her professional knowledge and skills did afford a degree of expertise particularly in relation to being continually updated on 'best practice' and research through professional development. Eileen gave a qualified opinion of her expertise:

Eileen I think child and family health nurses are experts. Um, I guess it depends on what definition of expert is. I think that we can't see information in terms of black and white because it all happens to be at what level best practice is at ... the research is constantly evolving.

Eileen described her access to up-to date research as a positive element of her professional expertise. She acknowledged the value of the scientific discourses but also problematized the value of that knowledge. Noting the evolution of medical knowledge allowed Eileen to acknowledge her expertise and minimise the differences between child and family health nurses' knowledge and the knowledge of non-professionals.

In her interview Lyn also problematised the reliability and accuracy of medical knowledge (c.f. Abbott and Sapsford, 1990) and implied a problematising of scientific

motherhood. But her description of using medical evidence to determine if something is 'normal' suggests Lyn implicitly recognised child and family health nurses' expertise in judging the wellbeing or health of children.

Lyn I guess if we're working from an evidence based point of view then the more we can back up what we say, like it's normal ...I just hope that's right (laugh), you know how we say we work from an evidence based practice - are you absolutely sure that's right?! (laugh)

Eileen and Lyn's comments both accepted and problematised the value of expert medical authority. Highlighting the limits of this knowledge aligned with their discomfort at the suggestion of power arising through their expert knowledge and their emphasis on the value of mothers' knowledge and confidence.

Child and family health nurses also valued their skills in medical emergencies. They contextualised these medical skills within what they described as pre-existing caring and trusting relationships. They described these relationships as necessary to enable them to effectively apply their medical knowledge. For example, Lyn had known her client for some time and made a home visit after a family bereavement to find her client in the middle of a psychotic episode. Lyn described how her approach to this situation had been built upon her relationship with the mother, and resulted in the mother accepting Lyn's advice to be admitted to the psychiatric ward.

Lyn she was having a psychotic episode ... I think the relationship was on a slightly different level [to that of a less known client] ... and I said something to her about her grief, and she just looked at me and ... it wouldn't happen with every client, I just gave her a hug ... And she seemed to really appreciate that ... there was a connection there ... I think that really made her trust that I was going to help her ... getting her into an ambulance and things was tricky, but I think maybe that little moment just made it just that little bit easier to trust.

Eileen described using her knowledge of post-natal depression to identify the signs of it during a first consultation. She emphasised the value of this medical knowledge in creating the beginnings of an on-going relationship. This in turn made Eileen's use of medical knowledge more effective when she was able to support the mother through a major anxiety attack at a later meeting.

Eileen It all happened just out of the blue at this consultation ... and it was very complex. ... She had obsessive compulsive disorder ... I had done the Edinburgh Postnatal Depression Scale. It was like 28 out of 30. ... I was able to help that mum through this very difficult stage. ... But just to put some context on it and the trust that clients build up with their child and family health nurses. ... three years later, [at a community centre] she was having a major panic attack ... and recognized me and called me over. Implicitly that trust had developed, and ...I helped her through the next hour ... So you can never underestimate the role of trust.

The episodes that Lyn and Eileen recounted were more dramatic than the 'soul saving' work that Lyn and the other nurses presented as the more valuable aspect of their practice. However, their accounts foregrounded their relationship-building with mothers, which was presented as just as necessary as medical knowledge when responding to mothers' medical needs. The accounts also highlight the place of pastoral power in nursing practice. This power was a means of more effectively providing medical care, and facilitating compliance.

Lyn's actions were also critical in a life-threatening situation when she recognised at a glance that a child brought into the centre was gravely ill and the mother was unaware of the seriousness of the situation:

Lyn The mum was a bit concerned about him but not overly ... But he looked incredibly unwell, to me. And um ... he went to hospital ... he had meningitis ... and it was probably the timing that was pretty critical [resulting in a good outcome].

The link between expertise and power in these scenarios, however, did not challenge nurses' understanding of their role as essentially one of support. In the first two examples the child and family health nurses had applied their medico-scientific expertise within relationships of care. They frame these experiences as using knowledge to protect mothers or their children in extreme circumstances. The mothers' knowledge was not medically correct but the specificity and extremity of these instances cannot easily be used to challenge nurses' claims that in everyday practice, a nurse's knowledge is not more inherently valuable than mothers.

Expertise and intervention

There are tensions between the child and family health nurses' emphasis on caring and support and their use of expertise to intervene in mothers' behaviours. In these contexts, child and family health nurses call on 'objective' scientific discourses when discussing mothers' practices and suggesting interventions. Nurses appeared strategic in their choices about how, what and when to confront concerns they may have, and this appeared to be affected by the degree they knew the families.

Trish, for example, described her response to Donna and Clive's 'quite, quite early' introduction of solid foods to their first baby, Ella. Donna and Clive had visited Trish at the centre on a regular monthly basis since Ella was two weeks old. In discussing her response to the parents' decision, Trish drew upon information on the contemporary scientific research based, recommended first foods:

Trish I mean she's (Donna) got really good parenting skills but I think some of her, like her knowledge is a little bit limited. Like with the first one they started her on solids really early and by the time I saw them they'd already done it and were using custards and stuff like that. So because I was seeing them every fortnight I said to them well yes OK you've started and she loves it, so we went to the fruit and vegies rather than the custards. And I said just stick on that don't go anywhere near dairy

for a while. I mean this was three and a half months or something so it was quite, quite early.

Trish made a distinction between what Donna does as a mother (her skills, which were 'really good') and her knowledge, which is 'lacking'. Trish implicitly defined legitimate knowledge as the dominant medico-scientific knowledge, which she saw as a more appropriate indicator of feeding practices than Donna's situated choices about what might be best for her child. But Trish presented herself as supporting Donna's mothering: she did not challenge Donna on the introduction of solid foods earlier than the recommended age of six months and in the interview she prefaced her comments with a statement that acknowledged Donna's ability to be a parent. However Trish implicitly valued her own expertise, based on her medico-scientific knowledge, by attempting to influence Donna's choices to change to giving foods that are scientifically defined as more appropriate first foods.

Lyn also provided information and 'guidance' during her consultation with Angela and Sean and their eight month old baby. Again, the issue was food. Lyn described the parents as 'anxious parents' who were responding to their child's early medical problems. Angela and Sean had visited and phoned Lyn regularly following their child's birth, and were visiting monthly at the time of the observation and interview. Their main concern at the observed visit was Bradley's problem with constipation, a side effect of medication. Lyn explored the problem looking at foods.

Lyn: And the cereal that you're giving him, have you noticed on the pack, most baby cereals are fortified with iron as well, have you noticed if that one is.

Angela: I just give him the jars, the baby jars.

Lyn: It probably does, most baby cereals have extra iron in them as well, um but yeah I'm not too sure about the jar ones.

Discussion around this topic continued, and Lyn provided comments and advice directed toward a particular type of feeding: cereal powder mixed with water or milk, and not the instant pre-mixed food provided in the jars that Angela was using. Lyn valued home-made fresh foods even more, and mentioned:

Lyn So that's another thing you can start to do is make a bit extra of whatever you're having um and just give him a bit of that ... say you're going to have carrots or pumpkin or sweet potato or that, make up a batch of it and then you can freeze it into ice cube trays ... ultimately you want him to be having the food that you're having, just because it's easier. (A: yeh). When you think about him being a toddler you don't want to be having to continue

Angela Cooking him different stuff.

In this interaction Lyn did not directly challenge Angela's feeding choices or knowledge. Guiding the possibilities of action for Angela, she presented her own knowledge as suggestions and an observation that her approach would not create more work for Angela later on. This presentation of knowledge echoed nurses' understandings of themselves as resources and supports for mothers, rather than powerful and authoritative experts. However, Lyn's approach suggested she valued medical knowledge over Angela's knowledge of her child's tastes. This was suggested in Lyn's response to Angela's re-framing of her choices in ways that emphasise her experiential knowledge of her child:

Lyn: and things like custards and things are OK every now and then. A bit like for us, (A: yeh) they don't have a lot of nutritional value to them (A: yeh) so

Angela: I tried the strawberry and banana custard and he loved that,

Lyn: mm (non-committal)

Angela: but that's the only custard I've tried

Lyn I guess they're the ones that people use because they're the right texture. But yeh from the nutritional point of view you're probably better to stick to things like fruits ...

Lyn countered Angela's emphasis on her knowledge of her child and her ability to give him joy with a non-committal reply. The legitimacy and impact of Lyn's authority was evident when Angela adds defensively it was just the one type of custard. Lyn's response 'they're the ones that people use' did not directly criticise Angela's action but contextualised it. Lyn then used gentle guidance and persuasion as she continued to press the dominant medical understandings of age appropriate feeding.

At the end of the discussion Lyn changed the topic to address Bradley:

Lyn Good stuff. What are you doing there Bradley? He's got great muscle tone there with his legs hasn't he!

Lyn's comments were an example of a commonly observed practice of praising the child's development, a topic that affirms parents' choices, after problematising mothering practices. This strategy worked to move the focus of the interaction away from a CFH nurses' expertise and authority and re-assert a relationship of care and emphasise mothers' expertise. In doing so, Lyn used normalising judgements, even when being supportive, subjecting Angela's practices to surveillance, which a Foucauldian analysis suggests is part of a nurse's role.

The challenging relationship between expertise and intervention was thrown into sharp relief when child and family health nurses were worried about the safety of children. So far in this chapter I have emphasised that at times child and family health nurses' were ambivalent about the nature of expertise in their relationships with mothers. However, the child and family health nurses also presented instances where they used, and did not soften, the legitimacy of their expertise. In these circumstances children became the focus of concern. Mothers, most commonly presented as experts on their own children, were re-defined as engaging in behaviours that were potentially

endangering their children's wellbeing - actions that were qualitatively different from conforming to 'best practice'.

Joy, who was very highly trained in, and passionate about, breastfeeding, related one episode of an interaction with a mother she had known for several years. The mother had attended the service with her two week old breastfed baby who was extremely underweight and not gaining despite the mother reporting all the correct signs of a thriving baby i.e. breastfeeding well and having several yellow-soiled nappies a day.

Joy [The midwives from the hospital] had been really worried about the baby's weight. And she would say ... the baby's bowel motions ... 'oh yes they're yellow and they're four a day' ... So anyway in the middle of this really busy clinic, she came in and the baby pooed, and it was meconium [the first motions over first two days or so of life] still, and it was nearly two weeks old and of course way, way under its birth weight ... I said I can tell by the baby's poo that that's what the situation is and that's why the baby's not gaining, it's just not getting enough. ... It was obviously a lie. And that was obviously very hard for her to deal with, because she had told all these lies.

In this instance, Joy describes prioritising the child's wellbeing over her relationship with the mother.

Joy Anyway I went [to her home] the next day, [to assess the breastfeeding] ... and she ignored me for nearly twenty minutes. ... I found it incredibly hard to deal with. Anyway the next thing I knew um she decided to go to [a nearby clinic] having seen her for all these years.

This situation highlighted the tension between nurses' supportive role in affirming 'good mothers', and their professional expertise and authority. In most of the examples they shared, child and family health nurses were careful to avoid any

suggestion that they were judging mothers' knowledge and practices. In these instances, the child and family health nurses did not judge mothers negatively for not following expert advice, which again suggests the nurses may not have been fully accepting of scientific motherhood. However, when nurses used their expertise to determine health risks to the babies, the way they describe mothers' choices openly challenge the mothers' mothering. In contrast to nurses' more common representation of mothers as doing their best, Joy's account shows how she held the mother to the expectation of scientific mothering, Joy presented herself as the expert, in defining what is best for the baby, and in explaining why the mother was uncomfortable. The example also throws into relief the disciplinary techniques of hierarchical observation, normalising judgments and the examination – and the mothers' ability to resist – and nurses' ultimate ability to impose their expertise (Bradbury-Jones et al., 2008; Foucault, 1991a; Gilbert, 1995: 868; Lupton, 1997: 99).

Joy explained breakdown of a longstanding relationship between her and the mother as a result of the mother's discomfort at being caught lying, rather than the mother's fear or discomfort at the direct surveillance to which she was subject, and the implications of failing to conform to good mothering. Joy's interpretation of the mothers' motivations and actions had the effect of marginalising the presence of her authority within the CFH nurse-mother relationship and the impact this can have on the mothers' feelings of confidence and safety.

Authority and expertise were particularly fraught when the intervention of child protection became a possibility.

Lyn We get this whole dilemma of um trying to work respectfully with clients on their grounds, and pressure from other people, especially Family Services where they have a vested interest in us being in there. ... And I find that really disrupts the whole process of building up a relationship with the client at a pace that is going to enable them to feel comfortable. If they feel like we're pushing them in terms of us going back in there. But at the same time you know, you're in that situation of

asking yourself well is it the baby who's the client here or the parent. And if the concerns Family Services have are going to potentially impact on the baby, you know? ... I just find that really a difficult thing to know where to sit with [this].

Lyn's comments suggest her discomfort lies in the tension between the ideal of nurses' support of mothers and the need to foreground the care of the child. Such instances were a more extreme manifestation of the examples presented earlier, in which concern for the wellbeing of the child tended to be the impetus for nurses to apply gentle coercion to the mothers' parenting practices. But Lyn's situation made her monitoring role overt, and created a challenge in maintaining her relationships with the mother and her claims that child and family health nurses did not impose their authority and expertise upon mothers. Lyn is also trying to develop and maintain engagement of a vulnerable family with the service. The 'process of building up a relationship' at the right pace is an important strategy for Lyn in this process of engagement and ongoing surveillance. In these instances, child and family health nurses' position as 'instruments of governmentality' (Perron et al., 2005: 536) are particularly evident and discomforting to nurses. But Lyn presents this as a tension between the 'real' role of nurses – building a caring and empowering relationship – and external imposed expectations, rather than an alternative understanding i.e. pastoral power as one element of governmentality, where nurses' knowledge and relationships with their clients are a technique of governance.

Unlike medical and developmental problems that are more obviously addressed by medico-scientific knowledge, concerns about child safety and assessing risk were much less clear within the claims to professional expertise of the child and family health nurses.

Lyn I have a dilemma every single time I do a home visit. When you first walk in you're overwhelmed with 'Oh this place ... must be a Family Services issue' ... It's just weighing up what's actually happening underneath all that superficial stuff. That's where all that middle class

judgement stuff has to be put aside. But you can't not acknowledge that it's there. ... But then it's every time, trying to work through what's happening. Are the children safe? Are they well cared for? Are they loved? And they're my benchmarks I suppose.

Lyn acknowledged that her judgement of these situations was informed by her class position, rather than an objective judgement based on professional knowledge. Nonetheless the questions Lyn posed were directed to herself, not the mother of the children. Her expertise and her authority to make judgements on mothering practices were the key referents in her decisions.

Even in situations where child and family health nurses' expertise and authority may directly impact on the lives of families, nurses privilege the relationship of care they establish with a mother. Having offered advice to a mother around the safety of the home environment, Diane reflected she was placing her relationship with a mother at risk.

Diane That's what I was saying about going too far with the safety stuff you know, I was almost uninvited, and I would hate to risk that, you know you've got the potential to go another 18 months to go the gently, gently and if I go across the line with that then I won't get in at all. I just, I do find it a dilemma ... just sitting on that level of discomfort and letting things pan out.

Sitting on discomfort highlights the tension child and family health nurses experience when they have concerns about the care of children by their parents. In these situations, nurses' authoritative power becomes more overt and creates a sense of discomfort when trying to maintain a relationship of support, which at the same time highlights their disciplinary power and surveillance (Wilson, 2003).

Expertise in child and family health nurses' professional identity

Child and family health nurses draw on their expertise when discussing their professional identity. It was a source of contention when these skills and knowledge were not recognised by others. Lyn expressed a frustration felt by many nurses (Shepherd, 2011: 142) that their professional expertise was not recognised or acknowledged when she commented:

Lyn Perhaps some of them [clients] look at us and think anybody could do that job, put a baby on the scales.

Lyn wanted parents to know she was a qualified practitioner and not:

Lyn just somebody who had a couple of kids and then decided to set up a shingle because I thought I could teach people a few things ... that there are actually some qualifications there.

Lyn's comment reflects the lower professional status of child and family health nurses in the medical hierarchy, and within the community. It may be for this reason Eileen felt it was very important for parents to know about the child and family health nurses' level of education:

Eileen I think it's really important that parents know our level of education and preparation for this role. I don't think all parents realise, even when we have our signs [on the door]. ... But I don't think parents would always understand what that meant.

While all child and family health nurses were provided with a sign with their name and qualifications to put on the door to their consulting room, not all nurses chose to display their sign (c.f. Clancy, 2012). Eileen intimated parents may not have been aware of what the large variety of qualifications meant. However it was important for

nurses that parents knew they were qualified professionals because this provided acknowledgement of their professional status.

Similarly, Joy, who was particularly knowledgeable in breastfeeding, was concerned that people did not recognise her professional authority and her expert knowledge, although she also was reluctant to broadcast the fact:

Joy People don't really know what training you've had, and that's probably our fault as well, and I don't tell people either. And everyone else [other professionals] is seen as, as more authoritative, or more knowledgeable.

When the above concerns are contrasted with the comments in the previous section, we see a tension between child and family health nurses wanting parents to know they were dealing with highly qualified nurses and at the same time not wanting to impose their expert knowledge upon mothers in ways that were counter to their ideal of a caring and empowering relationships.

This concern that people did not recognise the expertise child and family health nurses held related not just to families but other professionals, particularly doctors. Generally nurses described good working relationships with many other professionals in the community but there were examples given by the nurses of professionals who were apparently not aware of child and family health nurses' work. Lyn wondered how people would know what she does when the professionals she works with did not know. She related the example of a client who had visited a newly graduated GP who was measuring the baby in an 'odd' way and who had no apparent knowledge of the child health service when the patient tried to explain what it was a child and family health nurse did. These concerns reflect Keleher's (2000) argument that public health nurses such as child and family health nurses are in a marginalised position, not only among their professional peers, but due to a lack of public knowledge about the value of their contribution in this area of primary health care.

For Joy, the concern was that mothers go to a GP for advice, believing the GP to be more knowledgeable in the area.

Joy but I think now that people are just so busy, they often don't see that the nurse has skills and more time than the GP does. They just think I've got to go to the GP anyway, the GP's got more knowledge and more power to give antibiotics or whatever, so might as well just go there.

Joy linked the doctors' knowledge with a professional power she lacked due to her status in the medical hierarchy (Lupton, 2012: 123). There is a paradox here in that child and family health nurses want their expertise to be acknowledged in their professional capacity but are wary of the impact this may have on the care ethic.

In this section I have presented three themes of child and family health nurses' troubled relationship with power. First, child and family health nurses are ambiguous about their expertise only as it is coercive and can impact mothers' behaviours, reflecting their pastoral power. Secondly, the relationship between their expertise, (calling on their knowledge), and interventions, when they make suggestions and impose a bio-medical approach to mothering, is problematic for the nurses and a reflection of their disciplinary power. Thirdly, there is a paradox or tension in that while child and family health nurses want their expertise acknowledged (in the field, and by mothers) their identity is constructed as caring so they are wary of the implications of their role as expert in the nurse-mother relationship. This reflects elements of pastoral power, and their discomfort with disciplinary power and surveillance.

MOTHERS' RELATIONSHIPS WITH CHILD AND FAMILY HEALTH NURSES

The mothers in this study recognised and valued the nurses for their professional expertise and visited them for their knowledge and skills. Like the child and family health nurses, mothers were uncomfortable with nurses' authority, and most were

prepared to question it or to reject nurses' authority on some level. The mothers also described the benefits of talking with a nurse they knew and who knew them and their family. These are important elements of pastoral power.

Mothers using child and family health nurses' expertise

Nurses as experts

Most mothers recognised child and family health nurses as an authority with expertise on child health and development and valued what Murphy (2003) describes as their technical knowledge. They described child and family health nurses' scientific training and qualifications, and their knowledge, skills and experience in the position as the source of valuable expertise. Going to the expert for advice is a feature of scientific mothering (Apple, 1995: 161; Hays, 1996: 54; Miller, 2007: 339) and was reflected in the comments of the mothers in this study who saw the child and family health nurses as a source of information for problem solving and providing feedback on a child's development (and, implicitly, the mothers' choices).

Mothers most commonly spoke of the value of expertise when it related to their children's health and development. For example, Tanya, a single mother with eighteen month old twins and a seven year old, described her understanding of Joy's ability:

Tanya She is very observant and obviously she is an expert. She can look at a kid, assess a kid, know if a kid's happy, healthy, or not within fifteen or twenty minutes. ... That makes her an expert. ... I assume she reads all the latest things.

Tanya's comments describe a child and family health nurse as someone who has the necessary professional skills in her specialist area and one who keeps up to date with medico-scientific research i.e. the dominant form of expert knowledge – scientific knowledge. Similarly, Jenni placed an unambiguous value on the child and family health nurses' expertise, and favourably contrasted this to other sources of knowledge. She discussed this with Eileen, her child and family health nurse, at a visit with her two children.

Jenni And I always say myself; always go to the experts, not the other people.

Eileen Yeh.

Jenni I've learnt that. Never ask other people's advice. Always go to the experts first and then you get the right advice straight up. ... You get so many people's different experiences. It usually doesn't help you because their experience is completely different.

Eileen Yes.

Jenni So expert advice is better, I think.

Jenni believed there was one correct way of doing things, and that was to be found in the advice of the qualified experts. Jenni recognised diversity in parenting experiences and, implicitly, in children, but she did not translate a diversity of experience into a diversity of useful advice or appropriate behaviours. When Jenni contrasted nursing knowledge with 'people's different experiences' she implied that child and family health nurses' expertise is scientific, evidence-based, and more useful and true than that of – for example - other mothers.

The mothers' overt recognition of child and family health nurses' expertise stood in contrast to the child and family health nurses' hesitation to privilege their knowledge and practice over those of the mothers. This was evident in an observed exchange between Eileen and Jenni about knowledge and support from other mothers in which Eileen responded to Jenni's clearly stated preferences for child and family health nurses' expertise over the experiences and knowledge of other mothers.

Eileen Yeh [other mothers] can be, although sometimes they...

Jenni Sometimes they can be ...

Eileen can be helpful

Jenni Yeh.

Eileen sharing with other parents' experiences too. Mm. It all depends. It's wherever the parent's at.

Jenni With health, I prefer the experts' advice.

Eileen did not directly contradict Jenni but attempted to present an alternative source of advice and support – other parents. Her suggestion echoed other CFH nurses' emphasis on valuing and supporting parents' own expertise. But for Jenni, like many of the mothers in this study, ensuring a child's health is an important feature of parenting, and requires the specialised knowledge and input of an expert.

Expert knowledge and personal experience

The mothers valued child and family health nurses' scientific knowledge but some also referred to the importance of nurses' own experiences as mothers. Jenni described this additional dimension:

Jenni They all have good advice because they're all parents themselves, which helps. If they're not parents you think; do you listen? Their experience with their qualifications as well, both are an advantage.

Personal experience counted, and a sense that experience is absent could be used as a criticism of child and family health nurses, even when the mothers considered their advice to be medically correct. This is evident in Sharon's comments about her nurse Joy: 'I think she's a bit text-booky. ... I actually wondered if she had kids'. These comments suggest the value and relevance of expert knowledge is greatest when it is contextualised within an understanding of the lived experience of mothering – medico-scientific knowledge is dominant but not the only form of valued knowledge.

Murphy (2003: 454) suggests nurses are constrained in their use of their practical knowledge due to their professional position of having to conform to scientific discourses. This is reflected in the interactions observed in this study: only rarely did a child and family health nurse share her own parenting practice. In one instance, (nurse) Trish and (mother) Donna spoke about their experiences and practices around their children watching TV. Pritchard (2005: 242) has found that child and family health nurses do call on their 'hidden private life experience and personal knowledge' which can have transforming effects on both nurses and mothers. However as there is no

professional model for legitimating personal and private knowledge as a resource this remains an invisible process in practice (Pritchard, 2005: 236). During the interviews, child and family health nurses did not comment on the relationship between their technical and personal knowledge, an absence that also supports Pritchard's (2005) ideas in this regard.

Knowledge and authority

Many of the mothers evaluated child and family health nurses' technical expertise and authority in the context of other forms of knowledge. Jenni (above) represented an extreme position of ranking nurses' information as 'the right advice' but several other mothers did consider professional information and advice alongside advice from family and friends, seeing both as useful – but different. This is evident in Tanya's comments in interview:

Tanya I'd probably rate it [nurse's advice] above other mothers' advice. ... and [I assume they've] kept up with the latest research and stuff ... so I'd rate it a bit above family advice.

Marie Do you value family advice?

Tanya I do yes at the same time, I do.

Tanya's comments highlight the distinction between valuing technical expertise and valuing the more experiential or practical advice of her social and familial circle.

Mothers Sharon and Emma said they were prepared to dismiss child and family health nurses' advice if they did not agree with it. Their comments indicate the difference between child and family health nurses' expertise, which mothers valued as an informational resource, and their authority, which was less commonly accepted. Sharon had been visiting nurse Joy for approximately 18 months but had disagreed with what Joy said on previous visits and had been upset at times by the interaction. While she acknowledged Joy's expertise Sharon did not accept her authority in directing her parenting, and was prepared to dismiss advice that she did not agree

with. Sharon said, with a laugh, she would take such advice (she did not agree with) 'with a grain of salt'.

Emma, also with a laugh, said if she felt the advice was being forced on her she would 'probably just tell her to shut up anyway'. Indeed Emma described such a reaction in a visit to a relief nurse who had used a very different approach to Eileen, her usual nurse, when telling her what she should be doing with her baby to improve his development. This was considered just 'opinion' and what the nurse said carried no authority for Emma:

It doesn't bother me like she's got her opinion on what I should and shouldn't be doing. But you know, I think yeah, whatever! I'm not listening. ... I see her being an expert on babies but that's about it. ... I'm always under the impression that everyone has their own opinion ... for me it's if I agree with it or if I want to do it then I do it, and if I don't, I don't.

Emma's rejection suggested a distinction between technical knowledge that nurses attain in the course of their professional training and practice, and the application of that knowledge to individual circumstances, which became classed as 'opinion'. Emma's comments suggested she did not accept nurses' technical and expert knowledge and authority over her own contextualised and practical knowledge (a point I discuss in more detail in the next chapter). As with mothers in Mollidore's (2013) study, Emma acknowledged child and family health nurses' expertise around babies, but at the same time recognised her own knowledge and agency – a position that the child and family health nurses promoted through their interviews, and to a lesser extent, in their interactions with mothers.

Mothers' attitudes towards child and family health nurses' expertise and authority sit along a continuum between acceptance and dismissal. Mothers generally acknowledged that child and family health nurses have expertise in the area of raising babies. However mothers were less accepting of the authority nurses had to impose

that advice and expect conformity. For one mother, child and family health nurses were uncontested experts and authorities. For the other mothers, nurses' expertise is considered alongside that of family and friends, although it may hold slightly more legitimacy. This continuum suggests mothers resist scientific knowledge as the only form of expert knowledge and in so doing, challenge the expectation of mothers' conformity to medico-scientific expertise, a core element of scientific mothering.

Expert knowledge as a resource

The importance of the information and advice given to mothers is evidenced by mothers' requests for this in all of their interactions with child and family health nurses. All the mothers sought information on their babies' progress and many asked for advice about particular problems. Emma had been visiting Eileen every one to two weeks for the past six months with her breastfed baby to have him weighed to reassure herself he was 'getting enough'. This was Emma's fourth child but she asked many brief questions about her baby during the two visits such as 'Should I start trying him with two meals a day?' and 'Is it normal he prefers the television over people?' Emma did not challenge or obviously reject the responses she received from Eileen. From her comments above, Emma may have responded differently if Eileen had been imposing her advice.

Previous studies of mothers and child health nursing practice emphasise the advice-giving aspects of the interactions, and suggest that nurses' imposing unsolicited advice is not welcomed by mothers (Baggens, 2002; Foster and Mayall, 1990; Kendall, 1993). Several mothers commented on the helpful nature of the advice they received, which child and family health nurses presented as a range of options when mothers requested. Comments from other mothers I spoke to suggested that they experienced the information presented in visits as a set of options rather than the imposition of the nurses' authority. They described feeling comfortable discussing with nurses advice that was not useful, as Kylie explained in relation to her child and family health nurse Lyn who she found easy to talk to:

Kylie Lyn just gives you information like about how things can work, and you come home and try them and if it doesn't work you go back (laugh) or whatever, tell her it didn't work.

This freedom to discuss the effectiveness of parenting practices was particularly important for some mothers. For example, Rachel and child and family health nurse Lyn had developed a relationship over many years. Lyn had been a very valued support for Rachel when she had her first baby, six years earlier, as Rachel had been isolated and in a violent relationship. Rachel was now in a stable relationship with a new partner and was attending the child health centre on a less regular basis with her second child who continued to have treatment for a major medical condition. Rachel spoke about her appreciation for Lyn's help:

She's [Lyn] given me so many hints and tips and ... Like she wouldn't just say one thing she'd always suggest different options on how to deal with certain situations ... she was always thorough in how she answered so that you would fully understand and then she'd offer you different opinions on what you could do to sort of help that problem and, you know, that was definitely helping. ... And if she couldn't think of any off the top of her head she'd always bring more information the next visit and ... it was really, really helpful.

Angela also viewed the nurse's information and advice as suggestions or options to choose or try.

Like Lyn went over all those different things with us and just so he could try and gain a bit more weight, and most other people would have said oh don't worry about giving him a bottle he'll be right. Whereas she actually said oh well try this and try this. And anything that just comes up she gives you lots of different, not just one straight like 'do this'. She said would you like to try this which is much better; you don't feel like you're being pushed into it when you've got options.

Rachel's and Angela's comments show that they perceived the child and family health nurse was not imposing particular practices on her, and that in presenting a series of possible actions to mothers, rather than imposing any particular practices, the powerful position of child and family health nurses was rendered invisible, in terms of the mothers' perspective.

For the mothers in this study, the child and family health nurses' expertise was valued as a legitimate source of information that enabled them to assert their agency to combine nurses' expertise (presented as suggestions) with their own situational knowledge in order to explore what was appropriate. Mothers were happy to receive nurses' professional advice when they could maintain their 'autonomy and freedom to manoeuvre' (Murphy, 2003: 453).

Expertise and authority as a strategy

Researchers largely examine child and family health nurses' authority and expertise with respect to their impact on mothers. However, in this project I identified instances when mothers themselves actively used nurses' authority to strategically manage others' expectations. Carolyn used Joy's professional expertise and authority to reinforce what she had told her ex-partner about breastfeeding practices. She had ensured Graham was present when Joy visited to help with breastfeeding. It was important to Carolyn that Graham knew how the breast pump worked and how important it was for maintaining breastfeeding. Carolyn stressed how important it was for her partner to hear the child and family health nurse explain the technicalities and science behind the process, as this ensured he had the correct and legitimate information which Carolyn may not have been able to explain so clearly.

The main topic of conversation was the breast pump. And um Graham was here as well, so he heard things from her rather than saying to me 'Oh well blah, blah, blah what?' and with her being there as well she could back up what I'd already told him.

In saying this, Carolyn explains how she expected Graham would take more notice of a professional with recognised and legitimate expertise than he would of her.

In a different scenario, Angela and her partner Sean used information presented by the child and family health nurse to advocate for specialist care for their baby:

Lyn had actually told us to watch them [indications of a medical condition] to know what to look for and so then we went to the doctor going on what Lyn told us ... then as soon as we walked into the specialist she rung and got straight onto the hospital and sent us in.

This section highlights how Angela valued Lyn's expertise, and the strategic use of this child and family health nurses' authority. Mothers described child and family health nurses as experts with useful technical knowledge and skills that they could draw on in mothering their children and in negotiating expectations and demands with other professionals and people in their personal lives. Essentially, the mothers both recognised and borrowed child and family health nurses' authority to reinforce and operationalise their judgements on what they thought was best for their children.

Someone to talk to

All of the interactions I observed between mothers and child and family health nurses revolved around discussions of the baby or children's progress, within the context of the examination (Foucault, 1991a: 191). Many of the mothers also appreciated the nurses as someone they could 'talk to'. Some mothers enjoyed just having another adult to talk to, some valued having someone who knew them and their child's story, and some valued the opportunity to disclose personal troubles. This shaping can be understood as an example of enacting and accepting pastoral power

An adult to talk to

Having another adult to talk to was particularly important to those mothers who were socially isolated. For example, Jenni was a stay-at-home mother with little social

support. She visited Eileen regularly although her sons had no medical conditions that required on-going medical support.

Jenni Once they start school I can get on with getting a job and stuff, and be my own person again. That's why I like coming to the nurse too, because you get adult contact. When you're a parent, you feel like it's just kids, kids, kids and no adult contact. And that's hard. ... Even when you feel down I still go. I feel good when I leave. I've had someone to talk to and know that the kids are good and healthy. And that actual reassurance actually makes me feel better, you know, that I'm doing a good job with them. ... Just to come here today [for our interview held at the centre] it's just I'm out of the house! Yes! I can talk to an adult, yes! That's exciting [laugh].

Jenni's comment indicates the importance of both 'having someone to talk to' and her valuing of child and family health nurses' technical expertise. She enjoyed and benefited from 'adult contact', despite the fact that the visit I observed was focussed almost entirely on conducting assessments on both children. The value of expertise is evident here, as a visit to the nurse provided Jenni with reassurance about her mothering - that she was 'doing a good job', that the 'kids are good and healthy'. For mothers like Jenni, the relational elements of care that are emphasised by child and family health nurses matter, but do so only in conjunction with expert knowledge.

The importance of having someone to talk to was also evident in the responses of some of those mothers who did not see child and family health nurses as experts. Emma, for example, was also socially isolated; caring for young children and at the time of the interview in an unhappy relationship. In this context, having someone to talk to was essential for Emma:

Emma I think my biggest thing is just not having that adult conversation. And you know like sometimes it's good to just talk to an adult, because like Brodie (baby) won't listen, Dylan (4 years) won't listen, my telephone

goes flat when I use it for too long (laughter). And you know, sometimes it's just nice to just, to be able to talk to someone and just get everything out, and stuff, and not just think I wish I had someone to talk to.

While Emma enjoyed talking with the nurse it was not the explicit reason for the visits. In her two observed visits to Eileen, Emma's reason for attending the consultation was to have her baby weighed; however the major proportion of both hour long visits was spent talking about her own situation about parenting and her struggling relationship with her partner. Eileen listened, sitting quietly facing Emma, with lots of gentle and affirmative 'mms' and 'yeses' before offering suggestions such as going out together as a family, or having counselling and offering to make an appointment for them, reflecting Eileen's role in pastoral power. Emma continued to talk about her feelings and came to a clearer picture of why she was so upset and what her response – different to those options offered by Eileen – would be.

When I interviewed Emma I asked her about the consultation

Marie Talking about that visit, how did you think it went?

Emma I can't remember. I'm trying.

Marie You weighed the baby and then had a talk, because you talked then a little bit about ...

Emma About Craig?

Marie yes ...

Emma and about stress.

Emma at first had trouble thinking about the visit then went on to talk again about her situation with the children and how difficult parenting was. However it was clear in the interview that Emma does not primarily define her relationship with Eileen in terms of an opportunity to talk about her personal life:

Marie And that's what you can do down there with Eileen, do you find?

Emma Yees, sometimes (said slowly and unconvincingly).

This interpretation was particularly evident in a second interview that almost immediately followed a different visit in which Emma spent the first 45 minutes on an hour long consultation talking about her relationship with her partner. Her response to how she thought the visit went was:

Good. It was good. It was good getting Brodie weighed again, it had been ages!

Emma's perception of her visits stands in contrast to child and family health nurses' understandings of their role as empowering and based on relational care. For Emma, getting Brodie weighed was the part of the visit she emphasised. Yet for nurse Eileen, it was Emma talking that was the important part of the interaction. Eileen was pleased Emma had been 'able to open up' and discuss her relationship issues, but Emma, in common with most of the mothers in the study, emphasised the expert knowledge and technical expertise of the nurses.

Someone who knows you

For those mothers whose children had complex medical histories or conditions, having a child and family health nurse 'know' them gave them a personal connection that helped when they were seeking medical advice. Angela, who had been an anxious first time mother, according to her nurse Lyn, had a baby with high medical needs.

Angela: I'm grateful for her being there anyway so, I don't know how many times I've rung up (with laugh). ... Zillions! ... It's nice that you can ring up somebody and actually know 'em. Like with all these parenting lines and this and that you don't know who you are talkin' to and you never get the same person and at least with Lyn, you actually know her, and you can just turn up there and she's "oh how are you?" Like you actually got that face to face personal too, you can actually make a bond and not just get some idiot fobbing you off.

Knowing the nurse well enough to develop a personal relationship with her was important for Angela. She felt that a nurse who knew her was more likely to understand her situation and respond in ways that acknowledged her particular situation and met her and her child's needs.

An on-going relationship could have emotional and pragmatic implications. Rachel was the mother of a child who had been subject to multiple medical procedures in his early life. Having continuity of care meant not having to keep explaining their story to new people, as well as having a nurse who understood them.

Rachel: it's always constant [seeing different health professionals] and you have to keep trying to explain it all the time about certain things and it makes life a lot harder. But um yeah with Lyn she hasn't left so I can still talk to someone that actually does understand and someone that does know what Tom's been through.

The importance of understanding the history of the family situation was demonstrated in an interaction between Lyn, Rachel and baby Tom. During the visit Lyn talked gently and reassuringly to Tom when he started to cry while having his weight and length measured. Lyn later explained this was a procedure he found upsetting due to the many medical interventions he had had since birth:

Lyn Because of all his negative experiences in hospital, he's quite resistant to anything new. So when I would go and do home visits initially, it took months before he would not cry when I came because he knew that he had to sit on the scales, and that was different and new, and so he'd get really distressed. Eventually he was OK with that. But like today when we just sat him up there, [on the scales] he started to cry and that was just his usual ... reaction was to cry because he thought 'oh here we go, something bad's going to happen'.

Knowing and understanding this child's behaviour affirms the mother's trust that the nurse 'knows' her child. Angela and Rachel's comments echo those above relating to child and family health nurses' expert knowledge: it is valued as something that can and should be applied to the particular situation.

Someone to disclose to

When mothers had developed a trusting relationship with their child and family health nurse they felt safe to confide in them about behaviours and situations that did not always reflect 'good mothering'. For instance Tanya was concerned about her drug and alcohol use during her first pregnancy and worried about the effect on her baby. She was able to 'chat' to Joy about it.

Tanya When Rose [7 years] was a baby I was concerned and still dealing with drug problems so I had a little chat with her (Joy). ... I'd used some amphetamines, early in my pregnancy. ... And she was all right but I was still worried, you know (small laugh). But Joy seemed to think well you've got a happy healthy baby. So, everything seems okay.

Tanya had been able to raise an underlying concern and receive some reassurance from Joy. The importance of a nurse's technical expertise for mothers is again seen through this instance. Tanya is using the interaction as a form of emotional support, to perhaps stop her worrying, but the impact of Joy's reassurance comes from her expertise and authority.

Rachel had Lyn support her through domestic violence when she had her first baby. As Rachel relates:

Rachel When she found the bruises on me ... she made regular visits after that to make sure that we were definitely OK ... and making it so that Gary didn't exactly know what was going on at the same time ... She gave me a lot of information about how to get out of it and things like that ... I had a lot of support from Lyn and it was really good.

Rachel had trusted Lyn enough to let her continue visits to her isolated, rural home, but had not trusted other nurses in this way. Rachel discussed how being able to talk to Lyn during this time provided a major means of support.

The mothers who were in difficult circumstances talked about valuing someone who listened and supported them. This type of interaction reflects features of relational care that the child and family health nurses saw as important. In being willing and indeed wanting to talk and disclose to nurses, mothers generally can come under a professional 'gaze'. As personal disclosures have the quality of confessional practices, a technique of pastoral power (Foucault, 1990: 58) nurses can come to know their client and take on 'the role of guiding the conduct of living' (May, 1992a: 598-597). The subtlety of this process is seen in that, for the mothers it remains the child and family health nurses' technical expertise that provides the impetus for the visits, and that has reassured and confirmed them as good mothers.

CONCLUSION

My findings indicate that care, expertise, authority and power are important concepts for understanding the relationship between child and family health nurses and mothers. Nurses presented their work with mothers within a relational framework of care. They described their expertise in terms of specialised scientific knowledge, skills and experience particularly relating to child health and development. At the same time, the nurses were careful to emphasise each mothers' own experiences as a more important source of knowledge for raising children. Both nurses and mothers recognised and valued nurses' expertise but were uncomfortable with authority; nurses explicitly so and mothers more implicitly.

The findings suggest the ways in which knowledge and expertise are entwined with power (Foucault, 1977: 27) in the context of relationships between child and family health nurses and mothers. Child and family health nurses, with their focus on

relational caring, found their own power uncomfortable. Yet power is present in any interaction between mother and nurse. The exercising of this power, however, is substantially hidden and indeed the success of power is in its secrecy of operation (Foucault, 1990: 86). This is evident in the nurses' generally unproblematic acceptance of their surveillance work (which they did not define as such), such as assessing children's development. However, as discussed in chapter two, surveillance is a technique of disciplinary power that is particularly pertinent in nurses' work.

The importance for nurses in focusing on their relational caring over the surveillance aspect of their role is reflected at times of tension between the two. Sitting on discomfort highlights the tension child and family health nurses experienced when they had concerns about the care of children by their parents. In these situations, nurses' authoritative power became more overt and created a sense of discomfort at trying to maintain a relationship of support with the mother which at the same time highlighted their disciplinary power, and with it a more directive surveillance.

Developing a relationship with the parent has been argued by other scholars to be a means of accessing the family for surveillance purposes (Armstrong, 1983; Wilson, 2003: 285). Child and family health nurses in this study employed methods of 'gentle' surveillance (Wilson, 2001; 2003) such as the use of a nonthreatening approach to engage mothers and keep mothers attending the clinic. Nurses also used information and good-mothering messages as a form of gentle persuasion or 'subtle coercion' (Foucault, 1977: 137) to redirect practices which were not 'recommended' ways of child rearing. In common with other studies (Brennan, 1998; Fowler, 2000; Peckover, 2002: 375), the child and family health nurses I spoke to revealed a reluctance to recognise the power and authority implicit in such practices. Rather, in their relationships with mothers, the nurses aimed to act as resources of emotional and practical support in order to empower mothers. In marginalising the impact of their authority and expertise in this way, they made plain their concerns about appearing directive or as an authoritative 'expert' wielding power over another. It was when child and family health nurses were called upon to foreground their authority, such as when

concerns about child-rearing practices arose, that their discomfort with power grew, and reflected their concern about possible negative impacts on their relationship with the mother.

The subtle techniques of disciplinary power and pastoral power make the exercise of power less obvious in the mother-nurse relationship. The mothers sought out the child and family health nurses for their technical expertise and in the process became subject to surveillance. Rather than being compliant with directives however, most of the mothers balanced the authority of nurses' expert knowledge with knowledges from other sources as well as their own contextualised and child specific knowledge. Some mothers also spoke about accessing the therapeutic benefits of talking and being listened to by the nurse. These are features of pastoral power; where the person talking becomes known by the nurse through a professional gaze and often in a confessional sense (Peckover, 2002: 372). For the child and family health nurses this was an important feature of their emphasis on nursing as a process of relational care. For the mothers it was a more pragmatic feature. It was easier for mothers when the nurse they saw knew them and they did not have to tell their story again. For the mothers it was the nurses' technical expertise that remained the more important feature. How this information and knowledge was imparted reflected nurses' desire not to be the directive 'expert' and mothers' desire to be affirmed as good mothers.

The child and family health nurses' professional expertise and authority was an underpinning and complex aspect of their interactions with mothers and was the basis of the child and family health nurse-mother relationship. In developing a caring relationship with the mother the focus of the child and family health nurse's caring changed from a technical to a more relational, indeterminate level of care, reflecting the CFH nurses' experiential expertise and tacit knowledge (Belle, 2013; Polanyi, 1967). If this caring relationship was not established, if the nurse highlighted her expertise without coming to know the mother, there was less likelihood that the nurse would be listened to or be able to influence change in the mother's behaviours. Where the mother felt listened to by the child and family health nurse and not judged on her

parenting she was more likely to listen to the nurse particularly in relation to ideas on child rearing.

The imperative for mothers to seek and follow expert guidance and knowledge on childrearing as an element of scientific motherhood is both accepted and contested by the child and family health nurses and mothers in this study. Child and family health nurses are reluctant to overtly impose advice and mothers are reluctant to accept advice that is imposed. However medico-scientific knowledge remains an element of the relationships between mothers and child and family health nurses. As we shall see in the next chapter, both child and family health nurses and mothers use this knowledge in their negotiations over mothers' child raising choices and motherhood identities.

CHAPTER SIX

NEGOTIATING GOOD MOTHERING

INTRODUCTION

The focus of this chapter is child and family health nurses' and mothers' negotiations over mothering practices. The findings show that child and family health nurses and mothers implicitly reference mothering attitudes and practices to a good mother ideal. A good mother identity is negotiated in various ways, sometimes with the active participation of the child and family health nurse, and sometimes by the mother's strategies to redefine her practices. Key elements of a good mother identity reflected some of the dominant ideals of intensive mothering and scientific mothering such as seeking expert advice, breastfeeding and giving healthy foods, and meeting the needs of her child. Also key to a good mother identity but challenging scientific mothering, was privileging the mother's own experiential knowledge in mothering decisions. I argue that rather than being compliant with CFH nurses' expertise and authority the mothers actively draw upon their own contextualised, child specific and practice-based knowledge when negotiating their identities as good mothers.

In the first section I present two themes which describe the negotiations where mothering practices were uncontested. Firstly, in *affirming the good mother* I describe how a shared understanding based on medico-scientific knowledge and CFH nurses' technical skills enables CFH nurses to affirm a good mother identity. Secondly, I present how mothers and CFH nurses *work together to accomplish a good mother identity*.

In the second section I present negotiations contesting mothering practices. These contested negotiations occurred when there was not a shared understanding on child rearing practices between a mother and the CFH nurse. Three examples of contested negotiation are evident in the examples presented. In the first, *inscribing the good*

mother, the CFH nurse is able to reinforce good mother identity through her authority to document the baby's progress. In the next example of contested negotiations, *resisting through counter discourse*, similarities with some forms of resistance described by Bloor and McIntosh (1990) and Armstrong and Murphy (2012) are evident in the strategies of resistance used by the mothers. In the final section, I give examples of mothers' *rejection through redefinition*.

AFFIRMING THE GOOD MOTHER

As discussed in the previous chapter, mothers recognised child and family health nurses' specialist knowledge and expertise, and this was the primary reason they attended the child health centre. CFH nurses held authority to affirm mothers as good mothers by their expert knowledge and skills to assess a child's progress. The mothers accounts show that they went to seek advice and receive reassurance from an expert that they were doing 'the right thing', even when they could see for themselves that their baby was healthy, growing and had no obvious developmental issues. When the CFH nurses and mothers' understandings of a baby's wellbeing generally aligned, both used this wellbeing to reaffirm the mother's knowledge and practices, and also as an indicator of her good mother status.

The affirmation of good mothering is particularly evident in the practice of weighing infants, an activity valued by mothers and performed by CFH nurses. The activity involves the processes of normalising judgement in the context of the examination, key techniques of disciplinary power (Foucault, 1977: 184). CFH nurses, with their professional expertise, have the authority to make judgements by comparing against the accepted norms, and thus provide reassurance to mothers about their mothering practices. Having their baby weighed was a significant and welcome marker of good mothering for some mothers. Perron and colleagues (2005: 540) note that 'statistics define the norm'. Weighing babies provides numbers that are interpreted, by both mother and CFH nurse, as an indicator of both the baby's health and the mothers' conformity to normative expectations. The persuasive power of numbers is shown in

the interaction below between CFH nurse, Trish, and mother Donna. Donna had visited Trish for her baby's eight-week health assessment. There is the anticipation about what the numbers will reveal, and then the result is received with excitement:

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; both look at digital read out on the scales.]

Donna WHAT [with almost a scream. Looks at Marie to share in the news]

Trish Eleven pound five. (Laughing).

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

Trish Four pounds.

Donna Four pound (excited voice) you little porky.

Through her own observations Donna knew her child was gaining weight and thriving. But Trish's expert knowledge, mediated through the scales, provides a strong affirmation of this. Trish affirms Donna's good mothering practices in her immediate response:

Trish [to baby] Your mother must be doing something right then huh?

The numbers on the scale, or the 'results' that are identified through expert knowledge, are not problematised but welcomed, and Donna accepts, rather than contests, this expertise and knowledge, and the implications they hold about her mothering.

Several of the mothers drew upon CFH nurses' expert knowledge to affirm their identities as good mothers. Emma was one of these mothers who needed the hard evidence of her baby's progress in the form of data generated through the CFH nurses' technical skills, in order to believe she was 'doing something right'. Even though, as discussed in the previous chapter, Emma was prepared to resist the CFH nurses' authority by dismissing unwanted advice, she continued to access their expertise.,

Emma did not rely on her own assessments of her babies' health, nor did she completely trust the CFH nurses' assessment that she was doing well as a mother, she needed the actual weight to believe it. Weight was an objective fact that could not be doubted. For Emma, an economically and socially marginalised mother, the truth value of the numbers provided evidence that would establish her mothering beyond dispute. As Emma explains she finds it difficult to believe the frequent affirmations from nurse Eileen that she was doing well, and to have her doubts allayed without the evidence:

Emma I guess the biggest thing with the health centre is taking him there, getting him weighed, and just the assurance that, that he's growing and putting on weight ... And, like Eileen kept telling me all the time, um you're doing really well. You're doing really well. Like you've got nothing to worry about, he's getting plenty. Like look at him. Look how bright he is? And I'm like okay, yeh he looks alright, but I still can't um I still can't quite get my mind around the fact that I'm successfully breast-feeding. I just can't, I don't know, suppose picture myself as being successful at something (said with a laugh).

For Emma this embodied practice of breastfeeding is a physical confirmation of her ability to be a good mother – both because she is breastfeeding (a criterion of good mothering (Knaak, 2010; Schmied and Lupton, 2001; Wolf, 2007) - and because she was able to do so successfully; so that her baby put on the required weight. With her background of hardship and perceived failures it is difficult for Emma to accept these features of achievement without authoritative confirmation. She continues:

I have so many doubts in my head that I need that reassurance of getting him weighed all the time just to make sure, you know, that he's doing all right. So I guess that's been, you know, I suppose my sanity saver, getting him weighed.

Similarly, Alissa, a young teenage mother said:

That regular check up on Ethan to make sure he's doing all right. ... For me it just shows, you know, he's healthy and to make, you know, I'm at least doing something right.

For Emma weight is the evidence of her baby's progress and provides the indication of good mothering. The mothers used their baby's progress as a reflection on themselves. The confirmation by a CFH nurse can be a benefit and a relief. Melissa was visiting the child health centre fortnightly with her second baby (she had gone weekly with her first). She also spoke about needing the evidence of the measurements and assessments to 'know' her baby was progressing, and saw attending the child health centre as a responsible practice of a good mother.

It's good to know I guess how well they're going, if they're you know gaining or not losing things like that. 'Cause I've got a lot of friends like one friend doesn't take her kid [to a child health centre] and hadn't been for eight or nine months, and I thought no, if they do things I like to know how they are going. Whether they're progressing or whether they're you know, backwards or whatever.

For Melissa, the interaction with her CFH nurse went well and my observation had been of a friendly exchange between nurse and mother. The CFH nurse's authority to provide the undeniable evidence of good mothering in these interactions had the effect of supporting these mothers in seeing themselves in a positive light. Mothers regularly received praise and encouragement from the CFH nurses on what a good job they were doing. Eileen was forthcoming in her support of mother of three, Jenni, and the work involved in caring for children and running a household:

Eileen You're a wonderful parent Jenni.

Jenni Oh thank you.

Eileen Just wonderful. Just so many skills. Like we were saying it's multi-tasking
(J: Yes) in a way isn't it?

Even while Eileen was pointing out Jenni's considerable skills at the many tasks needed in parenting, that they had been discussing, Jenni continued to view the CFH nurse as the one with the authority and expertise on child health. In the interactions the positive progress of the baby reflected good mothering, as Jenni stated in the interview:

Jenni I feel good when I leave. I've had someone to talk to and know that the kids are good and healthy. And that actual reassurance actually makes me feel better you know that I'm doing a good job with them.

These mothers sought out and accepted CFH nurses' expert judgements on their child's progress and thus were affirmed as good mothers. The dominant discourse that mothers are responsible for their children's development, and that guidance by experts is required for this to be achieved, were not in dispute here. In going to the CFH nurses, these mothers demonstrated the self-regulatory practice of accessing experts and became the subjects of a 'gentle' surveillance (Wilson, 2003: 284). As Wilson (2001: 298) highlights, the success of surveillance is the invisibility of the underlying power relations because the process calls on the desire of individuals to 'do the right thing'. The mothers who spoke to me accessed their CFH nurses to confirm to themselves that they were 'doing the right thing', which was also evidenced by their babies' weight gain. When a child was not growing or developing as expected, or there was a concern by the mother or CFH nurse, the interactions and negotiations around good mothering practices became more contested.

Working together to accomplish the good mother identity

The mothers and child and family health nurses appeared adept at working together to normalise the behaviours of both parents and children. I observed many discussions which focused on concerns raised by the mothers about their children, with negotiations resulting in affirming good mothering identity through positive parenting practices. The CFH nurses' responses to seemingly simple, innocuous concerns raised by the mothers actually prompted interactions that involved complex negotiations. A particular pattern of talk was evident in many of the interactions when minor concerns were being discussed. The CFH nurse would acknowledge the mother's concern and offer explanations to normalise the concern; the mother's actions were often supported; and at the end of the episode the subject would change to highlight a positive aspect, or aspects, of the child's progress and, implicitly, the legitimacy of the mother's practices.

In the following interactions, processes of normalisation are evident. These processes are invoked when mothers raise concerns about their babies or about their mothering practice. First, I observed Emma and her six month old son Brodie, attending a regular appointment with Eileen. Emma, who has four children, has a comfortable relationship with Eileen who she has known four years. Emma came into the consulting room and proceeded straight to the change table to undress her baby to be weighed. Nurse Eileen joined her at the bench, and Emma raised her concern about a red mark on baby Brodie's leg.

Emma See that?

Eileen Yes.

Emma That's been there for nearly two weeks now. It's his socks.

Eileen Yes I was going to say it looks like a pressure mark. Mm a sock, very much like it, and it could even be just his little legs are expanding in width, and um sometimes these elasticised socks um can get tight before our very eyes.

Emma is demonstrating a trusting relationship with her nurse when admitting a possible fault in her caring - putting tight socks on her baby which has left a mark. Eileen is quick to respond; she has looked with concern and agreed with the mother about the cause. She then proceeds to give an explanation of how this can happen by relating the cause to the baby's growth and deflecting blame from Emma's actions. This can act to relieve any guilt Emma may have felt. Eileen continues to assess the situation and explore what actions Emma has taken:

Eileen Do you still use the same socks?

Emma No, I threw them away.

Eileen Threw them away. And have you found that eased them a bit, the reddened bit?

Emma It's starting to get smaller, but it's still there.

Eileen has completed an 'examination', in that the problem was assessed and identified (the red mark), the cause determined (tight socks), the treatment checked (stop using the tight socks), and the outcome evaluated (the mark was getting better). Eileen then uses her authority to normalise the situation by referring to 'some babies' and reassures Emma, and herself, with her medical observations (that the mark is not serious or in need of medical follow-up and treatment) before changing to a positive focus on the baby.

Eileen Mm. Mm. It just might take it a while to go. It doesn't look like um it's causing any pain. It's red isn't it? There we go little man. (Talking to baby). Some babies have skin that can be more susceptible to those little marks made by tight elastic or whatever. The circulation's nice and good. Pink. Mm. (Baby makes a sound). Hello young Brodie. How are you? Look at your long, long eyelashes.

Without any more reference to the issue, and as frequently occurred in the interactions, the subject is changed to positive statements about the baby: his

circulation and his 'long, long eyelashes'. In this interaction it is the socks and the baby's rate of growth that are focused on as the problem and not the mother's actions of using socks that were too tight. The CFH nurse affirms the mother's actions in discarding the socks and thus taking preventive action which supports a good-mother identity. I observed comparable situations in other interactions that drew similar responses.

Melissa expressed guilt at causing her baby a minor harm. Melissa had dropped into an open session at the centre to have her second child, eight week old Simon, weighed with nurse Lyn.

Melissa I cut his finger while cutting his nails.

Lyn Yeah it happens, don't worry.

Melissa He cried, oh I felt terrible.

Melissa is expressing her guilt at hurting her son. She has brought up the subject without prompting. Lyn uses her expertise to make a judgement about the situation. She responds with care to the mother as she normalises the situation with 'yeah it happens' and reassures Melissa with 'don't worry'. She then addresses the care of the baby when she offers advice on an alternative method to prevent the problem.

Lyn If you do it in deep sleep, he's much more relaxed.

Melissa Yeh, oh no I'm too scared to do it. I get Tony [partner] to do it.

Although Melissa has her own solution Lyn still offers another suggestion.

Lyn The other thing is an emery board and file them off a bit.

In both these examples mothers Emma and Melissa had their own solutions and were not asking for advice, although suggestions were offered. The mothers were expressing concern and some guilt at what had happened and received understanding and normalising from the CFH nurses. For these CFH nurses, listening to the mother

and providing advice, after first normalising the situation, were part of their nursing role. This reflects practices of pastoral power, of confession by the mother and reassurance by the CFH nurse.

The pattern of normalising of behaviours is also seen in relation to children's development and behaviour. When it becomes evident children may not be meeting expected milestones, mothers and CFH nurses undertake additional work to affirm good mothering. This negotiation around child development was conducted during assessments. In many cases, any negative responses by the mother may be addressed only briefly, or are normalised by the CFH nurse, or in some cases, other positive mothering achievements are listed by the mother, and parenting approved by the CFH nurse. This negotiation of normal behaviour is seen in the following example between Jenni and nurse Eileen during three year old Cameron's three and a-half year health assessment. The mother and CFH nurse were filling out a questionnaire on child development.

Eileen Riding a tricycle?

Jenni Oh he can't pedal yet. I haven't really given him much time on that yet.

(E: No) But he will get on it.

Eileen Of course. And jumping on the spot?

Eileen responds minimally to the negative response and positively to the mother's follow up reply of what the child can do before she moves onto the next question.

Jenni Yep. ...

Eileen And toilet trained?

Jenni No I haven't really attempted it yet.

Eileen No, maybe just wait because of the brand new baby. (J: Mm) And then it's winter months. (J: Yeh.) Yeh.

Jenni's negative response could possibly reflect adversely on her parenting and identity as a good mother. A mother may feel she is failing as a mother if her baby is

not meeting normal milestones, reflecting the power of normalising judgements (Foucault, 1991b: 195; Perron et al., 2005: 539). Eileen gives two reasons why delaying toilet training is occurring, which affirms Jenni's parenting decisions. Eileen reinforces Jenni's experiential knowledge of her child and her seeking other expert 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, that's clever.

Jenni Because I've been reading up on it.

Eileen praises Jenni's parenting practice and Jenni confirms her good mother status by expressing her seeking of expert knowledge about the toilet training process. These interactions suggest that mothers and CFH nurses accept and value the good mother discourse. They work together to negotiate a shared understanding of the situation when mothering practices and child outcomes that may reflect on mothering practices deviate from dominant expectations. Together, they reframe practices, rather than contesting the expert discourses of child-raising. In other situations, however, this is not the case, and discourses are more directly contested.

CONTESTED NEGOTIATIONS

At times, child health nurses and mothers did not have shared understandings of good mothering practices. In these instances, they would contest elements of scientific mothering. These negotiations occurred when the issue was not as straightforward as weighing or measuring, or normalising a concern about mothering practice. Practices of good mothering were particularly contested, around issues of food, developmental milestones, and when the CFH nurse had concerns about the physical health or development of the baby. In some interactions, mothers and their CFH nurses worked

together to negotiate good mothering where CFH nurses used disciplinary techniques of normalisation and expert discourses. In other encounters, mothers resisted CFH nurses' authority. Mothers also called on their own contextualised and experiential knowledge to challenge and redefine or reject the CFH nurses ideas of good mothering.

Inscribing the good mother

Murphy (2003) argues that most mothers deviate from expert advice in some way, and this was evident in my findings. In my observations and interviews, mothers and CFH nurses engaged in quite complex negotiations to reinforce a good mother identity. The CFH nurses drew on their medico-scientific discourses to provide information and education to guide and persuade mothers towards appropriate mothering practices (Perron et al., 2005: 542).

The following exchange focuses on Jenni's parenting practice on introducing foods to her baby. As discussed earlier, Jenni values the expert knowledge of the CFH nurse. The current health policy followed by CFH nurses is that babies should 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, five and a half-months old Logan, 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 breast milk? [Part of the 6 month health assessment questionnaire].

Jenni A little bit, but not a huge amount at this stage.

Eileen No.

Jenni I thought I'd wait till six months (E: Yeh.) plus and then go for it.

Eileen That's clever, wonderful idea.

Eileen affirms the mother's practice of starting with just small amounts of solids up to six months.

Jenni But I make sure I breast feed more and because of ...

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

Jenni Yeh. 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.

Eileen affirms Jenni's parenting again, and shows an understanding of the personal context within which Jenni is working.

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

Jenni Yeh, we're five and a half now.

Eileen So I'd tend to just breastfeed and wait till six months.

Now, however, Eileen is calling on scientific discourses and beginning to implicitly problematise Jenni's practice of giving solid foods before six months. Jenni responds non-committedly.

Jenni Mm.

Eileen And even if you wanted to um start even the vegetables, you can start the rice cereal they say six months and over. (J: Mm) I'd ...

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

Eileen Exactly, yes.

Jenni is now explaining herself to Eileen who in turn praises her actions again.

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.

Eileen No.

Eileen then raises the topic of teething with the implication that it might be teething and not hunger that was the cause of the unsettled nights, as a way of reinforcing the appropriateness of exclusive breastfeeding. Jenni then accepts Eileen's 'diagnosis' although it does not reflect her contextualised knowledge of her child.

Eileen The teeth should be cut ...

Jenni Yes they are ...

Eileen starting now ...

Jenni dribbling heaps ...

Eileen So I think that's it, I reckon. Have you got any teething gel?

Jenni No, I'll have to get some. But he is chewing. I've got lots of teething rings.

Eileen Wonderful, wonderful, so I think ...

Jenni Definitely the teeth.

Jenni appears to have been persuaded it is teething that is the problem. She presents her own solutions to the problem – 'lots of teething rings' – which Eileen affirms. In

this interaction, there has been no explicit contestation over Jenni's practices, and neither Jenni nor Eileen has explicitly rejected the other's understanding of what good mothering is, given the context. Indeed, each has explicitly accepted the other's interpretations. By the end of the interaction an account of Jenni's practices has been negotiated that allows her to conform to good mothering by following expert medico-scientific advice about appropriate feeding of her baby (Apple, 1995; Hays, 1996).

At the end of this visit, Eileen made a written record in the baby book. The 'baby book' is the Personal Health Record given to each baby at birth and kept by the parents. It contains parenting and health information, record of immunisations, and CHN nurses' record of health assessments, and comments on growth and development at each visit. Eileen recorded the 'correct' breastfeeding practices for a six-month old, generating a written record that demonstrates a good mother, an account that Jenni does not expressly reject although it does not reflect her chosen practices:

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

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

Jenni's final comment to her baby suggests her conformity to Eileen's advice may be stronger in the interaction than in her practice, with her agreement to 'give it a bit of time' immediately followed by a statement which implies that she will continue to feed her baby solids, irrespective of the official account documented by Eileen.

In such interactions, CFH nurses and mothers can accommodate accounts of non-compliant practices while still affirming a mother as a good mother. However it is the CFH nurse who has the power to define the mother as 'good'. She is the one who fills in the baby book. Thus, the CFH nurses control the official record of how well the mother is performing, and the 'concrete representation to them of their role as a mother' (Clendon and Dignam, 2010: 973).

Resisting through counter discourse

For Foucault (1990: 95) points of resistance occur everywhere in the power network. In the interactions, different forms of resistance are evident in negotiations between CFH nurses who call on their authoritative expertise and mothers with their contextualised and child specific practical knowledge. There are many strategies of resistance that mothers employ in their interactions with CFH nurses, and many of these are exemplified in the examples provided in this chapter. Bloor and McIntosh (1990) have described four forms of resistance to nurses' authority which are all covert, and where differences of opinions are not generally expressed by the mothers to the CFH nurses. Armstrong and Murphy (2012) make the distinction between resistance at a behavioural level and resistance at a conceptual level with one not necessarily ruling out the other. In some instances, a mother and CFH nurse may disagree about mothering practices or the needs of the child, 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: 321). Understanding strategies of resistance provides insights into the exercise of power at the micro level, and how mothers speak back to expertise and authority, and assert their own experiential knowledge.

The provision of information is an integral role of the CFH nurse, and the information provided reinforces the value of scientific knowledge as expert knowledge. However, as is shown in the example below, considerable re-negotiation of such knowledge is required when it does not sit well within a mother's frame of reference or experience. At her interview Sharon recalled being upset by the advice provided by the CFH nurse, which contradicted her own situated understanding of her child. This occurred when she attended the child health centre for her child's twelve month assessment. At this time, nurse Joy had pointed out a concern she had detected with baby Thomas' head measurement and progress, as Sharon related:

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.

Sharon had silently challenged the CFH nurse's findings – she could not see a problem, thus reflecting resistance in the form of individual ideological dissent (Bloor and McIntosh, 1990: 171). However Sharon acknowledged the CFH nurse's expertise in this area and was worried enough to act on the concern. Instead of going to the therapy centre however, Sharon consulted her own doctor; someone in turn she perhaps considered had higher authority than the CFH nurse or was seen as independent from the CFH nurse. As Lupton (2012: 123) states nurses remain far below doctors in the medical hierarchy. This finding also reflects Chiarella's (2002: 18) work that nursing, in the view of the public and law, remains subordinate to medicine, even though the child and family health nurse works independently from the medical profession. The doctor had given a different opinion to Joy and had agreed with the mother there was no concern; consequently confirming Sharon's knowledge about her own child. Despite being upset following that visit Sharon returned to the CFH nurse for her baby's eighteen month assessment, reflecting the dutiful action of the good mother to be guided by experts, and thus again becoming subject to soft surveillance. When Joy raised the topic Sharon imposed her own definition of the situation, one that Joy accepted:

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.

Joy accepted the doctor's authority and Sharon's seeking advice from the doctor, rather than her suggestion of the therapy centre. Both mother and CFH nurse then reinforced their own meaning and legitimacy of the situation.

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.

Sharon was demonstrating her definition of the situation had been correct and affirmed by a higher authority, the doctor – and playfully links this to her baby's wellbeing and genetic connection rather than a physical problem. In her response Sharon is also suggesting the 'problem' was a reflection of her son's growth, which in turn reflects her abilities as a mother. While Joy was arguing there had been a reason behind the higher than normal head measurement. Joy was calling on her expert scientific knowledge which guided her practice and conduct as a professional CFH nurse. This expertise included what advice to offer mothers as a result of her observations and definition of the situation. Sharon resisted, and subordinated, Joy's professional nursing discourse. She incorporated the higher authority of her GP's scientific discourses with her own contextualised knowledge of her child in a counter discourse of scientific expertise which confirmed her own belief regarding her child's development.

The differences between the CFH nurses' expert knowledge and the mothers' contextualised knowledge of their own child were present in other interactions and could result in sometimes lengthy negotiations particularly over infant feeding practices. These would ensue with both CFH nurse and mother able to acknowledge and contest each other's expert knowledge to eventually settle at a negotiated outcome. In the following example Rachel uses her contextualised and very specific knowledge of her own child to engage with Lyn in negotiating an outcome that meets her needs around her son. Rachel was a young mother confident in her knowledge of two year old Tom. Lyn found Rachel somewhat of a challenge in trying to negotiate a

change in Rachel's parenting practices, particularly around feeding. Lyn, who had known Rachel for several years, admitted in her interview to finding her quite 'frustrating' at times as Rachel 'had her own way of doing things'. These comments tend to counter Lyn's earlier claims (in chapter five) of CFH nurses working in an empowering and collaborative manner, and being a resource of knowledge rather than imposing expert advice. This time Rachel had dropped in to the open session to see Lyn to have Tom weighed at the request of the dietician. Tom had a medical condition that affected his food intake. Rachel brings up her concern about wanting him to eat and Lyn responds with many suggestions.

Rachel I feel that he's too skinny for his build and ... I'd rather encourage his food.

Lyn Yeh, is he interested, like when you guys have a meal ...

Rachel Yeh he gets really excited and then as soon as he's up to the table he gets a fork and eats the sauce basically um in with the sauce I've noticed he has little bits of food but not a great deal for him to notice. So I've tried.

Lyn tries to direct the Rachel's parenting practices towards offering healthier food options in line with expert knowledges on nutrition. Rachel, however, rejects these on the basis of her more experiential knowledge and understanding of her child.

Lyn I wonder if you could start um making the sauce less of tomato sauce but actually make it more of a bolognaise sauce perhaps ...

Rachel Yeh ... but if you tell him no you're going to have a tantrum.

Lyn Mm so not so much telling him no but just not having that on offer (R: Yeh.) just offering him different things in sauce.

Rachel ... but he doesn't want a bar of anything other than sauce ...

Lyn Will he drink milk?

Rachel No, I tried him on milk.

Lyn So have they talked about trying to make up some nutritional kind of ... milkshakes?

Rachel: No. I didn't even think of milkshakes actually. I might. But no, I'm not sure.

Even when Lyn presents a previously unconsidered option, Rachel dismisses it. Lyn tries to continue a focus on nutritious foods in response to Rachel's practices.

Lyn Do you try and offer him things that you guys are having?

Rachel Yep ... but no luck.

Lyn But I think trying to get him on to the more nutritious foods is the way to go.

Rachel: Yeh well, I know he likes lollies, and we've tried different lollies just to see how he'd go like with a lollipop ... and ... there's been other sorts of small lollies ... and he's liked those as well so we're actually thinking of getting him, I don't know, some sort of fruit stick, or the chewy bar ones (mm) try something like that.

Lyn I guess if he can handle the texture of that why not just try him with a piece of fruit.

Lyn is trying constantly to suggest what she considered to be more appropriate foods to try without saying what Rachel is doing is wrong. Rachel responds decisively and usually in the negative, to all Lyn's suggestions. They continue to negotiate back and forth influenced by their nursing and mothering roles; Rachel, seeking help for her son and reinforcing her own expertise in the situation, and Lyn, in the traditional nursing role of trying to fix the problem and drawing on medical knowledge to do so. They continue to negotiate:

Rachel: He won't eat it. [fruit]...

Lyn Maybe try, I guess where I'm coming from is there's not much point giving him the choices of sweets and salty things ... I guess just trying to keep those things pretty much out of the picture.

Rachel: Well, um like with the mashed potato adding food colouring to it so it looked like a lolly sort of thing. ... But um yeh, I'm stuck. (Little laugh). I really don't know what to do with him now. [Silence].

After a brief silence Lyn comes up with more ideas to try and fix the nutrition problem while Rachel points out the problem for her child is to actually chew. They continue their back and forth negotiation which has seen both of them listening and attending respectfully to each other throughout, until a solution is reached.

Lyn The other thing is I guess ... going back to introducing solids ...

Rachel Well I've actually tried some of the baby foods and ... he didn't want a bar of that either.

Lyn Mm. Tried him with sandwiches or?

Rachel Yeh ... he just puts it in his mouth and looks at it.

Lyn Mm. What about pasta, do you have pasta?

Rachel We've tried pasta ... he doesn't really go much on the pasta.

Lyn Can he eat chips?

Rachel No, not really.

Lyn Mm. Do you think it will be helpful if I rang and spoke to Alexis [speech therapist] before your next visit and just say look can you come up with some more ideas around um offering him different textures or ways to getting him used to having that chewing action?

Rachel Yeh, no, that'd be excellent.

Lyn Yep. OK.

Lyn's suggestions throughout have offered choices within the scientific definitions of healthy foods, thus trying to direct Rachel in the 'right' path. This is a form of 'quiet coercion' where the use of disciplinary techniques including expert discourses and normalising judgements encourages the mother to adopt the appropriate actions (Murphy, 2003: 436). Powers (2003: 227) has argued that providing only the 'correct' choices for the client to choose from is a 'coercive strategy'. Rachel however has rejected and countered Lyn's suggestions calling on her own contextual knowledge

and experience of her child. Lyn responded to the rejection of all her many ideas with equanimity continuing to try to find a solution which in the end she did by involving the speech therapist. In doing so she potentially incorporated another expert and implicitly defined expert knowledge as more effective and more useful than other resources.

For both, this interaction was about helping the child but the interaction was also about mothering and nursing identities. Lyn found meaning in being able to work with Rachel in a collaborative manner to come to a solution together, an important feature of her nursing identity. Rachel, while not showing the apparent good mother response of doing what the professional was advising or conforming to expert knowledge on nutrition, shows her good mother identity through responses that reflected she had already thought of and tried many of the professional's suggestions. Rachel knew her child. She would not try options she knew would not work or that would distress her child.

Lyn saw the problem of nutritious eating as an issue with the child and not the mother. Rachel was not being blamed. As Lyn said in the interview later:

Lyn I guess because of all his negative experiences in hospital, he's quite resistant to anything new. ... I guess that's part of the problem of getting him to eat is he's not going to easily try new things.

In her interview later Rachel indicated the acceptability and helpfulness to her of Lyn's approach:

Rachel: [Lyn] doesn't tell you whether you are right or wrong cause there's never, never a right or wrong answer and she fully understands, she doesn't try and rush you off or anything like that. She does try to take the time out to, you know, if you've got any worries or concerns then she's always there to sort of talk to about those. ... The visit with the speech was absolutely fantastic, we came out with so many options that

we could do ...So Lyn sort of helped a lot ... When the speech therapist turned up she really understood what I was actually on about whereas I feel that if Lyn didn't get in touch with her she wouldn't have known.

Lyn's intervention ensured Rachel remained under a process of surveillance in an approach that maintained their relationship. The extended exploration and discussion of the problem of Tom's eating does not reflect findings from some studies which found CFH nurses responded to problems raised by the mothers with stereotyped advice giving (Baggens, 2002; Kendall, 1993). What is evident is that Lyn worked to maintain a respectful relationship with Rachel and to allow for equal participation in the dialogue. However also evident is the underlying power dynamics involving disciplinary practices and resistance. In offering healthy food suggestions and advice to Rachel Lyn attempts to effect change in Rachel's conduct by calling on her expert knowledge based on the dominant health promoting discourses. Rachel's resistance calls on her own contextualised knowledge of her child. While resisting the healthy food messages Rachel continues to use Lyn as a resource to have her needs met i.e. Rachel has Tom weighed, and negotiates an answer to her problem by having Lyn advocate on her behalf with the speech therapist. Rachel continues to follow good mother principles of seeking expert guidance, and Lyn has been able to provide background information to the speech therapist so Rachel becomes 'known' within a wider field of surveillance.

A contrast to the above encounters is provided in this third example of resistance to the CFH nurse's authority in the interaction. While occurring within a trusted relationship that had developed over several months, this interaction is a rare example of an overt negotiation of resistance when the CFH nurse directly confronts the family about a parenting practice the family had not been concerned about but the CFH nurse disagreed with. Diane was home visiting her teenage client Alissa and her partner Kade, who lived with another relative, Judy. During the visit Judy leaned over giving her half empty bottle of Coke to seven month old Ethan who held it up to his mouth, but it was not tipped up far enough for him to get a mouthful. In a light-hearted but shocked

manner Diane challenged Judy who responded with an explanation suggesting there was no choice:

Diane Judy, you don't give him Coke do you?!!

Alissa He screams if he doesn't get what we have.

Diane Oh gosh. [With a big laugh, as Ethan keeps trying to drink].

Alissa He's sort of half feeding himself now.

Diane Is he?!

Diane responds when the subject digresses onto a potentially less controversial topic, acknowledging the baby's progress to self-feeding. However she immediately returns to the Coke issue with a reason for her concern – the teeth. The relative's challenge is met with more information supporting Diane's argument.

Diane That's no good for his teeth Judy.

Judy Oh BULL!

Diane It isn't bull, it's truuue.

Judy Bull. Nothing wrong with it.

Diane You know what they do with a penny? They put it in Coke and it dissolves!

Although it was implicit that Dianne did not agree with the practice of giving the baby an unhealthy drink, it was the Coke itself that Diane named up as the problem. She talked of the Coke and its effects as the issue rather than focusing on the practice. Diane provides information in an attempt to persuade a change in behaviour. She does not draw directly on medical knowledge but rather presents the iconic example of the corrosive effects of the drink, perhaps in an attempt to temper her strong message that Alissa and the family are not conforming to good parenting practices of giving healthy foods and drinks. The discussion goes on to what else Ethan now has to eat. Diane returns to the Coke issue, however, thirteen minutes later when Judy brings up the subject of teeth:

Judy He had a tooth before he was five months old.

Diane That's why you don't want him to have Coke! [With a laugh].

Judy Ohh shut up about Coke! [Loudly, light heartedly]. [Big laugh from Diane].

Diane We need to organise a deal here. [With a laugh]. No Coke!

Judy He has what I have [loudly] if I don't give it to him.

Diane What about his teeth?!

Judy If I don't give it to him he'll just ...

Alissa He'll sit and scream.

Judy He'll scream and scream, and scream!

Alissa and Judy are drawing upon their own contextual knowledge, reflecting good mother discourses of knowing their baby and addressing his needs (Hays, 1996: 54), including his emotional needs - not letting their baby cry. They know what makes their baby happy and Diane's proposal of 'no Coke' is not an option. Their decision reflects their contextual understanding of how this particular child behaves. Diane then changes tack with some response forthcoming from Judy.

Diane Well you might need to start cleaning his teeth then.

Judy Yeh. [In quiet voice]. It's only been a little bit. Not that much.

Diane Yeh. The trouble is that it sits on their teeth and you know it just sits on, like they get a covering over their teeth.

Judy Yeh.

Diane And um, then when that Coke goes on that covering ...

Judy Yeh.

Diane that's what eats the enamel.

Judy Yeh. He only has a little mouthful to keep him quiet.

Judy has responded with lowering her voice and becoming more serious. Neither wants confrontation and they are working at maintaining their relationship. While Diane continues to use her knowledge to support her view Judy replies with 'yeh', 'yeh', 'yeh' but still does not change her mind about her actions making the mitigating

comment 'it's only a little mouthful'. With this Diane makes her last suggestion but it is Judy who has the last, triumphant word/s 'He has apple! And pears!' to lead onto a more positive topic:

Diane He needs to have an apple afterwards. [With a laugh].

Judy He has apple! And pears! [In an excited, proud voice].

Diane How much food does he have?

Judy's excitement suggests she does not reject all of Diane's knowledge and authority, and is pleased to be able to present herself and her family's practices in ways that conform to dominant scientific knowledge around feeding children. At this point the discussion turned to how well Ethan was doing – a tactic that is evident throughout these interactions and one that allows CFH nurses to re-establish a mother's claim to good mothering. During this interaction all three women worked at keeping their relationship between them intact.

Rejection through redefinition

Rather than reject outright child and family health nurses' reasoning based on scientific and expert knowledge, mothers drew on strategies of redefinition, of redefining expert knowledge, in order to apply such knowledge to their context. In doing so they used their experiential knowledge of their own situation to challenge and negotiate CFH nurses' medico-scientific expertise. Resistance to CFH nurses' authority is again evident in this process of redefining expertise. This redefinition is evident in the two, quite different, examples presented here. In the first case 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. The CFH nurse, Joy, has a strong belief in the importance and benefits of breastfeeding. Her attempts to persuade Carolyn are evident throughout this interaction:

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 (C: Yeh), just until she's at least above her birth weight. (C: Yeh). Yeh.

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 um 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 ...

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

Carolyn I've suggested an hour or two in between feeding times.

Joy Yeh, well that's what I'm saying.

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 based in expert knowledge - 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 (C: Yeah) just say she's below her birth weight. Really by six weeks she should be ... ideally by 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. Although rejecting Joy's advice in letting the baby go to her father's, Carolyn does not reject the concept of the scientific imperative to breastfeed. She re-defines the technical knowledge around exclusive breastfeeding that allows her to continue the good mother practice of providing breast milk to her baby in a manner that fits with her family situation. Carolyn defines her position without explicitly rejecting Joy's expertise. While acknowledging that Joy's knowledge may be appropriate for some families, in the interview, 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 ... And it doesn't mean we think she's wrong, it's just not right for our situation that's all.

Mothers are able to resist dominant constructions of the good mother, such as to exclusively breastfeed and to follow expert guidance, through emphasising alternative dimensions of the discourse. In this instance Carolyn has listened to expert information and then called on her own contextualised expertise to make her own judgement about what is best in her situation. She reinforces what she believes to be good mothering behaviour by continuing to provide breast milk for her baby (by expressing) while allowing her child access to both parents. However the impact of expert

knowledge remains as Carolyn's difficulty in rejecting Joy's advice outright shows. Murphy (2003: 443) found in her study relating to infant feeding and breastfeeding that, as with Carolyn, mother's resistance did not deny expert knowledge but rather redefined and relocated it legitimating their practices. In concealing from Joy what she has done Carolyn has also undertaken a common form of resistance (Bloor and McIntosh, 1990: 176). This resistance to Joy's authoritative expertise has been at a behavioural level but not, however, at a conceptual level (Armstrong and Murphy, 2012).

When the mother's parenting practice, rather than the problem itself, was being judged the CFH nurse's expert knowledge and advice was much more likely to be rejected outright impacting on the relationship as occurred in the following example. Emma's experience with a CFH nurse, filling in when her usual nurse was away, revealed how having her mothering practices challenged was upsetting and led to the CFH nurse's authority being dismissed as mere 'opinion'.

Emma When I went to the health centre a month ago and Eileen wasn't there, the lady that was down there was like um, is he crawling yet? And I'm like 'No'. And she's like well he's not spending enough time on the floor. [In a loud accusing voice]. And she's like, have you jolly jumpers and walkers and stuff. And I'm like 'Yep'. And she goes well you need to keep him out of them and keep him on the floor!

Emma confronts these challenges reinforcing her mothering identity with further good mother practices that reflect intensive mothering - managing the care all her children and her home, cleaning her house, and keeping her baby happy, as she continues:

Emma And it's like I've said to her, well that's all fine and good. I have three other kids to look after. I have a house that I need to keep clean. I can't just put my baby on the floor and keep him entertained all day. Like I put him in his jolly jumper, I put him in his walker so he's entertained so I can go do something.

As Murphy (2003: 442) found mothers rejected expert-definitions of good mothering practices when trying to balance the competing demands on their time and energy. When asked how she had felt about the encounter Emma replied:

Emma It doesn't bother me like she's got her opinion on what I should and shouldn't be doing. But you know, I think yeh, whatever! I'm not listening.

Emma was also upset the CFH nurse had not recognised the importance of breastfeeding to her. Eileen had been very aware of this, with several supportive comments relating to Emma's successful breastfeeding during the visits and she had confirmed this awareness in an interview after. At the visit with the relief CFH nurse a slower than usual weight gain, due to sickness of both mother and baby at the time, had prompted the CFH nurse to suggest using formula with the implication Emma may not be doing the best thing for her baby, as Emma continued:

Emma And then there was, what else was she saying? About his weight and stuff. And she's like oh well you just need to give him formula. And I'm like I don't want to give him formula, I want to breast-feed him!

There is a stark contrast here to how Emma has described the visits with the two CFH nurses. Emma did not trust her own authority when it came to the baby's measurable growth and weight progress, when seeing Eileen. However when her parenting practices were challenged by the relief CFH nurse she was able to dismiss this 'opinion' of what she should be doing with her child and expressed confidence in her own mothering style which was based on knowing her children and what worked in her very busy and often stressed, situation. Thus Emma called on her own contextual knowledge and definition of the situation to present as a good mother. In this process of resistance the mother asserts the authority of her own contextualised and child specific knowledge over that of the CFH nurse and so denies the professional any legitimate role (Murphy, 2003: 447). Expertise has been redefined, based on individual

knowledge of a particular baby, and relocated to the mother as expert (Murphy, 2003: 449).

Emma's very different encounters with the two CFH nurses highlight a difference among CFH nurses in their interactions with mothers when mothering practices may not meet the norms of 'scientific' mothering. In Emma's encounter, the relief CFH nurse has called on scientific rationality firstly to assess the progress of Emma's baby, i.e. the normalised/expected weight gain and developmental milestones based on statistical measurements. The CFH nurse has then overtly used her authority to question Emma's mothering practices and provide unsolicited advice on more 'appropriate' mothering practices. The CFH nurse's disciplinary power has been prominent but pastoral power was not a feature of the encounter, thus rendering it ineffective as a process of governmentality.

On the other hand pastoral power was a key factor in Lyn's interaction with mother Rachel who she had come to know very well. This relationship allowed Lyn to engage with Rachel in a collaborative discussion relating to what foods were being offered to baby Tom. Lyn, in her interaction with Rachel relating to what foods were being offered to baby Tom, was also calling on a scientific rationality to influence Rachel's actions. But in this case Lyn marginalised her authority and engaged with Rachel in a collaborative discussion. Lyn did not comment on Rachel's more questionable actions such as giving lollies rather than nutritious foods to her child, but responded in an empathetic manner reflecting her knowledge of the family and a caring approach. In this process Lyn was recognising and working with the mother's knowledge and expertise in relation to her child.

CONCLUSION

The key finding in this chapter has been that mothers and child and family health nurses call on their own expert knowledges to negotiate and affirm good mothering practices, with infant feeding a prime example of this. At times this is uncontested

reflecting the invisibility of the underlying power relations in the gentle of surveillance practices by CFH nurses in the examination. In many instances there is negotiation and resistance over what constitutes good mothering. In these situations child and family health nurses call on their medico-scientific knowledge to persuade and guide mothers in 'correct' mothering practices. Mothers on the other hand call on their contextualised and practical knowledge which they balance with CFH nurses' expert discourses to redefine good mothering.

Foucault's concept of power-knowledge is reflected here in the dominance of medico-scientific knowledge as the basis of scientific mothering. The power of the dominant medico-scientific approach is that certain practices are identified as 'healthy' and therefore legitimate while others are 'unhealthy' and thus illegitimate (Murphy, 2003: 437). Surveillance and normalising judgements are a means by which particular mothering practices are reinforced and negotiated as was evident here with CFH nurses' guiding of mothers in conforming to dominant 'healthy' parenting practices. However with the exercise of power there is also resistance and this was evident in the negotiations.

The resistance to and negotiation of dominant elements of good mothering is built on relationships of power. The existence of power relationships, as Foucault (1990: 95) states, 'depends on a multiplicity of points of resistance ... [which] are present everywhere in the power network'. Mothers in this study were able to challenge the power of the child and family health nurses' professional expertise and institutional authority with their own corresponding contextualised and experiential knowledge as experts on their own child.

A range of strategies were evident in the negotiation of good mothering. When there were shared understandings of good mothering practices mothers called on and accepted CFH nurses' authority and expertise to affirm them as good mothers. In the interactions, the mothers' contextualised knowledge was not (usually) subordinated by the CFH nurses, with both mothers and nurses acknowledging the other's expertise in their negotiations. At times they worked together to accomplish the good mother by

overcoming mothers' and, or, CFH nurses' concerns about mothers' practices or a child's development. The negotiating of good mothering was evident in more contested situations when understandings of good mothering were not shared by CFH nurse and mother. The medico-scientific mothering approach was resisted by mothers when it did not affirm their good mother identity. Resistance was not a simple matter of rejection and nor was it concealed in most instances. Rather resistance occurred in a process of negotiation between mother and CFH nurse. In resisting through counter discourse mothers called on alternative discourses which confirmed their own understanding of the situation. One mother called on a higher authority (the doctor). Mothers also called on their own contextualised knowledge of their child and negotiated with the CFH nurse. Mothers were also able to reject CFH nurses' dominant definition of good mothering by redefining their situation and emphasising a different aspect of good mother practice. As with Foster's (2009) and Mollidore's (2013) studies of low-income mothers (described in chapter three), mothers in this study were found to have agency in defining their good mother identity.

In a Foucauldian conceptualisation, power can be productive and generate subjectivities (Foucault, 1980b: 119; Holmes and Gastaldo, 2002: 559). In this study both conformity and resistance occur within the interactions as a shared pursuit between mother and CFH nurse in the construction of good mothers. Characteristics of a good mother evident here reflected many of those of scientific mothering and intensive mothering. Specifically, a good mother breastfeeds and gives the right healthy foods, and at the right age, reflecting the dominant medico-scientific messages on infant feeding (Bartick, 2013; NHMRC, 2013). Reflecting the scientific mothering imperative to seek expert guidance on mothering (Apple, 1995: 161; Hays, 1996: 54; Murphy, 2003: 437), a good mother, in this study, has her children weighed and examined by an authoritative expert, i.e. CFH nurse, a) to determine the child is progressing 'normally', and b) as a measure that reflects her successful mothering practices. A good mother ensures she is meeting the needs of her child and uses the CFH nurses' knowledge and expertise as a resource in meeting these needs, reflecting scientific mothering and the child-centred approach of intensive mothering (Hays, 1996: 54). A good mother, however, did not submissively follow the CFH nurses'

advice. Rather good mothering required CFH nurses' knowledge and advice to be considered and balanced with the mother's own experiential, expert knowledge of her child within the context of her family situation. A good mother balanced and adapted expert advice with 'what's right for their situation', as mother Carolyn stated.

CHAPTER SEVEN

CONCLUSION

Nearly every woman who becomes a mother in Tasmania, and in most of Australia, visits or is visited by a child and family health nurse (Schmied et al., 2014; Tasmanian Government, 2013). Despite this being a widespread experience of mothering, and despite historical indicators which link CFH nurses to the governance of poor women, interactions between low-income mothers and CFH nurses remain an under researched area. This is significant, given that low-income mothers are generally portrayed negatively in literature, particularly health literature, as unable to meet the norms of culturally dominant definitions of good mothering (Breheny and Stephens, 2007: 113; 2009: 256). Such portrayals are predominantly based on quantitative statistical data (Butler et al., 2010: 5) and commonly present low-income mothers as failing to conform to health priorities, for instance, having poor rates of attendance at ante-natal clinics, low birth weight babies, low breastfeeding rates, low immunisation rates and poor social outcomes (Breheny and Stephens, 2007: 113; Hanna, 2001; Olds, 2006). Empirical work on how low-income mothers themselves define and negotiate good mothering can challenge these dominant representations. Visits with CFH nurses are a particularly useful site in which to explore power and power relationships. CFH nurses' institutional role constitutes processes of surveillance and regulation which facilitates the imposition of scientific mothering (Brennan, 1998; Peckover, 2002). Additionally, CFH nurses articulate a professional identity that incorporates a relational approach. The humanitarian goals of care within this approach mean that CFH nurses problematise this power imbalance, by actively questioning the link between their legitimated (medico-scientific) knowledge and their expert role and authority to assess and direct mothers' attitudes and actions (Briggs, 2007; Davis and Day, 2010: 80; De la Cuesta, 1994). The routine interactions between low-income mothers and their CFH

nurses offer a case study in the management of not only mothering and nursing identities but the intersection of power, knowledge and care.

Given the wide reach of child health services in Australia, and the absence of low-income mothers from much of the available research, I pursued three aims: to identify how low-income mothers and CFH nurses construct good mothering; to identify how good mothering practices are negotiated between CFH nurses and low-income mothers; and to identify how CFH nurses and mothers understand the role of CFH nurses. My research has been informed by the question 'How do child and family health nurses and low-income mothers negotiate good mothering practices?' I argue that both mothers and CFH nurses call on their own knowledges and expertise in order to negotiate these understandings of good mothering.

KEY FINDINGS

Mothers and CFH nurses co-construct and navigate good mothering practices by repositioning expertise, by minimising or problematising CFH nurse authority and challenging the tenants of scientific motherhood, and by proposing alternative constructions and practices of motherhood which take into account context and lay knowledges. The next section addresses the first aim: to identify how low-income mothers and CFH nurses construct good mothering.

Constructions of the 'good mother'

In this study, mothers and CFH nurses defined characteristics of a good mother that both conformed to and resisted elements of dominant constructions of scientific mothering, particularly, perceptions that mothers ought to seek and follow expert guidance (Apple, 1995: 161; Hays, 1996: 54; Murphy, 2003: 437), and constructions which privilege the child-centred approach of intensive mothering (Hays, 1996). A key characteristic of the good mother construction, which emerged in this study, was the expectation that mothers enact preventative health by submitting to the care of a CFH nurse, as an authoritative expert, to assess the child's progress. This includes the process of weighing and examining the child to determine if progress is 'normal'. The child's progress was, for many mothers, a measure of her success as a mother. For the

participants in this research, giving the right nutrition was also a key characteristic of a good mother. Breastfeeding was an important feature of their constructions of a good mother – for some it was the most important feature. Giving the right (healthy) foods to her child, and at the right age (i.e. solid foods from six months in accordance with official recommendations) (Bartick, 2013; NHMRC, 2013), was an important factor. A further key characteristic of a good mother in this study, for both CFH nurses and mothers, is the imperative to meet the needs of her child, and to use the CFH nurse as a resource for knowledge and expertise in meeting these needs. For example, a good mother raises health concerns she has about her child with the nurse, in person or by phone. This construction reflects at least a partial incorporation of both scientific mothering and the child-centred approach of intensive mothering (Hays, 1996: 54).

Mothers and CFH nurses negotiated, sometimes at length, to maintain the mother's conformity to dominant definitions of good mothering. This finding contrasts with previous studies which describe nurses as constructing low-income mothers as deviant or unable to attain a good mother status (Breheny and Stephens, 2007; 2009; Hanna, 2001; McDermott and Graham, 2005; Stapleton, 2010; Verduzco Baker, 2011). In this literature, health professionals focused on social and structural factors - such as mothers' young age, single status, or situations of domestic violence - and could not reconcile these with good mothering. Participants in this study did not consider such factors as defining of good mothering status.

In this study, judgements by CFH nurses about mothers' conformity to dominant definitions of good mothering were contingent and negotiated between the nurses and mothers, rather than imposed by CFH nurses. Nurses used disciplinary techniques (Foucault, 1991b; Perron et al., 2005: 541) including surveillance, examination, normalisation, and using medico-scientific knowledges, in a process of teaching and persuading, and defining mothers as good mothers. In the case of this study, surveillance is the ongoing monitoring of a child's health and development, a process aided by having a good relationship with the mother and by a nursing 'gaze' that enables coming to know the family (Wilson, 2001). The 'examination' is assessment and evaluation by the CFH nurse who makes interventions which are approved and

recommended by the medical and scientific professions (and their institutions)(Gilbert, 1995: 868). The CFH nurse evaluates a child against normative milestones, in order to guide mothers in the event of any deviation from appropriate child-rearing behaviour. These normative constructions of child development are dominated by medico-scientific discourses, and remained mostly unquestioned by the nurses in this study.

As in other studies (Fagerskiold et al., 2003; Mayall, 1990; Tarkka et al., 2002), mothers in this research accessed CFH nurses for their knowledge, expertise and experience, and also to gather evidence that suggested they were good mothers. The visible and measurable progress of their baby was a particularly important indicator of good mothering because this technical and scientific evidence provided the proof to the mother, and others, that she was doing the 'right thing'. Thus, through CFH nurses' expert knowledge, mothers were affirmed to be good mothers. Mothers welcomed this expertise and affirmation. The next section addresses the second aim: to identify how good mothering practices are negotiated between CFH nurses and low-income mothers.

Negotiations of 'good mothering' practices

In this study some practices from within scientific mothering were accepted, and some where resisted. Mothers and CFH nurses questioned those elements of scientific mothering and dominant discourses that subjugated maternal and other lay knowledges to medico-scientific knowledges (Foucault, 1980c: 82; Gilbert, 1995: 869; Miller, 2005: 43). While good mother constructions included seeking expert knowledges for the health of the child, this was balanced by the mothers' own knowledge and context, and the needs of the child. Within their relationship, negotiations often occurred between mother and CFH nurse to balance these expert knowledges such that the characteristics of a good mother were qualified and redefined. A good mother might not breastfeed; a good mother might not give the recommended foods at the right time; a good mother's child might not reach all their milestones. While behavioural outcomes may not always have met 'appropriate'

behaviours, within individual contexts, the practices were redefined as good mothering.

The CFH nurses in this study rarely rejected or critiqued mothers' practices explicitly. Rather, by using a particular style of speech and interaction the CFH nurses and mothers negotiated the meaning of knowledge, practice and identities to maintain the mothers' conformity to dominant definitions of good mothering, whereby a concern was acknowledged and discussed, usually briefly but sometimes at length, with explanations offered by the nurse to normalise the situation or actions of the mother. The mother may list other positive mothering achievements which the CFH nurse would show approval of, and at the end of the episode the topic would change to highlight a positive aspect of the child's progress and, implicitly, legitimate the mother's practices and thus her good mother identity. The next section addresses the third aim: to identify how CFH nurses and mothers understand the role of CFH nurses.

Understandings of the CFH nurse role

The mothers in this study referenced the role of the CFH nurse to expertise and authority. They recognised CFH nurses as community professionals whose role was to support parenting. Mothers saw this as a legitimate role due to the CFH nurses' education, training and history as specialists in the area of child health. Reflecting scientific mothering (Apple, 1995) mothers accessed CFH nurses for their expertise in assessing their child's development. CFH nurses' position as 'agents of the state' (Perron et al., 2005: 543) situated them in defining the health and well-being of children and their families based on a dominant medico-scientific paradigm for child development and child rearing, however mothers implicitly and sometimes explicitly accepted this role, in utilising CFH nurses to confirm their good mothering.

The CFH nurses in this study saw their role as giving support and guidance to mothers in raising their children, and this was facilitated through their relationship with the mother. The nurses experienced a tension between this ethic of care, and their expertise and professional identity. Some CFH nurses were concerned that their expertise was not recognised in the community and by other professionals, however in their work with low-income mothers, CFH nurses were uncomfortable with their level

of expertise and power. The CFH nurses felt that these aspects of their role could have a negative impact on mothers, particularly their confidence in their own mothering practices. Therefore, nurses' discourse reflected an attempt to marginalise their own expertise and emphasise the mother's skills and knowledge. The nurses employed these discursive strategies in line with their perceptions of their role as empowering mothers, and their stated intentions to focus on strengths and build confidence in the mothers. This was in contrast to several studies which found CFH nurses advice-giving practices were not empowering and reinforced the nurse as expert (Baggens, 2002: 351; Heritage and Sefi, 1992: 391; Kendall, 1993: 105).

The nurses and mothers constructed the relational side of the CFH nurse role differently. Mothers visited with the CFH nurse primarily because of their technical skills and professional knowledge, and this formed the basis of the interaction. For the CFH nurses this technical caring was a means to develop a more relational style caring. As nurse Lyn said, often clients see nurses as standing behind the scales but the real aim was to build a 'respectful, trustful relationship' from the first visit. For the CFH nurses their relationship was an important means of conducting their caring work with mothers. Caring for mothers both as an individual and in their mothering role was fundamental for the CFH nurses. This approach reflects the humanistic conceptualisation of caring and developing the human potential in nursing ethos (Paterson and Zderad, 2008; Traynor, 2009; Watson, 1999). However, the mothers in this study also appreciated a good relationship with their CFH nurse, and acknowledged the value of a nurse who listened to them and came to know them. These constructions of the CFH nurse by both nurses themselves and mothers is a new perspective on the humanistic ethos, or care relationships within mothers' interactions with CFH nurses.

Pastoral Power

From a Foucauldian perspective we can understand the importance of relational care in child and family health nursing as the means by which nurses' have pastoral power. Developing relationships of trust increases nurses' pastoral power. Pastoral power comes from a deep knowledge of the person which is built on confession and knowing. Through respectful and trusting relationships mothers feel able to confide in nurses

and CFH nurses come to know the mothers at a deeper level. This increase in coming to know the client involves a 'searching nursing gaze' (Thompson, 2008: 82) which allows and encourages ongoing gentle surveillance (Wilson, 2001: 298). In the process the CFH nurses are influential in being able to 'structure the possible field of action of others' (Foucault, 1982: 221). The more the CFH nurse knows a mother the better able she is to provide advice and guidance in an acceptable manner for that mother, and for that advice to be listened to and followed. Further insights can be gained from exploring the concept of resistance within these interactions, however.

Resistance and negotiation

The exercise of power invites resistance (Foucault, 1990: 95) and as such the interactions between mother and CFH nurse were the site of negotiations, resistance and conformity. Mothers contested and resisted CFH nurses' authority, sometimes in lengthy negotiations. Mothers called upon others' authority, including other professionals, and their own contextualised, experiential and child specific knowledge to redefine CFH nurses' constructions of particular practices as 'good mothering' and to affirm their own good mother identity. They also resisted by using counter-discourses, rejecting CFH nurses' expertise and understanding of the situation by calling on alternative expert knowledges such as those of a different authority than the nurse, which confirmed their own understanding of the situation. This challenging of CFH nurses' expert knowledge reflected resistance at a behavioural level, but not at a conceptual level (Armstrong and Murphy, 2012). In calling on other professional authorities the mothers did not deny the scientific mothering practice of calling on expert guidance. Mothers also resisted through redefinition. They were able to reject CFH nurses' expert scientific knowledge and definition of good mothering by redefining their situation and emphasising their own contextualised expertise. This resistance was at a conceptual level (Armstrong and Murphy, 2012).

I identified three different styles of negotiation within the nurse-mother interactions, all of which were to do with the CFH nurses' scientific knowledge and expertise and the mothers' experiential and contextualised knowledge and expertise. In one, more infrequent style of negotiation, the dominance of the CFH nurses' expertise was

unquestioned by the mother, but questioned by the nurse. The mother accepted without question that the professional nurse held the expert knowledge relating to child health. The CFH nurse, however, was usually reluctant to accept this position. For example nurse Eileen had encouraged Jenni to consider her own and other mothers' experiences as legitimate knowledge.

A more prevalent style of negotiation in the interactions, was for the mothers to privilege their own contextualised and child specific knowledge above that of the nurses' scientific knowledge. While the mothers in these interactions generally listened to and considered the nurses information it was balanced within their broader circumstances, yet often in negotiation with the nurse who did not impose her expertise on the mother. Thus, these low-income mothers displayed agency in their interactions with the CFH nurses. Mother Angela, for example, appreciated the way nurse Lyn did not push information and advice on her but offered these as suggestions or options to try.

In a third style of interaction the nurse claimed the dominance of her medico-scientific knowledge above that of the mother's knowledge. In this type of interaction the CFH nurse presents as the expert without considering the context of the mother's situation. For instance the relief CFH nurse who saw Emma and her baby, who were both unwell, offered unsolicited, and impractical, advice in response to her observations of the baby, without considering Emma's situation. Emma ignored the advice and in the process dismissed the nurse's authority to direct her child rearing behaviours. This non-collaborative approach by the nurse reflects findings in other studies where nurses asserted their knowledge and authority over that of the mothers, and with the resultant dismissal of authority by mothers (Heritage and Sefi, 1992; Kendall, 1993).

CFH nurses' authority – that is, the ability to shape mothers' behaviours, depended to a large degree on the relational elements of respect and trust, thus the nurses' relative pastoral power. The CFH nurse's authority was evident through three different types of engagement.

First, respect and trust shaped the interaction. If there was no relationship of respect or trust felt by the mother, the nurse holds little authority or pastoral power in guiding

mothering actions. In such cases where the CFH nurse had failed to develop a connected relationship the mother resisted conceptually and subordinated the CFH nurse's knowledge and authority to her own contextualised knowledge and relocated expertise and authority to herself.

Secondly, where a supportive relationship had not developed, such as in mother Sharon and nurse Joy's case, the mother may have acknowledged the CFH nurse's professional knowledge and skills but if she disagreed with the CFH nurse's judgements would subordinate the CFH nurse's authority to a different authority, e.g. the doctor. Resistance is more covert as the mother did not discuss her disagreement with the nurse. At the same time resistance is at a behavioural level (the mother does not follow the CFH nurse's recommendation) but not at a conceptual level as the mother continued to acknowledge and seek expert advice and guidance (Armstrong and Murphy, 2012: 314).

A third type of engagement is when there is a trusted relationship between mother and CFH nurse, where the mother feels listened to and respected by the CFH nurse. In this case, the CFH nurse's pastoral power allowed her more influence on mothering behaviours. Lyn's client, for instance, who questioned the new doctor's role in assessing her child's development affirmed Lyn as the knowledgeable expert in this area of child health. It is also at this level of engagement that resistance is negotiated overtly and more productive outcomes occur. This was particularly evident in nurse Lyn and mother Rachel's interaction about what foods to give her child. The fact this conversation took place at all is evidence of the different level of relationship they had built up over time. While Rachel's only purpose for attending was to get a weight for her baby, to talk to the dietician, an extended negotiation occurred relating to what would appear questionable good scientific mothering practices, i.e. the offering of poor nutritional value foods not recommended by health experts. In this interaction the CFH nurse called on her own expert understandings of nutrition trying to influence Rachel's behaviours, while Rachel argued her case based on her own experiential knowledge. The subsequent shared understanding and actions taken by mother and CFH nurse resulted in both being happy with the outcomes. The caring and respectful relationship between mother and CFH nurse was maintained and Rachel's seeking

professional support and using Lyn as a resource to meet her child's needs reflected good scientific mothering practices. Lyn had come to know over time that Rachel 'had her own way of doing things'. Knowing these 'ways' guided the approach Lyn took in her dialogue with Rachel and thus she avoided confrontation when discussing mothering practices. This process reflects how CFH nurses' pastoral power is increased as the mother becomes more known to the CFH nurse, the nurse learns more about the mother's parenting behaviours and therefore how best to influence them.

In the example of Alissa and Judy's encounter with nurse Diane, who challenged Coke being given to the baby, a well-developed relationship was an important factor in allowing overt resistance to occur in the negotiation. Diane's established relationship with the mother and family directed her approach in discussing the subject, in this case a light-hearted though serious one, and in knowing the CFH nurse the family were able to respond openly saying what they thought.

What is evident in these levels of engagement between CFH nurses and mothers is that where there were high levels of trust there were also high levels of overt resistance and negotiation with both CFH nurses' and mothers' authority being respected. Whereas low levels of trust in the relationship resulted in low levels of pastoral power, with the CFH nurse's authority being subordinated to the mother's authority either overtly but more often covertly. This latter effect could have important implications for health care outcomes. As others have found, concealment is a common strategy of covert resistance as it avoids control without confrontation (Bloor and McIntosh, 1990; Wilson, 2003).

CONTRIBUTION TO THE LITERATURE

This thesis provides new insights and extends knowledge in two key areas. One relates to how CFH nurses construct their role and their relationships with mothers and the other relates to how mothers manage their encounters with CFH nurses in terms of their perceptions of the nurse role, and the co-negotiation of good mothering practices inherent in these interactions.

Mothers' constructions of the CFH nurse role

The findings in this study countered some findings in sociological literature of low income mothers' negative encounters with health professionals, such as CFH nurses imposing unsolicited advice on mothers (Bloor and McIntosh, 1990; Heritage and Sefi, 1992: 391; Kendall, 1993), the resistance of vulnerable mothers in situations of domestic violence to confiding in a nurse they saw as from 'a different world' (Peckover, 2002: 374), and the stigma young mothers felt from the behaviours of some professionals (Mollidore, 2013: 114). The interactions between mothers and child and family health nurses were experienced by mothers as friendly, good, and helpful with all but one of the mothers happy with their CFH nurse. Mothers generally enjoyed the interactions using them to be confirmed as good mothers and to get help with solving problems.

CFH nurses' constructions of the CFH nurse role: the tension between an authoritative and relational approach

This research also adds insight into to the nature of 'gentle surveillance' as termed by Wilson (2001: 298). The importance in nursing and particularly CFH nursing of the relational nature of care underpins the development of a trusting relationship (Briggs, 2007; Davis and Day, 2010; Jonsdottir et al., 2004) that in turn supports the enactment of both pastoral and disciplinary power (Holmes and Gastaldo, 2002). It was the relationship style and elements of trust and respect that determined negotiations and resistance within the interactions. A collaborative approach by CFH nurses, a marginalising of their authority, and the acknowledgement of mothers' own contextualised expertise encouraged overt negotiations of mothering practices which often redefined good mothering in different contexts. Mothers and CFH nurses thus work together to maintain their relationship, which will also maintain ongoing surveillance. This adds to the literature about CFH nurses' relationships and negotiations with low-income mothers.

Negotiation and resistance in mothers' constructions of good mothering

How mothers managed their interactions with the CFH nurses in this research also adds to our knowledge in the literature, particularly relating to resistance. This study has contributed to our understanding of resistance by empirically testing Armstrong and Murphy's (2012) conceptual work on resistance. Behavioural and conceptual levels of resistance were confirmed, while the in-depth findings also revealed how resistance can occur, not separately and in opposition to the CFH nurse, but in negotiation with her.

These findings reveal more variation in the manner of resistance by mothers than has been demonstrated in other studies. Previous research reported mothers' resistance as predominantly concealed from nurses (Bloor and McIntosh, 1990; Peckover, 2002). While concealment was noted as a strategy in this study, much more prominent was an overt resistance to CFH nurses' suggestions. Resistance was carried out in many negotiations often at some length, such as Rachel's overt resistance to nurse Lyn's feeding suggestions for her child. Overt resistance occurred more often in the interactions where CFH nurse and mother knew each other and had a trusting relationship. In the negotiation of knowledge in these encounters the dominant and hierarchical nature of scientific knowledge was challenged by the experiential knowledge of the mother having some authority in the discussion. Both CFH nurses and mothers balanced the dominant medico-scientific recommended child rearing practices with the mothers' contextualised and child specific knowledge and practices in resisting and redefining elements of scientific mothering. This research has revealed that within their negotiations of conformity and resistance both mother and CFH nurse work together to negotiate a good mother identity.

Insights into mothers' agency within their interactions were also revealed. Mothers in this study were able to raise their own topics and issues to talk about in their interactions. Unlike the mothers in Baggens' (2001) study who were deterred from raising their own concerns due to CFH nurses' domination of the consultations, the

mothers in this study raised many varied concerns all of which were addressed, some requiring minimal discussion but some which lasted more than half an hour. This may have been a reflection of the time limits or lack of flexibility available to the CFH nurses in Baggens' study. However, it also suggests that mothers in this study were able to introduce their agendas and have them succeed over - or at least within - institutional agendas. This also indicates the mothers had agency in these interactions and called on CFH nurses' knowledge and expertise as they needed.

This research adds insight into the exercise of power by low-income mothers in their interactions with CFH nurses. In answer to important calls for a (Foucauldian) critical analysis of nursing practice, which is often viewed through a humanistic lens (Gilbert, 1995: 865; Peckover, 2002: 375; Perron et al., 2005: 536), this study addresses Wilson's (2001: 299) concern of the impact of the exercise of power in the mother-CFH nurse interaction on marginalised groups, in this case low-income mothers. Low-income mothers do exercise power in their interactions with the CFH nurses. In their negotiations with CFH nurses, mothers have resisted and redefined good mothering practices based on their own contextualised and experiential knowledge. This research has shown low-income mothers do have agency in defining their good mother identity.

FURTHER RESEARCH

As I discussed earlier in this thesis, conformity to culturally dominant definitions of good mothering is differently available to social groups. For example middle-class mothers have more resources than low-income mothers to achieve or redefine good mothering. At the same time the definition of good mothering is different in diverse social groups. In order to understand this issue in greater detail, we need to capture these differences. My findings suggest several key areas for further research.

Other socially excluded groups of mothers would also benefit from further study. In particular, research relating to ethnic groups, indigenous mothers, and intellectually and physically disabled mothers' interactions with CFH nurses would provide insight

and information on how power and knowledge is negotiated in their interactions. Cutcher and Milroy (2010) conducted a discourse analysis of Aboriginal mothers in the media, and Moore and Riley (2010) have presented narratives of 'good' Aboriginal mothering, however there is a lack of sociological study of these mothers' interactions with CFH nurses. We need such research as Aboriginal women are a socially marginalised and disadvantaged group in Australia accessing services within a Western understanding of medicine, health and relationships, and situated within a context of institutional discrimination (Durey, Thompson et al., 2012). Intellectually and physically disabled mothers have a disproportionately high rate of children being removed from their care and also struggle to meet the cultural definitions of good mothering on a range of dimensions due to social and structural barriers (Lamont and Bromfield, 2009; Malcrida, 2009). Malcrida (2009: 100) points out several difficulties for this group of mothers. Accessibility issues such as no wheelchair access can mean mothers have limited involvement in their children's public lives, such as playgroups. Intellectually and physically disabled women are more vulnerable to being in abusive relationships and as mothers have difficulty protecting their child from harm thus failing to meet the imperative that mothers must protect their children. Mothers may also have impairments that make mothering difficult, such as limited mobility (Malcrida, 2009: 100). Research in this area is important in providing insights into how child and family health nurses' work can reinforce dominant good mother ideologies that can marginalise such groups of mothers. Studies such as this provide insight into what good mothering means for the mothers in different contexts and thus increases our social and cultural understandings of mothering.

While my project has focused on mothers' interactions with CFH nurses, there is a need to also focus on fathers' interactions. Daniel and Taylor (1999: 214) argue that in reality parenting means mothering. The relation between parenting and mothers is reflected in both literature and health institution practice where much discussion of parenting reveals a focus on mothers and an absence of fathers (Chalmers, 1992b: 5; Daniel and Taylor, 1999: 214; Johnston and Swanson, 2006: 517; Mayall, 1990; Reeves, 2006: 80). Further research in relation to fathers and child health services would be valuable because it would provide insight into the imposition of fathering ideals in a

situation where fathers could be considered out of place; the highly feminised environment of the child health centre. Insight can also be gained into how CFH nurses engage with fathers, who are not their primary client. Findings from such research would provide understanding about how current child health services and child rearing practices reinforce dominant ideologies of fathering.

Nurses' strategic use of the dominant medico-scientific knowledges is a further area of investigation. As I have argued CFH nurses have an ambiguous relationship with their authority and expertise. CFH nurses, at times, challenged the dominance of medico-scientific knowledge in relation to mothering practices when they questioned the 'truth' of medico-scientific messages and when they sometimes privileged the mothers' contextualised and experiential knowledge over the medico-scientific mothering messages. Such ambivalence is both a 'reflexive and uncomfortable response' and an important sociological indication to further inquiry (Arribas-Ayllon and Bartlett, 2014: 336). That medico-scientific knowledge is such a foundation of child and family health nursing and dominant good mother ideologies indicates further research on a larger scale in CFH nursing would be of great value towards a deeper understanding of resistance within hegemonic scientific rationalism and the construction of good mothering.

GOOD MOTHERS, GOOD NURSES: A CRITICAL REFLECTION FROM A NURSE-RESEARCHER

I would like to share a story of when I first started this research several years ago, when I moved from a nursing view to a sociological lens. One of my first readings of critical sociological literature relating to child and family health nursing came as a physical and emotional shock as I read how, as a nurse and particularly a child and family health nurse, I was apparently an agent of the state involved in the controlling of mothers and families in their parenting. I felt sick, and for a while considered that if that was what child and family health nursing was really about I would give that career away. No mention of the privileged and intimate position I felt I had working with

mothers and families, some for many years, and the mutually respectful relationships we had. This reading brought me down from the previous high I had after completing a small descriptive, ethnographic study of CFH nurses (Shepherd, 2001; 2011). That study had given me a great respect for the skill and work of my colleagues. However I kept on nursing and I kept on with my critical project. It was important for me to understand these tensions. Holmes and Gastaldo (2002: 564) weren't wrong when they said critical research can be challenging for nurses!

Of course a critical lens is crucial in our understanding of this work of child and family health nursing and mothering. A dominant sociological understanding of nursing, and indeed one I have used in this thesis, is that of CFH nurses' position in governmentality and bio-power and the focus on health outcomes. Child and family health nursing was established as a technology of governmentality (Foucault, 1982: 221) within the twin poles of bio-power and the management of both individuals and populations (Foucault, 1990: 139; Perron et al., 2005) to guide and educate mothers in the socially sanctioned methods of rearing healthy children. Such methods were, and continue to be, based on medico-scientific knowledges and approaches to mothering (Brennan, 1998; Murphy, 2003: 437; Reiger, 1985: 128).

When we step back we can see the tension between our critical lens as sociologists and the lived experiences of women. It is important to recognise the experience of the mothers in their interactions with CFH nurses. These were so often affirmative and something to look forward to. In this study I found nurses often acted as a resource for mothers negotiating the definition of good mothering as they worked together to form positive mothering identities. For most mothers and CFH nurses their interactions were a positive experience. Mother's relationships with the CFH nurse were particularly important for mothers who have no-one to talk to, or those who may have had traumatic pasts that seemed to have left them questioning their ability to mother 'correctly', and also for mothers who are dealing with their children's complex medical issues. The child and family health nurses are their means of knowing they are doing something right. Our Foucauldian analysis, using concepts including surveillance and pastoral power to understand the exercise of power within the interactions, provides a different interpretation of CFH nurses' care to the nursing perspective. However this

does not negate how CFH nurses see their relationships with their clients. Nor does a critical perspective negate the centrality of care in CFH nurses' identities, and as an ideal that guides their practice and interactions.

Foucault says we cannot escape networks of power (1980b: 119) and that power can be generative. A positive and liberatory path is to embrace power and understand its creative potential within our interactions, particularly when combined with caring. The interaction between a mother and her child and family health nurse has proved to be an exquisitely complex site of the exercise of power and care that can generate both 'good mothers' and 'good nurses'.

APPENDIX LIST

- Appendix 1 Nurse Information sheet
- Appendix 2 Nurse Consent form
- Appendix 3 Parent Invitation and Information sheet
- Appendix 4 Parent Consent form
- Appendix 5 Nurse Interview Schedule
- Appendix 6 Parent Interview Schedule
- Appendix 7 Parent Demographic Data
- Appendix 8 Observation chart
- Appendix 9 Flyer for child health centres

APPENDIX 1

Nurse Information Sheet

The title of the project is called
Crossing social and cultural divides: How do low socio-economic parents and child health nurses negotiate meaning around motherhood, fatherhood and child-raising?

Chief Researchers

Dr Karen Willis

Snr Lecturer

School of Sociology and Social Work

University of Tasmania

PH: 6324 3499

Dr Kristin Natalier

Lecturer

School of Sociology and Social Work

University of Tasmania

PH: 6324 3370

Researcher/interviewer

Marie Shepherd

Masters student

School of Sociology and Social Work

University of Tasmania

PH: 0409 808 868

Purpose of the research

The purpose of this study is to learn how interactions between nurses and parents, both men and women, influence the parents in making sense of motherhood or fatherhood and child-raising. Its aims are:

- To identify what motherhood, fatherhood and child-raising mean to both yourself and the parents.
- To identify how parents respond to dominant social ideas of parenting and to the expert knowledge of child health nurses, and how you respond to the ideas and practices of parents.
- To identify what parents want and need in their interactions with child health nurses.
- To inform policy and practice by identifying what helps and what hinders the health and wellbeing of parents raising their children.

What it's all about.

There is a lot of 'expert' knowledge and ideas about parenting and being a parent but this project aims to learn from you as well as parents themselves what is important in being a mother or a father and raising children, and what role the interaction between parent/s and the child health nurse has in this. This will provide information about what is helpful for advancing the health and wellbeing of parents.

This project provides an avenue for low socio-economic, i.e. non middle-class, parents' voices and perspectives to be heard. Families in disadvantaged circumstances are often seen in negative terms with interventions implemented from a top down bureaucratic institution. This much needed perspective from families whose input is rarely directly sought will aid understanding on how to provide more effective services for disadvantaged groups.

The study will advance the knowledge of men's perspectives on fatherhood and how they relate within a traditionally female environment. It will provide information on how services can be improved to address the needs of men who are fathers.

This research will be important in understanding and raising awareness of other relevant parenting practices, in order to counteract the more negative focus on inadequate parenting often highlighted in low income groups.

This project is being conducted by me, Marie Shepherd, to fulfil the requirements for a Master of Arts degree through the School of Sociology and Social Work at the University of Tasmania.

Benefits of your participation

Being involved with this research project will allow your valuable knowledge and experience gained from practicing in this area, to be used for the benefit of both the nursing profession and for this group of parents. It provides the opportunity for your voice to be heard on what you as a nurse have come to find is important in supporting women and men through their parenthood. Your generous participation will also allow your clients to be able to participate.

Who is being asked to participate?

All Family and Child Health Nurses working in child health centres are being invited to participate. I will be focusing on the northern region first due to convenience. If further numbers are needed I will seek nurses from the north-west and southern regions. Urban and rural areas will be covered. I will be seeking up to 10 nurses to take part.

If you choose to participate the parent participants will be sought from among your clients who hold Health Care Cards. Up to three of your clients will be recruited in one or all of the following ways:

- Posters and information sheets will be put up in the waiting rooms and consultation rooms at the centres, inviting people who hold a Health Care Card, to take part. Parents who are interested will either inform you and you then let me know so I can contact them, or they will be able to contact me directly themselves.
- You can provide your clients with an invitation to participate and seek permission for me to contact them if they are interested, or they can contact me themselves. The invitation and information sheet will be provided for you to use.
- I will attend open sessions and offer waiting parents a flyer and information sheet. It will provide parents the opportunity to meet me, and they will be able to ask questions and get more information if interested.

Study procedures: What will be involved?

I will discuss the project with you in detail first so you clearly understand what it is about and what is involved. I will then ask you to sign a consent form to take part. There are 2 sections to the project:

First

I would like to observe and audio record a client visit, either at their home or at the centre. Recording the interaction will provide an accurate recording and therefore more reliable information to be used in analysis. I will also write notes while observing.

Second

As soon as possible after the visit I would like to conduct a recorded interview or conversation with you about how you experienced the interaction, about your experiences of working with both men and women, and about parenting. It is expected the interviews would last an hour but may be longer. They can be held at the centre or wherever is suitable.

Number of interactions

I would like to observe up to 3 interactions with you.

This will be with 3 different families unless an interaction is more involved.

In such cases where there are issues which need follow up appointments I may ask to observe this same family again.

I will also be interviewing the parent/s about how they experienced the interaction and about parenting.

If you agree to take part you can still change your mind at any time.

During the interview you do not have to answer a question if you do not want to; just ask me to move on.

To avoid issues of potential coercion, I will ensure that parents are aware they have a choice to take part or not and their decision will have no effect on them, or you or the service they receive from you, and that the observation or interview can be stopped at any time.

Possible risks or discomforts

There are three main things you may be concerned about and which we take great care to address. These are:

- feeling uncomfortable or distressed
- anonymity, or will you be able to be identified in the report
- confidentiality, i.e. how private is the information you give

These are discussed below.

You or your client feeling uncomfortable or distressed

- It is not anticipated that the observation will be distressing but if you do feel uncomfortable or are concerned that my presence or the recording is inhibiting you or your client then please voice your concern. I can stop immediately and leave.
- During the interview section if you become uncomfortable or distressed we can stop the interview and you can decide if you wish to continue later, or would like me to leave.
- You can withdraw from the project at any time without any problems.
- You will be able to contact me to talk about any concerns you may have during or after the project.
- If you feel the need for counselling due to any issues that may have arisen **Newport and Wildman 1800 650 204** provide independent counselling services to DHHS staff free of charge.

Anonymity

We will be very careful in the report to make sure you will not be able to be identified.

- All participants will have a false name in the report
- No names of places or child health centres will be used, for instance the report may say a rural child health centre
- Anything personal that could identify you will not be included in the report
- You will have the chance to read the written version of your interview and change or remove any parts you think may identify you.
- Small quotes of what you have said may be written in the report as examples. However your real name will not be used and anything that could identify you will be removed or changed.

Confidentiality

The information you give in the interviews and any other information will be kept very private.

- Only myself and my supervisors, Karen and Kris who are helping me with this project, will have access to your information.
- I will not discuss what you have said with your client
- I will be the one who transcribes the audio tapes where no one will over hear them
- The information will be stored in a locked filing cabinet and the computer I use will be password protected.
- Hard copies of the interview materials and computer disks of the interviews will be kept by the University for at least 5 years from the date of publication of the project.
- When no longer required after five years, the hard copies will be shredded and discs will be destroyed.

Contact persons

If you have any questions about the research you can contact me or my supervisors

Karen - 6324 3499, or Kris - 6324 3370.

This project has been approved

This project has received ethical approval from the Human Research Ethics Committee (Tasmania) Network which is constituted under the National Health & Medical Research Council. The Committees under the HREC (Tasmania) Network use the *National Statement on Ethical Conduct in Research Involving Humans* to inform their decisions.

Concerns or complaints

If you have any concerns of an ethical nature or complaints about the way the project is conducted, please contact **Nadia Majouri, Phone 03 6226 7479** email:

Human.Ethics@utas.edu.au Nadia is the Executive Officer of the Human Research Ethics Committee (Tasmania) Network, and can direct you to the relevant Chair of the committee that reviewed this research project.

Results of the research

I will be very happy to provide you a summary of the findings when the report is finished – although this may be 18 months after we have talked. I can post or email it to you and I would be very happy to hear any comments you may have. You will be invited to a presentation of the findings when the study is completed.

Information sheet and Consent form

You will be given copies of this information sheet and the statement of informed consent to keep.

If you would like to take part please contact me

- in person or
- email: marie.shepherd@dhhs.tas.gov.au
- phone: Work 6336 4430; mobile 0409 804 868 or
- complete and return the section below.

THANK YOU for taking the time to consider this request to help us learn more about what parents want and need. We look forward to hearing from you soon.

Karen Willis

(Kristin Natalier

Marie Shepherd

Dear Marie

I would be interested in talking to you about taking part in your research project.

Name:

Contact details:

Please send to me via post or internal mail:
FCYHS,
13 Mulgrave Street
South Launceston TAS 7250

APPENDIX 2

Crossing social and cultural divides: How do low socio-economic parents and child health nurses negotiate meaning around motherhood, fatherhood and child-raising?

CONSENT FORM FOR NURSES

1. I have read and understood the 'Information Sheet' for this study.
2. The nature and possible effects of the study have been explained to me.
3. I understand that
 - the study involves observing and recording up to three interactions with clients
 - each interaction will be followed by an interview about the consultation and about parenting
 - each interview may be up to 1 hour in length.
4. I understand that participation involves the possibility that my client may become uncomfortable or inhibited by the recording or presence of the researcher and that I can raise this concern and the observation can be ended. I also understand there is a possibility I may become uncomfortable or distressed during the observation or interview and can stop the interview, then decide if I wish to continue or not. Counselling is available from an independent source if I need this.
5. I understand that all research data will be securely stored on the University of Tasmania premises for at least five years, and will be destroyed when no longer required.
6. Any questions that I have asked have been answered to my satisfaction.
7. I agree that research data gathered from me for the study may be published provided that I cannot be identified as a participant.
8. I understand that the researchers will maintain my anonymity and that any information I supply to the researchers will be used only for the purposes of the research.
9. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish may request that any data I have supplied to date be withdrawn from the research.

Name of Participant:

Signature:

Date:

Statement by Investigator

☐ I have explained the project & the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have the opportunity to contact me prior to consenting to participate in this project.

Name of Investigator

Signature of
Investigator

Name of investigator

Signature of investigator

Date

APPENDIX 3

INVITATION TO PARTICIPATE

Dear parent,

My name is Marie Shepherd and I am a Masters student at the university. Together with my supervisors, Karen and Kris, I am asking for your help in carrying out a research project about being a parent.

I have worked in child health for a number of years and I have 3 sons, all in their twenties. I am very aware that parenting can be very rewarding and very difficult - often at the same time! I believe very strongly that it is important that parents are able to say what is important for them about parenting and be listened to by health workers and the community. Most families come to the child health nurses with their babies and young children at some time, so it is important that nurses know what parents want and need from them. That's why I would like to invite you to take part in this project.

I would like to be with you during a visit with the child health nurse and later on talk to you about being a mother or father and what is important for you in bringing up your children. The information sheet attached explains the project and what is involved.

I would very much appreciate hearing from you. What you have to say is important as you are the one living the life of a parent. By listening to others we can learn so much and I would like to learn from you.

Everyone who takes part will receive a photo of their child/ren as a memento and thank you.

If you would like to take part you can

- Tell your nurse, and she will ask me to get in touch with you.
- or
- Call or text me a message that you would 'like to take part' to **0409 804 868**
- or
- Phone me on 63364430 and leave a message if I am not there.

Thank you for considering this request.

Marie

Parent Information Sheet

The title of the project is called

Crossing social and cultural divides: How do low socio-economic parents and child health nurses negotiate meaning around motherhood, fatherhood and child-raising?

Chief Researchers

Dr Karen Willis

Snr Lecturer

School of Sociology and Social Work

University of Tasmania

PH: 6324 3499

Dr Kristin Natalier

Lecturer

School of Sociology and Social Work

University of Tasmania

PH: 6324 3370

Student researcher

Marie Shepherd

Masters student

School of Sociology and Social Work

University of Tasmania

PH: 6344 4793

What it's all about.

The purpose of this study is to learn how you, the parent, and child health nurses make sense of being a parent. There is a lot of 'expert' knowledge and ideas about parenting and about being a parent. But this project aims to learn from you about what is important for you in being a mother or a father and raising children. This will provide information about what is helpful for you and how the child health service can better meet the needs of parents. This project is being conducted by me, Marie Shepherd, to fulfil the requirements for a Masters degree at the University of Tasmania

Why you?

The child health nurse at your centre has agreed to take part so we are asking parents at this centre, and other centres where nurses have agreed, to help by taking part. I particularly want to talk with parents who are on low-incomes with a Health Care Card. Parents in this group are often not included in research about parenting and it is important to get the views of all groups in society. And we want mothers and fathers.

Why do this?

This will give you a chance to talk about what it's really like for you to be a parent. What you have to say is extremely important for us in the project, as well as for other parents and child health nurses. The findings will provide valuable information and understanding for others in the community to learn more about what it is really like to be a parent, especially when you are on a low income. It will also help better services to be provided.

There is no monetary payment but we will provide each participating family with a photo of their child.

What about the effect on you and your child health nurse?

Whether you choose to take part or not will have no effect on the way the nurse works with you, or the service you receive.

What will be involved?

I will discuss the project with you in detail first so you clearly understand what it is about and what is involved. I will also ask you to sign a consent form to take part. There are 2 sections to the project:

First

I will observe your visit with the child health nurse, either at the centre or your home, and audio tape what is said. This is so an accurate recording is made which can be used later in the study. I will also take notes of what is happening.

Second

Within a few days of your visit with the nurse I would like to meet up with you, at a time and place that suits us both, to interview you. I will ask a few questions to guide us but mainly I would like you to tell me about being a parent and about visiting the child health nurse. I will record this talk also. This interview may go for about an hour but may be longer.

Maybe third

In some cases I may ask permission to observe and record another one or two of your visits with the nurse and talk to you about it after.

I will also be interviewing your nurse after the visits.

You do not have to answer a question if you do not want to; just ask me to move on.

If you agree to take part you can still change your mind at any time.

The information I receive from watching and talking with you and the nurse is combined with all the other information from the other participants. This is studied to look for similarities and differences and to try to explain why things seem to be the way they are. This finally becomes written up in a report with suggestions of how things can be made better.

Some concerns you may have

There are three main things you may be concerned about and which we take great care to address. These are:

- feeling uncomfortable or distressed
- anonymity, which is will you be able to be identified in the report, or will people know it is you
- confidentiality, about how private the information you give us is.

These are discussed below.

Feeling uncomfortable or distressed

We do not anticipate that this will be distressing but if you do feel uncomfortable or upset or anxious at any time,

- We can stop the interview, and you can decide if you wish to continue, or would like me to leave.
- You can drop out of the project at any time without any problems, and you will still get the photo
- You will be able to contact me to talk about any concerns you may have during or after the project
- If you wish I will be able to refer you to a counsellor at the Parenting Centre, free of charge, if you find you need to talk to someone else about any problem that may have arisen. Or you can phone the Parenting Centre yourself on

; North— 6326 6188;
South— 6233 2700;
Northwest—6434 6201.

There is also the 24 hour Parenting Line— 1300 808 178.

Anonymity

We will be very careful in the report to make sure you will not be able to be identified.

- All participants will have a false name in the report
- No names of places or child health centres will be used, for instance the report may say a rural child health centre
- Anything personal that could identify you will not be included in the report
- You will have the chance to read the written version of your interview and change or remove any parts you think may identify you.
- Small quotes of what you have said may be written in the report as examples. However your real name will not be used and anything that could identify you will be removed or changed.

Confidentiality

The information you give us in the interviews and any other information will be kept very private.

- Only myself and Karen and Kris, my supervisors helping me with this project, will have access to your information.
- I will not discuss what you say with your nurse or your partner if they are also interviewed.
- I will be the one who transcribes the audio tapes where no one will over hear them
- The information will be stored in a locked filing cabinet and the computer I use will be password protected.
- Hard copies of the interview materials and computer disks of the interviews will be kept by the University for at least 5 years from the date of publication of the project.
- When no longer required after five years, the hard copies will be shredded and discs will be destroyed.

Contact persons

If you have any questions about the research you can contact me on 6344 4793, or my supervisors Karen—6324 3499, or Kris—6324 3370.

This project has been approved

This project has received ethical approval from the Human Research Ethics Committee (Tasmania) Network which is constituted under the National Health & Medical Research Council. The Committees under the HREC (Tasmania) Network use the *National Statement on Ethical Conduct in Research Involving Humans* to inform their decisions.

Concerns or complaints

If you have any concerns of an ethical nature or complaints about the way the project is conducted, please contact **Nadia Majouri, Phone 03 6226 7479** email: Human.Ethics@utas.edu.au Nadia is the Executive Officer of the Human Research Ethics Committee (Tasmania) Network, and can direct you to the relevant Chair of the committee that reviewed this research project.

Results of the research

I will be very happy to provide you a summary of the findings when the report is finished – although this may be 18 months after we have talked. I can post or email it to you and I would be very happy to hear any comments you may have. The report will also be given to the Family, Child and Youth Health Service with the recommendations for any changes that could benefit the service provided to parents and families.

Information sheet and Consent form

You will be given copies of this information sheet and the statement of informed consent to keep.

If you would like to take part please:

- Tell your nurse, and she will ask me to get in touch with you.
- or
- Text me a message that you would 'like to take part' to 0409 804 868
- or
- Phone me on 6336 4430 after hours, or leave a message and I will call you back

THANK YOU for taking the time to consider this request to help us learn more about what parents want and need. We look forward to hearing from you soon.

Karen Willis

Kristin Natalier

Marie Shepherd

APPENDIX 4

Crossing social and cultural divides: How do low socio-economic parents and child health nurses negotiate meaning around motherhood, fatherhood and child-raising?

CONSENT FORM FOR PARENT PARTICIPANTS

-
1. I have read and understood the 'Information Sheet' for this study.
 2. The nature and possible effects of the study have been explained to me.
 3. I understand that:
 - the study involves the observation and audio recording of my visit to the child health centre or my home
 - this will be followed by a recorded interview with me
 - the interview may last up to 1 hour
 - the interview will relate to the visit with the child health nurse and about being a parent
 - I may be asked to have one or two repeat visits observed with each followed by a shorter interview
 - I understand that participation involves the chance that I may feel uncomfortable or distressed during the visit or the interview, but that I can stop the recording, observation or interview at any time and the researcher will leave. I can also be referred to a counsellor if needed.
 4. I understand that all research data will be securely stored on the University of Tasmania premises for five years, and will then be destroyed.
 5. Any questions that I have asked have been answered to my satisfaction.
 6. I agree that research data gathered from me for the study may be published provided that I cannot be identified as a participant.
 7. I understand that the researchers will maintain my anonymity and that any information I supply to the researchers will be used only for the purposes of the research.
 8. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish may request that any data I have supplied to date be withdrawn from the research.

Name of Participant: _____

Signature: _____

Date: _____

Statement by Researcher

☐

I have explained the project & the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation

If the Researcher has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have the opportunity to contact me prior to consenting to participate in this project.

Name of Researcher

Signature of
Researcher

Name of researcher

Signature of researcher

Date

Appendix 5

Nurse Interview Schedule

Demographic Information

Tell me a little about yourself ...

Nursing experience and education

Length of time in child health nursing

Length of time at this child health centre

The interaction

- I would like to know about this interaction, tell me your thoughts on it...
How would you describe this interaction? eg routine, out of the ordinary, complex? Why?
What was the most important part of the interaction for you?
What do you think was the most important part for the parent?
What did you not say that you would have liked to? Why didn't you say it?
Why do you think this parent attended today?
- My questions about the observation
- What effect do you think my presence and audio recording had on the interaction — for you—for the parent?

Child health nursing in general

- Tell me about your most memorable good and difficult interactions
- Tell me about a situation where you believe you have developed a special/different relationship with a client.
- Tell me what you find challenging working with/supporting families
- Tell me about working with fathers compared to mothers
- What do you think is important for you to do – your role
- What do you think the parent sees as your role
- Do you think child health nurses are experts?
- What do you think they are expert in?

- What value do you think parents give the information you give them compared to information from other sources?
- What happens if the parent tells you something or is doing something that differs from the way you think?
- Would you say you work from a feminist perspective?

Section D: Parenting

- What do you think is important in bringing up children?
- What do you think parents want from you?
- From your experience what do you think helps a mother most?
- What helps a father the most?

Do you have any questions or have anything else you would like to say?

Thank you

Appendix 6

Parent Interview Schedule

Motherhood/Fatherhood and Parenting

- Tell me what your life was like before you had kids
Family, friends what did you do
- Tell me about having a child and becoming a mother/father
What was it like
How is it to what you expected?
Has it changed you – how?
Where do you find information?
- Tell me about being a parent and raising children
- What do you think is important in bringing up your child/ren? Why?
- How do you spend your day? What do you do? Give an example. Is this typical or different?
- What has been a good time tell me about a special time eg birthday
- What has been a difficult/challenging time

Tell me about it; What was the hardest part for you? What did you do?

The Child Health Service

- Tell me something about how you came to be using the child health service

The first visit with the nurse.

- Most memorable visits – good and not so good.
- What has helped the most seeing CHN and
- What hasn't been helpful?
- Visiting the CHN *How does seeing the nurse help?*
Are there things you would like done differently?
- Do you think your nurse has strong ideas about what's important about being a parent?
- What do you think the nurse is there for – her role
- Do you think the child health nurse is an expert? (in what)
- What value do you give the information the nurse gives you against information from other sources?

- What do you do if the nurse tells you something that differs from what you are doing or what you think?
- How do you find the centre itself (building etc)?
- Are you always the one to take the baby? Why is that?
- Why have you kept coming?

The observed visit

Tell me about this visit with the nurse *How do you think it went?*

- Was there something you wanted to say but didn't? Why not?
- How did you feel about the visit before you went and after wards? Why

Questions I have about the interaction.

Is there anything you'd like to say

Thank you

Appendix 7

Parent Demographic data

- Age
- Names and ages of children
- Marital/Partner status
- Occupation
- Income
- Level of education
- How long lived in this area

APPENDIX 8
Observation chart

Date

Note: Acts objects space feelings what where how

Time/topic	Nurse	Mother	Child/ren	Father	

Can You Help?

I am a student at the University of Tasmania and I would like to find out from parents who have a Health Care Card

What is important for you bringing up children?

What is it like to be a mother or father today?

This will help others to understand from **your point of view** so **services** offered to families will be **what you need**

What's involved?

I would like to watch and audio record your visit with the Family and Child Health Nurse and later talk to you about being a mother or father

The information sheet explains more, please take one.

If you are able to help me please tell your nurse
Or you can text or phone me Marie Shepherd on
0400 302 055

Thank you

REFERENCES

- Abbott, P. and R. Sapsford (1990) Health visiting: policing the family? In: P Abbott & C Wallace (eds.) *The Sociology of the Caring Professions*. Basingstoke: Falmer Press.
- Abel-Smith, B. (1960) *A History of the Nursing Profession*. London: Heinemann.
- Abrams, L. and L. Curran (2011) 'Maternal identity negotiations among low-income women with symptoms of postpartum depression'. *Qualitative Health Research* 21(3): 373-385.
- Allen, D. and P. Hardin (2001) 'Discourse analysis and the epidemiology of meaning'. *Nursing Philosophy* 2(2): 163-176.
- American Academy of Pediatrics (2005) 'Policy Statement Breastfeeding and the use of Human Milk'. *Pediatrics* 115(2): 496-506.
- American Academy of Pediatrics (2012) 'Breastfeeding and the use of human milk'. *Pediatrics* 129(3): e827-e841.
- Amir, L. and S. Donath (2008) 'Socioeconomic status and rates of breastfeeding in Australia: evidence from three recent national health surveys'. *Medical Journal of Australia* 189: 254-256.
- Andrews, T. (2006) 'Conflicting public health discourses - tensions and dilemmas in practice: The case of the Norwegian mother and child health service'. *Critical Public Health* 16(3): 191-204.
- Angen, M. J. (2000) 'Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue'. *Qualitative Health Research* 10(3): 378-395.
- Angrosino, M. (2008) Recontextualizing observation: ethnography, pedagogy, and the prospects for a progressive political agenda. In: Norman Denzin & Yvonna Lincoln (eds.) *Collecting and Interpreting Qualitative Materials*. 3 edn. Thousand Oaks: Sage Publications.
- Apple, R. (1995) 'Constructing mothers: Scientific motherhood in the nineteenth and twentieth centuries'. *The Social History of Medicine* 8(2): 161-178.
- Arendell, T. (1999) Hegemonic Motherhood: Deviancy discourses and employed mothers' accounts of out-of-school time issues. Working paper No, 9. In. University of California, Berkeley: University of California.
- Arendell, T. (2000) 'Conceiving and investigating motherhood: The decade's scholarship'. *Journal of Marriage and the Family* 62(4): 1192-1207.
- Armstrong, D. (1983) 'The fabrication of nurse-patient relationships'. *Social Science & Medicine* 17(8): 457-460.
- Armstrong, D. (1995) 'The rise of surveillance medicine'. *Sociology of Health and Illness* 17(3): 393-404.
- Armstrong, N. and E. Murphy (2012) 'Conceptualising resistance'. *Health* 16(3): 314-326.
- Arribas-Ayllon, M. and A. Bartlett (2014) 'Sociological ambivalence and the order of scientific knowledge'. *Sociology* 48(2): 335-351.
- Aston, M., Meagher-Stewart, N. Edwards and L. Young (2009) 'Public Health Nurses' primary health care practice: Strategies for fostering citizen participation'. *Journal of Community Health Nursing* 26: 24-34.
- Aston, M., D. Meagher-Stewart, D. Sheppard-Lemoine, A. Vukic and A. Chircop (2006) 'Family health nursing and empowering relationships'. *Pediatric Nursing* 32(1): 61-67.
- Atkinson, P. and A. Coffey (2002) Revisiting the relationship between participant observation and interviewing. In: Jaber F Gubrium & James A Holstein (eds.) *Handbook of Interview Research: Context and Method*. Thousand Oaks: Sage Publications.
- Australian Breastfeeding Association. 2014. <https://www.breastfeeding.asn.au/bf-info/your-baby-arrives/breastfeeding-faqs> [Online].

- Baggens, C. (2001) 'What they talk about: conversations between child health centre nurses and parents'. *Journal of Advanced Nursing* 36(5): 659-667.
- Baggens, C. (2002) 'Nurses' work with empowerment during encounters with families in healthcare'. *Critical Public Health* 12(4): 351-363.
- Barnes, M., M. Courtney, J. Pratt and A. Walsh (2003) 'Contemporary child health nursing practice: services provided and challenges faced in metropolitan and outer Brisbane areas'. *Collegian* 10(4): 14-19.
- Bartick, M. (2013) 'Breastfeeding and health: A review of the evidence'. *Journal of Women, Politics and Policy* 34: 317-329.
- Bartlett, A. (2004) 'Black breasts, white milk? Ways of constructing breastfeeding and race in Australia'. *Australian Feminist Studies* 19(45): 341-355.
- Barton, S. (2001) 'Infant feeding practices of low-income rural mothers'. *The American Journal of Maternal Child Nursing* 26(2): 93-97.
- Beck, U. (1999) *World Risk Society*. Cambridge: Polity Press.
- Bell, L. and L. Nutt (2002) Divided loyalties: Research ethics, professional and occupational responsibilities. In: Melanie Mauthner, Maxine Birch, Julie Jessop & Tina Miller (eds.) *Ethics in Qualitative Research*. London: Sage Publications.
- Belle, M.-J. (2013) 'Professional practice in contested territory: Child health nurses and maternal sadness'. *Contemporary Nurse* 43(2): 152-161.
- Benner, P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo-Park CA: Addison-Wesley.
- Benner, P., C. Tanner and C. Chesla (2009) *Expertise in Nursing Practice: Caring, Clinical Judgment, and Ethics Second Edition*. New York: Springer Publishing Company.
- Bentham, J. (1843) *The Works of Jeremy Bentham Vol IV*. Edinburgh: William Tait.
- Bentley, M., L. Gavin, M. Black and L. Teti (1999) 'Infant feeding practices of low-income, African-American, adolescent mothers: an ecological, multigenerational perspective'. *Social Science & Medicine*. 49(8): 1085-1100.
- Bishop, E. and M. Shepherd (2011) 'Ethical reflections: examining reflexivity through the narrative paradigm'. *Qualitative Health Research* 21(9): 1283-1294.
- Blaxland, M. (2010) Mothers and mutual obligation: policy reforming the good mother. In: Susan Goodwin & Kate Huppatz (eds.) *The Good Mother: Contemporary Motherhoods in Australia*. Sydney: Sydney University Press.
- Bloor, M. and J. McIntosh (1990) Surveillance and concealment: a comparison of techniques of client resistance in therapeutic communities and health visiting. In: Sarah Cunningham-Burley & Neil McKeaganey (eds.) *Readings in Medical Sociology*. London: Tavistock/Routledge.
- Borrow, S., A. Munns and S. Henderson (2011) 'Community-based child health nurses: An exploration of current practice'. *Contemporary Nurse* 40(1): 71-86.
- Bowen, G. (2008) 'Naturalistic inquiry and the saturation concept: a research note'. *Qualitative Research* 8(1): 137-152.
- Bowns, I. R., D. J. Crofts, T. S. Williams, A. S. Rigby, D. M. Hall and R. P. Haining (2000) 'Levels of satisfaction of 'low-risk' mothers with their current health visiting service'. *Journal of Advanced Nursing* 31(4): 805-811.
- Bradbury-Jones, C., S. Sambrook and F. Irvine (2008) 'Power and empowerment in nursing: a fourth theoretical approach'. *Journal of Advanced Nursing* 62(2): 258-266.
- Breheny, M. and C. Stephens (2007) 'Irreconcilable differences: Health professionals' constructions of adolescence and motherhood'. *Social Science and Medicine* 64: 112-124.
- Breheny, M. and C. Stephens (2009) 'A life of ease and immorality: Health professionals' constructions of mothering on welfare'. *Journal of Community & Applied Social Psychology* 19: 257-270.
- Brennan, S. (1995) *Nurses and constructions of motherhood: 'scientific motherhood' and the rise of the child welfare services in Tasmania 1918-1930*. Masters, University of Tasmania.

- Brennan, S. (1998) 'Nursing and motherhood constructions: implications for practice'. *Nursing Inquiry* 5(1): 11-17.
- Bridges, J., C. Nicholson, J. Maben, C. Pope, M. Flatley, C. Wilkinson, J. Meyer and M. Tziggili (2013) 'Capacity for care: meta-ethnography of acute care nurses' experiences of the nurse-patient relationship'. *Journal of Advanced Nursing* 69(4): 760-772.
- Briggs, C. (2007) 'Nursing practice in community child health: Developing the nurse-client relationship'. *Contemporary Nurse* 23(2): 303-311.
- Briggs, C. (2012) 'The population health approach in community child health services'. *Australian Journal of Child and Family Health Nursing* 9(2): 4.
- Brosco, J. (2001) 'Weight charts and well-child care'. *Archives of Pediatrics and Adolescent Medicine* 155: 1385-1389.
- Brown, C. E., M. A. Wickline, L. Ecoff and D. Glaser (2009) 'Nursing practice, knowledge, attitudes and perceived barriers to evidence-based practice at an academic medical center'. *Journal of Advanced Nursing* 65(2): 371-381.
- Brown, S., R. Small and J. Lumley (1997) 'Being a 'good mother''. *Journal of Reproductive and Infant Psychology* 15(2): 185-200.
- Browner, C. and N. Press (1996) 'The production of authoritative knowledge in American prenatal care'. *Medical Anthropology Quarterly* 10(2): 141-156.
- Butler, K., G. Winkworth, M. McArthur and J. Smyth (2010) *Experiences and Aspirations of Younger Mothers*. Canberra: Institute of Child Protection Studies, ACU.
- Byrd, M. (1997) 'Child-focused single home visiting'. *Public Health Nursing* 14(5): 313-322.
- Byrd, M. E. (1998) 'Long-term maternal-child home visiting'. *Public Health Nursing* 15(4): 235-242.
- Callen, J. and J. Pinelli (2004) 'Incidence and duration of breastfeeding for term infants in Canada, United States, Europe, and Australia: A literature review'. *Birth* 31(4): 285-292.
- Cannon, L., E. Higginbotham and M. Leung (1988) 'Race and class bias in qualitative research on women'. *Gender & Society* 2(4): 449-.
- Cartwright, J. and B. Limandri (1997) 'The challenge of multiple roles in the qualitative clinician researcher-participant client relationship'. *Qualitative Health Research* 7(2): 223-235.
- Cawley, T. and P. M. McNamara (2011) 'Public Health Nurse perceptions of empowerment and advocacy in child health surveillance in West Ireland'. *Public Health Nursing* 28(2): 150-158.
- Chalmers, K. (1992a) 'Giving and receiving: an empirically derived theory on health visiting practice'. *Journal of Advanced Nursing* 17: 1317-1325.
- Chalmers, K. (1992b) 'Working with men: an analysis of health visiting practice in families with young children.'. *International Journal of Nursing Studies* 29(1): 3-16.
- Chalmers, K. (1994) 'Difficult work: health visitors' work with clients in the community'. *International Journal of Nursing Studies* 31(2): 168-182.
- Chandler, G. (1992) 'The source and process of empowerment'. *Nursing Administration Quarterly* 16(3): 65-71.
- Chiarella, M. (2002) *The Legal and Professional Status of Nursing*. Edinburgh: Churchill Livingstone.
- Christopher, K. (2012) 'Extensive mothering: Employed mothers' constructions of the good mother'. *Gender and Society* 26(1): 73-96.
- Clancy, A. (2012) 'The ceremonial order of public health nursing consultations: an ethnographic study'. *Journal of Clinical Nursing* 21: 2555-2566.
- Clarke, K. (2006) 'Childhood, parenting and early intervention: A critical examination of the Sure Start national programme'. *Critical Social Policy* 26(4): 699-721.
- Clendon, J. and D. Dignam (2010) 'Child health and development record book: tool for relationship building between nurse and mother'. *Journal of Advanced Nursing* 66(5): 968-977.
- Cody, A. (1999) 'Health visiting as therapy: a phenomenological perspective'. *Journal of Advanced Nursing* 29(1): 119-127.
- Colbourne, L. and M. Sque (2004) 'Split personalities: Role conflict between the nurse and the nurse researcher'. *Nursing Times Research* 9(4): 297-304.

- Cooper, D. (1994) 'Productive, relational and everywhere? Conceptualising power and resistance within Foucauldian feminism'. *Sociology* 28(2): 435-454.
- Cowley, S. (1995) 'Health-as-process: a health visiting perspective'. *Journal of Advanced Nursing* 22: 433-441.
- Cowley, S., L. Kemp, C. Day and J. Appleton (2012) 'Research and the organisation of complex provision: conceptualising health visiting services and early years programmes'. *Journal of Research in Nursing* 17(2): 108-124.
- Cox, J., J. Holden and R. Sagovsky (1987) 'Detection of postnatal depression: development of the 10 item Edinburgh postnatal depression scale'. *British Journal of Psychiatry* 150: 782-786.
- Crotty, M. (1998) *The Foundations of Social Research: Meaning and perspective in the research process*. Sydney: Allen & Unwin.
- Cutcher, L. and T. Milroy (2010) Misrepresenting indigenous mothers: maternity allowances in the media. In: Susan Goodwin & Kate Huppatz (eds.) *The Good Mother: Contemporary Motherhoods in Australia*. Sydney: Sydney University Press.
- Danaher, G., T. Schirato and J. Webb (2000) *Understanding Foucault*. Sydney: Allen & Unwin.
- Daniel, B. and J. Taylor (1999) 'The rhetoric versus the reality: a critical perspective on practice with fathers in child care and protection work'. *Child and Family Social Work* 4: 209-220.
- Danowski, L. and L. Gargiula (2002) 'Attitudes and practices regarding the introduction of solid foods to infants'. *Family Practice* 19: 698-702.
- Davies, C. (1988) 'The Health Visitor as mother's friend: A woman's place in public health, 1900-14'. *Social History of Medicine* 1(1): 39-59.
- Davis, H. and C. Day (2010) *Working in Partnership: The Family Partnership Model*. London: Pearson.
- Davis, H., C. Day and C. Bidmead (2002) *Working in Partnership with Parents: The Parent Advisor Model*. London: Harcourt Assessment.
- Davis, L. (2005) 'A phenomenological study of patient expectations concerning nursing care'. *Holistic Nursing Practice* 19(3): 126-133.
- Day, C. (2013) 'Family Partnership Model: Connecting and working in partnership with families'. *Australian Journal of Child and Family Health Nursing* 10(1): 4-10.
- De la Cuesta, C. (1994) 'Relationships in health visiting: enabling and mediating'. *International Journal of Nursing Studies* 31(5): 451-459.
- de Souza, R. (2013) 'Who is a 'good' mother?: Moving beyond individual mothering to examine how mothers are produced historically and socially'. *Australian Journal of Child and Family Health Nursing* 10(2): 15-18.
- Deacon, D. (1980) 'Taylorism in the home: The medical profession, the infant welfare movement and the deskilling of women'. *Australian and New Zealand Journal of Sociology* 21(2): 161-171.
- Deal, L. and V. Holt (1998) 'Young maternal age and depressive symptoms: Results from the 1988 National Maternal and Infant Health Survey'. *American Journal of Public Health* 88(2): 266-270.
- Delmar, C. (2012) 'The excesses of care: a matter of understanding the asymmetry of power'. *Nursing Philosophy* 13: 236-243.
- Denzin, N. (2002) The Interpretive Process. In: A. Michael Huberman & Matthew Miles (eds.) *The Qualitative Researcher's Companion*. Thousand Oaks: Sage.
- Department of Health (2009) *Healthy Child Programme: Pregnancy and the first five years of life*. London: Department of Health. Available at: <https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life>.
- Department of Health and Human Services (2013) *Personal Health Record*. Hobart: Department of Health and Human Services.
- Department of Health and Human Services (2014) *Child Health and Parenting* http://www.dhhs.tas.gov.au/children/child_health.

- Dingwall, R. and K. Robinson (1993) Policing the family? Health visiting and the public surveillance of private behavior. In: A Beattie, Marjorie Gott, L Jones & M Sidell (eds.) *Health and Wellbeing: a reader*. London: Open University and MacMillan.
- Donath, S. and L. Amir (2000) 'Rates of breastfeeding in Australia by State and socio-economic status: Evidence from the 1995 National Health Survey'. *Journal of Paediatrics and Child Health* 36: 164-168.
- Doucet, A. (1998) 'Interpreting mother-work: linking methodology, ontology, theory and personal biography'. *Canadian Woman Studies* 18(2-3): 52-58.
- Douglas, S. and M. Michaels (2004) *The Mommy Myth: The Idealization of Motherhood and How it has Undermined all Women*. New York: Free Press.
- Dreyfus, H. and S. Dreyfus (2009) The relationship of theory and practice in the acquisition of skill. In: Patricia Benner, Christine Tanner & Catherine Chesla (eds.) *Expertise in Nursing Practice: Caring, Clinical Judgment and Ethics Second Edition*. New York: Springer Publishing Company.
- Dreyfus, H. and P. Rabinow (1982) *Michel Foucault: Beyond Structuralism and Hermeneutics*. Brighton: The Harvester Press
- Drummond, J. and L. Marcellus (2005) 'Making a difference: Using a social determinants of health approach to strengthen the role of maternal infant health nursing'. *Neonatal, Paediatric and Child Health Nursing* 8(1): 6-11.
- Durey, A., S. Thompson and M. Wood (2012) 'Time to bring down the twin towers in poor Aboriginal hospital care: addressing institutional racism and misunderstandings in communication'. *Internal Medicine Journal* 42(1): 17-22.
- Eckenrode, J., M. Campa, D. Luckey, C. Henderson, R. Cole and H. Kitzman (2010) 'Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial'. *Archives of Pediatric Adolescent Medicine* 164(1): 9-15.
- Edwards, R. and M. Mauthner (2002) Ethics and feminist research: theory and practice. In: Melanie Mauthner, Maxine Birch, Julie Jessop & Tina Miller (eds.) *Ethics in Qualitative Research*. London: Sage Publications.
- Elliott, S., R. Powell and J. Brenton (2013) 'Being a good mom: low-income, Black single mothers negotiate intensive mothering'. *Journal of Family Issues* XX(X): 1-20.
- Espezel, H. and C. Canam (2003) 'Patient-nurse interactions: care of hospitalized children'. *Journal of Advanced Nursing* 44(1): 34-41.
- Fagerskiold, A., T. Timpka and A.-C. Ek (2003) 'The view of the child health nurse among mothers'. *Scandinavian Journal of Caring Sciences* 17: 160-168.
- Falk-Rafael, A. (2001) 'Empowerment as a process of evolving consciousness: A model of empowered caring'. *Advances in Nursing Science* 24(1): 1-16.
- Finlay, L. (2002) "'Outing" the researcher: the provenance, process, and practice of reflexivity'. *Qualitative Health Research* 12(4): 531-545.
- Fontana, A. and J. Frey (2008) The interview: from neutral stance to political involvement. In: Norman Denzin & Yvonna Lincoln (eds.) *Collecting and Interpreting Qualitative Materials*. 3 edn. Thousand Oaks: Sage Publications.
- Foster, M.-C. and B. Mayall (1990) 'Health visitors as educators'. *Journal of Advanced Nursing* 15: 286-292.
- Foster, V. (2009) 'Authentic representation? Using video as counter-hegemony in participatory research with poor working-class women'. *International Journal of Multiple Research Approaches* 3(3): 233-245.
- Foucault, M. (1977) *Discipline and Punish: The Birth of the Prison*. Trans. A. Sheridan. New York: Pantheon Books.
- Foucault, M. (1980a) The eye of power. In: C Gordon (ed.) *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. New York: Pantheon Books.
- Foucault, M. (1980b) Truth and Power. In: Colin Gordon (ed.) *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. New York: Pantheon Books.

- Foucault, M. (1980c) Two lectures. In: Colin Gordon (ed.) *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. New York: Pantheon.
- Foucault, M. (1982) The subject and power. In: Hubert Dreyfus & Paul Rabinow (eds.) *Michel Foucault: Beyond Structuralism and Hermeneutics*. p. 208-226. Brighton: The Harvester Press.
- Foucault, M. (1988) Technologies of the Self. In: Luther Martin, Huck Gutman & Patrick Hutton (eds.) *Technologies of the Self: A Seminar with Michel Foucault*. Amherst: The University of Massachusetts.
- Foucault, M. (1990) *The History of Sexuality: Volume One An Introduction*. Trans. Robert Hurley. London: Penguin Books.
- Foucault, M. (1991a) *Discipline and Punish: The Birth of the Prison*. London: Penguin Books.
- Foucault, M. (1991b) The means of correct training. In: Paul Rabinow (ed.) *The Foucault Reader*. London: Penguin Books.
- Foucault, M. (1991c) Space, knowledge and power. In: Paul Rabinow (ed.) *The Foucault Reader*. London: Penguin Books.
- Foucault, M. (1995) *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books.
- Fowler, C. (2000) *Producing the new mother: surveillance, normalisation and maternal learning*. PhD thesis, University of Technology, Sydney.
- Francesconi, M. (2008) 'Adult outcomes for children of teenage mothers'. *The Scandinavian Journal of Economics* 110(1): 93-117.
- Fredriksen, A., A. Lyberg and E. Severinsson (2012) 'Health supervision of young women during pregnancy and early motherhood: A Norwegian qualitative study'. *Nursing and Health Sciences* 14(3): 325-331.
- Gastaldo, D. (1997) Is health education good for you? Re-thinking health education through the concept of bio-power. In: Alan Petersen & Robin Bunton (eds.) *Foucault, Health and Medicine*. London: Routledge.
- Giglia, R., C. Binns, H. Alfonso, J. Scott and W. Oddy (2008) 'The effect of alcohol intake on breastfeeding duration in Australian women'. *Acta Paediatrica* 97(5): 624-629.
- Gilbert, T. (1995) 'Nursing: empowerment and the problem of power'. *Journal of Advanced Nursing* 21: 865-871.
- Gillies, V. (2005a) 'Meeting parents' needs? Discourses of 'support' and 'inclusion' in family policy'. *Critical Social Policy* 25(1): 70-90.
- Gillies, V. (2005b) 'Raising the 'meritocracy': Parenting and the individualization of social class'. *Sociology* 39(5): 835-853.
- Gillies, V. (2007) *Marginalised Mothers: Exploring Working-Class Experiences of Parenting*. Milton Park: Routledge.
- Goldfeld, S., M. Wright and F. Oberklaid (2003) 'Parents, infants and health care: Utilization of health services in the first 12 months of life'. *Journal of Paediatrics and Child Health* 39(4): 249-253.
- Goodwin, S. and K. Huppatz (2010a) The good mother in theory and research: an overview. In: Susan Goodwin & Kate Huppatz (eds.) *The Good Mother: Contemporary Motherhoods in Australia*. Sydney: Sydney University Press.
- Goodwin, S. and K. Huppatz (eds.) (2010b) *The Good Mother: Contemporary Motherhoods in Australia*. Sydney: Sydney University Press.
- Gordon, S. (2006) The new Cartesianism. In: Sioban Nelson & Suzanne Gordon (eds.) *The Complexities of Care: Nursing Reconsidered*. New York: Cornell University Press.
- Gore, J. (1993) *The Struggle for Pedagogies: Critical and Feminist Discourses as Regimes of Truth*. New York: Routledge.
- Graham, H. and E. McDermott (2006) 'Qualitative research and the evidence base of policy: insights from studies of teenage mothers in the UK'. *Journal of Social Policy* 35(1): 21-37.

- Grant, J. (2012) 'Between a rock and a hard place: managing professional practice alongside organisational directives in child and family health nursing'. *Australian Journal of Child and Family Health Nursing* 9(2): 9-17.
- Grant, J. and Y. Luxford (2011) 'Culture it's a big term isn't it? An analysis of child and family health nurses' understandings of culture and intercultural communication'. *Health Sociology Review* 20(1): 16-27.
- Gray, D. (2004) *Doing Research in the Real World*. London: Sage Publications.
- Grossman, J. and F. Mackenzie (2005) 'The Randomized Controlled Trial: gold standard, or merely standard?'. *Perspectives in Biology and Medicine* 48(4): 516-534.
- Guest, G., A. Bunce and L. Johnson (2006) 'How many interviews are enough?: An experiment with data saturation and variability'. *Field Methods* 18(1): 59-82.
- Guttman, N. and D. Zimmerman (2000) 'Low-income mothers' views on breastfeeding'. *Social Science & Medicine* 50: 1457-1473.
- Hagell, E. (1989) 'Nursing knowledge: women's knowledge. A sociological perspective'. *Journal of Advanced Nursing* 14(3): 226-233.
- Hall, A. (2005) 'Defining nursing knowledge'. *Nursing Times* 101(48): 34.
- Hanna, B. (2001) 'Negotiating motherhood: the struggles of teenage mothers'. *Journal of Advanced Nursing* 34(4): 456-464.
- Hansen, E. C. (2006) *Successful Qualitative Health Research*. Crows Nest NSW: Allen & Unwin.
- Hausman, B. (2013) 'Breastfeeding, rhetoric, and the politics of feminism'. *Journal of Women, Politics and Policy* 34: 330-344.
- Hausman, B. L. (2004) 'The Feminist Politics of Breastfeeding'. *Australian Feminist Studies* 19(45): 273-285.
- Hays, S. (1996) *The Cultural Contradictions of Motherhood*. New Haven: Yale University Press.
- Hayter, M. (2006) 'Productive power and the 'practices of the self' in contraceptive counselling'. *Nursing Inquiry* 13(1): 33-43.
- Heinig, M., K. Ishii, J. Bañuelos, E. Campbell, C. O'Loughlin, L. Elvia and V. Becerra (2009) 'Sources and Acceptance of Infant-Feeding Advice Among Low-Income Women'. *Journal of Human Lactation* 25(2): 163-172.
- Heritage, J. and S. Sefi (1992) Dilemmas of advice: aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. In: Paul Drew & John Heritage (eds.) *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press.
- Hertz, R. (1996) 'Introduction: ethics, reflexivity and voice'. *Qualitative Sociology* 19(1): 3-9.
- Hewison, A. (1995) 'Nurses' power in interactions with patients'. *Journal of Advanced Nursing* 21: 75-82.
- Holmes, D. and D. Gastaldo (2002) 'Nursing as means of governmentality'. *Journal of Advanced Nursing* 38(6): 557-565.
- Holstein, J. and J. Gubrium (2005) Interpretive practice and social action. In: Norman Denzin & Yvonna Lincoln (eds.) *The Sage Handbook of Qualitative Research 3rd Edition*. Thousand Oaks: Sage Publications.
- Houston, A. M. and S. Cowley (2002) 'An empowerment approach to needs assessment in health visiting practice'. *Journal of Clinical Nursing* 11: 640-650.
- Hutchinson, D., E. Moore, C. Breen, L. Burns and R. Mattick (2013) 'Alcohol use in pregnancy: Prevalence and predictors in the Longitudinal Study of Australian Children '. *Drug and Alcohol Review* 32(5): 475-482.
- Ip, S., M. Chung, G. Raman, P. Chew, N. Magula, D. DeVine, T. Trikalinos and J. Lau (2007) *Breastfeeding and Maternal and Infant Health Outcomes in Developed Countries*. Evidence Report/Technology Assessment (Report 153). Rockville, MD: Agency for Healthcare Research and Quality.

- Jaffee, S., A. Caspi, T. Moffitt, J. Belsky and P. Silva (2001) 'Why are children born to teen mothers at risk for adverse outcomes in young adulthood? Results from a 20-year longitudinal study'. *Development and Psychopathology* 13(02): 377-397.
- James, N. (1992) 'Care = organisation + physical labour + emotional labour'. *Sociology of Health and Illness* 14(4): 488-507.
- Jamrozik, A. and T. Sweeney (1996) *Children and Society: The Family, the State and Social Parenthood*. Melbourne: MacMillan Education.
- Johnston, D. and D. Swanson (2004) 'Moms hating moms: The internalization of mother war rhetoric'. *Sex Roles* 51(9/10): 497-509.
- Johnston, D. and D. Swanson (2006) 'Constructing the "Good Mother": The experience of mothering ideologies by work status'. *Sex Roles* 54: 509-519.
- Jonsdottir, H., M. Litchfield and M. D. Pharris (2004) 'The relational core of nursing practice as partnership'. *Journal of Advanced Nursing* 47(3): 241-250.
- Kaplan, G., A. Goodman and I. Walker (2004) *Understanding the Effects of Early Motherhood in Britain: The Effects on Mothers*. Working Paper. Coventry: University of Warwick, Department of Economics. (Warwick economic research papers).
- Kaptchuk, T. (2001) 'The double-blind, randomized, placebo-controlled trial: Gold standard of golden calf?'. *Journal of Clinical Epidemiology* 54(6): 541-549.
- Keleher, H. (1998) Nurses in public health history. In: Helen Keleher & Fran Mcinerney (eds.) *Nursing Matters: Critical Sociological Perspectives*. Marrickville, NSW: Churchill Livingstone.
- Keleher, H. (2000) 'Repeating history? Public and community health nursing in Australia'. *Nursing Inquiry* 7(4): 258-265.
- Kellehear, A. (1993) *The Unobtrusive Researcher: A guide to methods*. Sydney: Allen & Unwin.
- Kelly, B. (1977) *A Background to the History of Nursing in Tasmania*. Hobart: Davies Brothers.
- Kemp, L., E. Harris, C. McMahon, S. Matthey, G. Vimpani, T. Anderson, V. Schmied and H. Aslam (2013) 'Benefits of psychosocial intervention and continuity of care by child and family health nurses in the pre- and postnatal period: process evaluation. '. *Journal of Advanced Nursing* 69(8): 1850-61.
- Kemp, L., E. Harris, C. McMahon, S. Matthey, G. Vimpani, T. Anderson, V. Schmied, H. Aslam and S. Zapart (2011) 'Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial'. *Archives of Disease in Children* 96: 533-540.
- Kendall, S. (1993) 'Do health visitors promote client participation? An analysis of the health visitor-client interaction'. *Journal of Clinical Nursing* 2: 103-109.
- Knaak, S. (2010) 'Contextualising risk, constructing choice: Breastfeeding and good mothering in risk society'. *Health, Risk & Society* 12(4): 345-355.
- Knapman, C. (1993) 'Reconstructing mothering: Feminism and the Early Childhood Centre'. *Australian Feminist Studies* 18(Summer): 111-131.
- Knott, M. and S. Latter (1999) 'Help or hindrance? Single, unsupported mothers' perspectives of health visiting'. *Journal of Advanced Nursing* 30(3): 580-588.
- Kulbok, P. and N. Ervin (2012) 'Nursing science and public health: Contributions to the discipline of nursing'. *Nursing Science Quarterly* 25(1): 37-43.
- Kuokkanen, L. and H. Leino-Kilpi (2000) 'Power and empowerment in nursing: three theoretical approaches'. *Journal of Advanced Nursing* 31(1): 235-241.
- Lamont, A. and L. Bromfield (2009) *Parental Intellectual Disability and Child Protection: Key Issues*. Melbourne: National Child Protection Clearinghouse, Australian Institute of Family Studies No: 31 2009.
- .
- Landy, C. K., w. Sword and R. Valaitis (2009) 'The experiences of socioeconomically disadvantaged postpartum women in the first 4 weeks at home'. *Qualitative Health Research* 19(2): 194-206.

- Lawler, J. (1991) *Behind the Screens: Nursing, Somology, and the Problem of the Body*. Melbourne: Churchill Livingstone.
- Lee, E. (2008) 'Living with risk in the age of 'intensive motherhood': Maternal identity and infant feeding'. *health, Risk & Society* 10(5): 467-477.
- Lee, E. and F. Furedi (2005) *Mothers' Experience of, and Attitudes to, Using Infant Formula in the Early Months*. Kent: School of Social Policy, Sociology and Social Research, University of Kent.
- Liamputtong, P. and D. Ezzy (2005) *Qualitative Research Methods. 2nd edn*. Melbourne: Oxford University Press.
- Luker, K., L. Austin, A. Caress and C. Hallett (2000) 'The importance of 'knowing the patient': community nurses' constructions of quality in providing palliative care'. *Journal of Advanced Nursing* 31(4): 775-782.
- Lupton, D. (1997) Foucault and the medicalisation critique. In: Alan Peterson & Robin Bunton (eds.) *Foucault Health and Medicine*. London: Routledge.
- Lupton, D. (2000) 'A love/hate relationship': the ideals and experiences of first-time mothers'. *Journal of Sociology* 36(1): 50-63.
- Lupton, D. (2011) 'The best thing for baby': Mothers' concepts and experiences related to promoting their infants' health and development'. *Health, Risk & Society* 13(7-8): 637-651.
- Lupton, D. (2012) *Medicine as Culture: Illness, Disease and the Body*. London: Sage Publications.
- Lupton, D. and J. Fenwick (2001) 'They've forgotten that I'm the mum': constructing and practising motherhood in special care nurseries'. *Social Science & Medicine* 53: 1011-1021.
- Machin, A., T. Machin and P. Pearson (2011) 'Maintaining equilibrium in professional role identity: a grounded theory study of health visitors' perceptions of their changing professional practice context'. *Journal of Advanced Nursing* 68(7): 1526-1537.
- Madsen, W. (2007) *Nursing History: Foundations of a Profession 2nd Edition*. Frenchs Forest, NSW: Pearson-SprintPrint.
- Maher, J. (2005) 'A mother by trade: Australian women reflecting mothering as activity, not identity'. *Australian Feminist Studies* 20(46): 17-29.
- Maher, J. and L. Saugeres (2007) 'To be or not to be a mother? Women negotiating cultural representations of mothering'. *Journal of Sociology* 43(1): 5-21.
- Malcrida, C. (2009) 'Performing motherhood in a disablist world: dilemmas of motherhood, femininity and disability'. *International Journal of Qualitative Studies in Education* 22(1): 99-117.
- Manne, A. (2005) *Motherhood. How should we care for our children?* Crows Nest NSW: Allen & Unwin.
- Manojlovich, M. (2007) 'Power and empowerment in nursing: looking backward to inform the future'. *OJIN: The Online Journal of Issues in Nursing* 12(1): Manuscript 1.
- Marcellus, L. (2005) 'The ethics of relation: public health nurses and child protection clients'. *Journal of Advanced Nursing* 51(4): 414-420.
- Marshall, J., M. Godfrey and M. Renfrew (2007) 'Being a 'good mother': Managing breastfeeding and merging identities'. *Social Science & Medicine* 65: 2147-2159.
- Mason, M. (2010) 'Sample size and saturation in PhD studies using qualitative interviews'. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* 11(3): Art. 8.
- Maushart, S. (1997) *The mask of motherhood: How mothering changes everything and why we pretend it doesn't*. Sydney: Vintage.
- Mauthner, N. and A. Doucet (2003) 'Reflexive accounts and accounts of reflexivity in qualitative data analysis'. *Sociology* 37(3): 413-431.
- May, C. (1992a) 'Individual care? Power and subjectivity in therapeutic relationships'. *Sociology* 26(4): 589-602.
- May, C. (1992b) 'Nursing work, nurses' knowledge, and the subjectification of the patient'. *Sociology of Health and Illness* 14(4): 472-487.

- Mayall, B. (1990) 'The division of labour in early child care - mothers and others'. *Journal of Social Policy* 19(3): 299-330.
- Mayeroff, M. (1971) *On Caring*. New York: Harper & Row, Publishers.
- McCabe, J. and D. Holmes (2009) 'Reflexivity, critical qualitative research and emancipation: a Foucauldian perspective'. *Journal of Advanced Nursing* 65(7): 1518-1526.
- McCain, M. and J. Mustard (1999) *Early years study: Reversing the real brain drain*. Toronto: Canadian Institute for Advanced Research.
- McCallum, S., H. Rowe, L. Gurrin, J. Quinlivan, D. Rosenthal and J. Fisher (2011) 'Unsettled infant behaviour and health service use: A cross-sectional community survey in Melbourne, Australia'. *Journal of Paediatrics and Child Health* 47(11): 818-823.
- McCorkel, J. and K. Myers (2003) 'What difference does difference make? Position and privilege in the field'. *Qualitative Sociology* 26(2): 199-231.
- McDermott, E. and H. Graham (2005) 'Resilient young mothering: social inequalities, late modernity and the 'problem' of 'teenage' motherhood'. *Journal of Youth Studies* 8(1): 59-79.
- McEvoy, P. (2001) 'Interviewing colleagues: addressing the issues of perspective, inquiry and representation'. *Nurse Researcher* 9(2): 49-59.
- McHugh, M. and E. Lake (2010) 'Understanding clinical expertise: Nurse education, experience, and the hospital context'. *Research in Nursing and Health* 33(4): 276-287.
- McKenna, J., H. Ball and L. Gettler (2007) 'Mother-infant cosleeping, breastfeeding and Sudden Infant Death Syndrome: What biological anthropology has discovered about normal infant sleep and pediatric sleep medicine'. *Yearbook of Physical Anthropology* 50: 133-161.
- McNair, R., A. Taft and K. Hegarty (2008) 'Using reflexivity to enhance in-depth interviewing skills for the clinician researcher'. *BMC Medical Research Methodology* 8(73).
- McNaughton, D. (2000) 'A synthesis of qualitative home visiting research'. *Public Health Nursing* 17(6): 405-414.
- Mein Smith, P. (1997) *Mothers and King Baby: Infant Survival and Welfare in an Imperial World: Australia 1880-1950*. London: Macmillan Press.
- Miller, T. (2005) *Making Sense of Motherhood: A narrative approach*. Cambridge: Cambridge University Press.
- Miller, T. (2007) "'Is this what motherhood is all about?" Weaving experiences and discourse through transition to first-time motherhood'. *Gender & Society* 21(3): 337-358.
- Mitcheson, J. and S. Cowley (2003) 'Empowerment or control? An analysis of the extent to which client participation is enabled during health visitor/client interactions using a structured health needs assessment tool'. *International Journal of Nursing Studies* 40: 413-426.
- Mollidore, C. M. (2013) *"I Deserve Respect Because I'm a Good Mum". Social Representations of Teenage Motherhood and the Potential for Social Change*. PhD Thesis, London: London School of Economics and Political Science.
- Moore, J. and L. Riley (2010) Aboriginal mother yarns. In: Susan Goodwin & Kate Huppatz (eds.) *The Good Mother: Contemporary Motherhoods in Australia*. Sydney: Sydney University Press.
- Morse, J. (2000) 'Determining sample size'. *Qualitative Health Research* 10(3): 3-5.
- Mulholland, J. (1995) 'Nursing, humanism and transcultural theory: the 'bracketing-out' of reality'. *Journal of Advanced Nursing* 22: 442-449.
- Murphy, E. (1999) 'Breast is best': Infant feeding decisions and maternal deviance'. *Sociology of Health and Illness* 21(2): 187-208.
- Murphy, E. (2003) 'Expertise and forms of knowledge in the government of families'. *The Sociological Review* 51(4): 433-462.
- Murphy, E., S. Parker and C. Phipps (1998) 'Competing agendas in infant feeding'. *British Food Journal* 100(3): 128-132.
- NHMRC (2009) *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*. Canberra: National Health and Medical Research Council.
- NHMRC (2012) *Infant Feeding Guidelines* Canberra: National Health and Medical Research Council.

- NHMRC (2013) *Infant Feeding Guidelines: Summary*. Canberra: National Health and Medical Research Council.
- Normandale, S. (2001) 'A study of mothers' perceptions of the health visiting role'. *Community Practitioner* 74(4): 146-150.
- O'Connor, K. (1989) *Our Babies, the State's Best Asset: A History of 75 Years of Baby Health Services in New South Wales*. Sydney: NSW Department of Health.
- O'Leary, C., L. Heuzenroeder, E. Elliott and C. Bower (2007) 'A review of policies on alcohol use during pregnancy in Australia and other English-speaking countries, 2006'. *Medical Journal of Australia* 186(9): 466-471.
- Oakley, A. (1979) *Becoming a Mother*. Oxford: Martin Robertson.
- Oakley, A. (1981) Interviewing women: a contradiction in terms. In: Helen Roberts (ed.) *Doing feminist research*. London: Routledge and Kegan Paul
- Olds, D. (2006) 'The nurse-family partnership: an evidence-based preventive intervention'. *Infant Mental Health Journal* 27(1): 5-25.
- Olds, D., H. Kitzman, R. Cole, C. Hanks, K. Arcoleo, E. Anson, D. Luckey, M. Knudtson, C. Henderson, J. Bondy and A. Stevenson (2010) 'Enduring effects of prenatal and infancy home visiting by nurses on maternal life course and government spending: follow-up of a randomized trial among children at age 12 years'. *Archives of Pediatric Adolescent Medicine* 164(5): 419-424.
- Osborne, R. (2004) 'The story of child and family health nursing: Registered nurses working with families to improve the outcome of infants and children'. *CAFHNA Journal* 15(2): 3-7.
- Paterson, J. and L. Zderad (1976) *Humanistic Nursing*. New York: Wiley.
- Paterson, J. and L. Zderad (2008) *Humanistic Nursing*. Project Gutenberg eBook <http://www.gutenberg.org/files/25020/25020-8.txt>
- Pearson, A. (1991) Taking up the challenge: the future for therapeutic nursing. In: Richard McMahon & Alan Pearson (eds.) *Nursing as Therapy*. London: Chapman & Hall.
- Peckover, S. (2002) 'Supporting and policing mothers: an analysis of the disciplinary practices of health visiting'. *Journal of Advanced Nursing* 38(4): 369-377.
- Perron, A., C. Fluet and D. Holmes (2005) 'Agents of care and agents of the state: bio-power and nursing practice'. *Journal of Advanced Nursing* 50(5): 536-544.
- Peräkylä, A. (2006) Observation, video and ethnography: case studies in Aids counselling and greetings. In: Paul Drew, Godfrey Raymond & Darin Weinberg (eds.) *Talk and Interaction in Social Research Methods*. London: Sage Publications.
- Petersen, A. and D. Lupton (1996) *The New Public Health: Health and Self in the Age of Risk*. Sydney: Allen & Unwin.
- Phillips, J. (2007) *Care*. Cambridge: Polity Press.
- Phoenix, A. (1991) Mothers under 20: outsider and insider views. In: Ann Phoenix, Anne Woollett & Eva Lloyd (eds.) *Motherhood: Meanings, Practices and Ideologies*. London: SAGE.
- Platt, J. (1981) 'On Interviewing One's Peers'. *British Journal of Sociology* 32(1): 75-91.
- Pocock, B. (2003) *The Work/Life Collision: What work is doing to Australians and what to do about it*. Sydney: The Federation Press.
- Polanyi, M. (1967) *The Tacit Dimension*. New York: Anchor Books.
- Porr, C., J. Drummond and K. Olson (2012) 'Establishing therapeutic relationships with vulnerable and potentially stigmatized clients'. *Qualitative Health Research* 22(3): 384-396.
- Powers, P. (2003) 'Empowerment as treatment and the role of health professionals'. *Advances in Nursing Science* 26(3): 227-237.
- Pritchard, J. (2005) 'Strengthening women's health visiting work with women'. *Journal of Advanced Nursing* 51(3): 236-244.
- Quinlivan, J., H. Box and S. Evans (2003) 'Postnatal home visits in teenage mothers: a randomised controlled trial'. *The Lancet* 361: 893-900.
- Rafael, A. (1996) 'Power and caring: A dialectic in nursing'. *Advances in Nursing Science* 19(1): 3-17.

- Raftery, J. (1996) Saving South Australia's babies: the Mothers' and Babies' Health Association. In: Bernard O'neil, Judith Raftery & Kerrie Round (eds.) *Playford's South Australia: Essays on the history of South Australia, 1933-1968*. Adelaide: Association of Professional Historians SA.
- Rao, A. (2012) 'The contemporary construction of nurse empowerment'. *Journal of Nursing Scholarship* 44(4): 396-402.
- Rautio, S. (2012) 'Parents' experiences of early support'. *Scandinavian Journal of Caring Sciences* 27(4): 927-934.
- Reeves, J. (2006) 'Recklessness, rescue and responsibility: young men tell their stories of the transition to fatherhood'. *Practice* 18(2): 79-90.
- Reiger, K. (1985) *The Disenchantment of the Home: Modernizing the Australian Family 1880-1940*. Melbourne: Oxford University Press.
- Reiger, K. (1991a) *Family Economy*. Ringwood, Vic.: McPhee Gribble.
- Reiger, K. (1991b) Motherhood ideology. In: Wendy Weeks & John Wilson (eds.) *Issues Facing Australian Families Second Edition*. Melbourne: Addison Wesley Longman Australia.
- Reverby, S. (1987) *Ordered to Care: The Dilemma of American Nursing, 1850-1945*. Cambridge: Cambridge University Press.
- Richards, L. (2005) *Handling Qualitative Data: A Practical Guide*. London: SAGE Publications.
- Ritchie, L. (2009) 'Wearing two hats: interviewing older people as a nurse researcher'. *Medical Sociology* 4(1): 14-24.
- Ritson, R. (1997) 'The birth of the baby clinic'. *Transition* 54(55): 42-53.
- Roche, B., S. Cowley, N. Salt, A. Scammell, M. Malone, P. Savile, D. Aikens and S. Fitzpatrick (2005) 'Reassurance or judgement? Parents' views on the delivery of child health surveillance programmes'. *Family Practice* 22(5): 507-512.
- Rollans, M., V. Schmied, L. Kemp and T. Meade (2013) 'Negotiating policy in practice: child and family health nurses' approach to the process of postnatal psychosocial assessment'. *BMC Health Services Research* 13(133): 1-13.
- Romagnoli, A. and G. Wall (2012) 'I know I'm a good mom': Young, low-income mothers' experiences with risk perception, intensive parenting ideology and parenting education programmes'. *Health Risk & Society* 14(3): 273-289.
- Rose, G. (1997) 'Situating knowledges: positionality, reflexivities and other tactics'. *Progress in Human Geography* 21(3): 305-320.
- Rose, N. (1993) 'Government, authority and expertise in advanced liberalism'. *Economy and Society* 22(3): 283-299.
- Rose, N. (1999) *Powers of Freedom: Reframing Political Thought*. Cambridge: Cambridge University Press.
- Russell, S. and V. Drennan (2007) 'Mothers' views of the health visiting service in the UK: a web-based survey'. *Community Practitioner* 80(8): 22-27.
- Ryles, S. (1999) 'A concept analysis of empowerment: its relationship to mental health nursing'. *Journal of Advanced Nursing* 29(3): 600-607.
- Sandelowski, M. (1995) 'Sample size in qualitative research'. *Research in Nursing and Health* 18(2): 179-183.
- Sawyer, M., J. Barnes, L. Frost, D. Jeffs and K. Bowering, Lynch, John (2013) 'Nurse perceptions of family home-visiting programmes in Australia and England'. *Journal of Paediatrics and Child Health* 49: 369-374.
- Sayal, K., E. Draper, R. Fraser, M. Barrow, G. Smith and R. Gray (2013) 'Light drinking in pregnancy and mid-childhood mental health and learning outcomes'. *Archives of Disease in Childhood* 98: 107-111.
- Schmied, V., J. Donovan, S. Kruske, L. Kemp, C. Homer and C. Fowler (2011) 'Commonalities and challenges: A review of Australian state and territory maternity and child health policies'. *Contemporary Nurse* 40(1): 106-117.

- Schmied, V., C. Fowler, C. Rossiter, C. Homer, S. Kruske and The CHoRUS team (2014) 'Nature and frequency of services provided by child and family health nurses in Australia: results of a national survey'. *Australian Health Review* 38: 177-185.
- Schmied, V. and D. Lupton (2001) 'Blurring the boundaries: breastfeeding and maternal subjectivity'. *Sociology of Health and Illness* 23(2): 234-250.
- Schwandt, T. (2003) Three epistemological stances for qualitative inquiry: interpretivism, hermeneutics, and social constructionism. In: Norman Denzin & Yvonna Lincoln (eds.) *The Landscape of Qualitative Research: Theories and Issues*. 2nd edn. Thousand Oaks: Sage.
- Shaw, R., L. Wallace and M. Bansal (2003) 'Is breast best? Perceptions of infant feeding'. *Community Practitioner* 76(8): 299-303.
- Shepherd, M. (2001) *Behind the scales: How Family and Child Health Nurses construct their home visiting practice*. Honours Thesis, University of Tasmania: Launceston.
- Shepherd, M. (2005) 'A Privileged position of trust: The family and child health nurse, home visiting and marginalised families'. *The Australian Journal of Child and Family Health Nursing* 1(2).
- Shepherd, M. (2011) 'Behind the scales: Child and family health nurses taking care of women's emotional wellbeing'. *Contemporary Nurse* 37(2): 137-148.
- Shonkoff, J. and D. Phillips (eds.) (2000) *From Neurons to Neighborhoods : The Science of Early Childhood Development* Washington, D.C.: National Academy Press.
- Shonkoff, J. P. (2010) 'Building a New Biodevelopmental Framework to Guide the Future of Early Childhood Policy'. *Child Development* 81(1): 357-367.
- Silverman, D. (1987) *Communication and Medical Practice: Social Relations in the Clinic*. London: Sage Publications.
- Silverman, D. (2001) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*. London: SAGE Publications.
- Spradley, J. (1980) *Participant Observation*. Orlando: Holt, Rinehart and Winston.
- Stapleton, H. (2010) *Surviving Teenage Motherhood: Myths and Realities*. Basingstoke: Palgrave Macmillan.
- Stevens, J. and M. Crouch (1998) 'Care' - The guiding principle of nursing? In: Helen Keleher & Fran Mcinerney (eds.) *Nursing Matters: Critical Sociological Perspectives*. Marrickville, NSW: Churchill Livingstone.
- Tammentie, T., E. Paavilainen, M.-T. Tarkka and P. Astedt-Kurki (2009) 'Families' experiences of interaction with the public health nurse at the child health clinic in connection with mother's post-natal depression'. *Journal of Psychiatric and Mental Health Nursing* 16: 716-724.
- Tarkka, M.-T., K. Lehti, M. Kaunonen, P. Astedt-Kurki and Paunonen-Ilmonen (2002) 'First-time mothers' expectations of public health nurses in Finland'. *Primary Health Care Research and Development* 3: 96-104.
- Tarrant, R., M. Sheridan-Pereira, R. McCarthy, K. Younger and J. Kearney (2013) 'Mothers who formula feed: Their practices, support needs and factors influencing their infant feeding decision'. *Child Care in Practice* 19(1): 78-94.
- Tasmanian Government (2013) *Kids Come First Update: Selected Outcomes for Children and Young People in Tasmania*. Hobart: Tasmanian Government.
- Tasmanian Numbered Acts (1949) *New Town Mothercraft Home Agreement 1949 (1949, No 5)* http://www.austlii.edu.au/au/legis/tas/num_act/ntmha19491949n5366/.
- Taylor, B. (1998) 'The nurse-patient relationship as the common ground of nursing specialities'. *Australian Journal of Advanced Nursing* 15(3): 6-7.
- Thompson, L. (2008) 'The role of nursing in governmentality, biopower and population health: Family health nursing'. *Health & Place* 14: 76-84.
- Traynor, M. (2009) 'Humanism and its critiques in nursing research literature'. *Journal of Advanced Nursing* 65(7): 1560-1567.
- Turner, B. (1995) *Medical Power and Social Knowledge*. London: Sage Publications.

- Van Esterik, P. (1989) *Beyond the breast-bottle controversy*. New Brunswick, New Jersey: Rutgers University Press.
- Van Manen, M. (1997) *Researching Lived Experience: Human Science for an Action Pedagogy*. Ontario: The Althouse Press.
- Verduzco Baker, L. (2011) *Charmed circle of motherhood: How discourses of motherhood discredit and empower young and low-income mothers*. Doctor of Philosophy, University of Michigan.
- Walkem, K. (2004) *Family and Child Health Nursing: through the eyes of practitioners*. Unpublished Masters Thesis. Masters, University of Tasmania: Launceston.
- Walker, K. (1997) 'Dangerous liaisons: thinking, doing, nursing '. *Collegian* 4(2): 4-13.
- Waters, J. (2006) Child Welfare Association. In Alison Alexander (ed.) *The Companion to Tasmanian History*. Hobart: University of Tasmania.
- Watson, J. (1999) *Nursing: Human Science and Human Care. A Theory of Nursing*. Sudbury MA: Jones and Bartlett Publishers.
- Watson, J. (2013) Nursing: The Philosophy and Science of Caring (Revised Edition) In: Marlaine Smith, Marion Turkel & Zane Robinson Wolf (eds.) *Caring in Nursing Classics: An Essential Resource*. New York: Springer Publishing Company
- Wearing, B. (1984) *The Ideology of Motherhood. A study of Sydney Suburban Mothers*. Sydney: George Allen & Unwin.
- Weisner, T. and R. Gallimore (1977) 'My brother's keeper: Child and sibling caretaking'. *Current Anthropology* 18(2): 169-190.
- WHO (1981) *International Code of Marketing of Breast-milk Substitutes*. Geneva: World Health Organisation.
- WHO and UNICEF (2009) *Baby-Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care. Section 2: Strengthening and Sustaining the Baby-Friendly Hospital Initiative: a course for decision-makers*. Geneva: World Health Organisation.
- Wilson, H. V. (2001) 'Power and partnership: a critical analysis of the surveillance discourses of child health nurses'. *Journal of Advanced Nursing* 36(2): 294-301.
- Wilson, H. V. (2003) 'Paradoxical pursuits in child health nursing practice: discourses of scientific mothercraft'. *Critical Public Health* 13(3): 281-293.
- Winstanley, M. and C. Ford (2012) The health effects of secondhand smoke In: Michelle Scollo & Margaret Winstanley (eds.) *Tobacco in Australia: Facts and Issues 4th Edition*. Melbourne: Cancer Council Victoria. Available from www.TobaccoInAustralia.org.au
- Witz, A. (1992) *Professions and Patriarchy*. London: Routledge.
- Wolf, J. (2007) 'Is breast really best? Risk and total motherhood in the national breastfeeding awareness campaign'. *Journal of Health Politics, Policy and Law* 32(4): 595-636.
- Wolf, J. (2011) *Is Breast Best? Taking on the Breastfeeding Experts and the New Stakes of Motherhood*. New York: New York University Press.
- World Health Organisation (1978) Declaration of Alma-Ata. In *International Conference on Primary Health Care*. Alma-Ata, USSR: September 6-12.
- World Health Organisation (1986) Ottawa Charter for Health Promotion. In *First International Conference on Health Promotion*. November 17-21, Ottawa, ON.
- Zadoroznyj, M. (1998) Transformation in collective identity of Australian and US registered nurses. In: Helen Keleher & Fran Mcinerney (eds.) *Nursing Matters: Critical Sociological Perspectives*. Marrickville, NSW Churchill Livingstone
- Zerwekh, J. V. (1991) 'A family caregiving model for Public Health Nursing'. *Nursing Outlook* September/October: 213-217.
- Zerwekh, J. V. (1992a) 'Laying the groundwork for family self-help: locating families, building trust, and building strength'. *Public Health Nursing* 9(1): 15-21.
- Zerwekh, J. V. (1992b) 'The practice of empowerment and coercion by expert Public Health Nurses'. *IMAGE: Journal of Nursing Scholarship* 24(2): 101-105.

