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The Role of Mothers in Family Health

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ABSTRACT

In many families the responsibility of family health falls mainly to the mother. There is a complex relationship between family health, care, and mothering practices that has not been fully investigated. The main aim of this research was to explore the complexity of the mother's role across all areas of family health including; food, sleep, exercise, medications, hygiene, health prevention such as immunisation, and safety. Multiple methods were used to uncover the embedded aspects of family health and to get rich and detailed discourses from stay-at-home mothers. Two interviews, household mapping, timelines of illness events and health diaries were used. The main finding revealed by analysis was that while family health was overseen by mothers predominantly it was practiced as a family, within a family health philosophy. This philosophy was a set of beliefs, ideals and practices, unique to each household, which were developed overtime and continually negotiated as a family. This philosophy influenced how family health was practiced across all areas in family health. The analysis also revealed that the mother's role as overseer of family health involved surveillance, provisioning and teaching. The mother positioned herself as the 'mother expert' in these processes based on her unique, embodied, historical and current knowledge of the family's health history, genetics, and illnesses. This expert position worked alongside the family health philosophy and allowed her and the family to resist health promotion, medical advice and healthisms. The 'mother expert' position empowered the mother with family health knowledge but it also constrained her into the position of 'expert' carer of family health. Surveillance played a key role in family health impacting on all areas of health, acting as a form of social control and leading to uncertainty over mothering practices, but conversely also providing reassurance. Provision of family health was a conflicting task that required balance, care of the mother, love and risk assessment. Teaching and modelling good health was embedded into mothering but also required a more formal process in teaching children about health and how to care for their own body. In summary, the mother's role in family health is complex, multifaceted and reflected in the family health philosophy.

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CHAPTER 1 - Introduction

Within many families much of the daily responsibility of keeping the family healthy and dealing with everyday ailments and illnesses falls to the mother. I am interested in stay-at-home mother's personal stories about their everyday experiences of managing, preventing and monitoring their family's health. The following quote illustrates the complexity of the mother's role, it demonstrates that managing health extends to all family members including extended family and it also suggests that being the mother may be detrimental to her own health. It is also a good summary of the main purpose of my study which is getting a more in depth understanding of the mother's role in family health.

"As a Mom, I make or influence health decisions and actions for my children, my spouse, my friends, my parents, and even my pets. I schedule my husband's colonoscopy appointment, get my kids immunized, buy the car safety seats, convince my Dad to use his hearing aids, and keep the family medical records. Sometimes I even care for my own health! Before seeing the pediatrician, I check my kid's developmental milestones, and a Web site or two" (Daniel, 2009, p. 2119).

The focus of this study is on mothers who do not work outside the home so the assumption is that these mothers will be largely responsible for the everyday health and illness practices of her family, especially with young children, as she is the one spending the most time with the children. While not discounting the role that fathers and children play in family health, the purpose of this study is to investigate the role of the stay-at-home mother within her family's health.

I believe that mothers will manage the health of their family's across two main areas: 1) behaviour that prevents illness and promotes health and; 2) dealing with ill health including minor ailments, chronic conditions and general and serious ill health. I also would argue that while the areas are made distinct for the purpose of this research they are dynamic, fluid and the mother may act across both areas at any one time. The specific areas of health that I suggest mothers manage are detailed in Table 1 and each of these areas will be explored in this study.

The chapter will be structured in a way that firstly looks at mothers as a group of women with an overview of current views and theories around motherhood. Then it will move onto an overview of the research on mothers and family health with a focus on medicalization, risk, surveillance, and morality.

Health/Illness Prevention	Dealing with ill health
<ul style="list-style-type: none"> • Food • Exercise/activity • Sleep • Dental care • Safety • Immunisation • Hygiene • Complementary and Alternative Medicines (CAM) use 	<ul style="list-style-type: none"> • Symptom recognition • Food • Hygiene/cleanliness • Decision making on sick roles • Medication use including CAM • Visits to health professionals • Self-treatment (folk remedies) • No treatment/action • Manage disruption of ill health

Table 1: Two main areas of family health

Mothering

To understand the mothers’ role within family health it is important to understand the nature of motherhood, the context of motherhood, and the pressures and influences on mothers. Therefore the main areas explored in this section are the dominant theories and discourses on mothering. Motherhood is socially constructed and as such is subject to ideologies and societal pressures. These will be explored in an effort to understand how they impact on mothers today (Gill & Liamputtong, 2011; Guendouzi, 2006).

Motherhood is something that the majority of women and frames the identity of all women, even those who are not mothers experience (Kelly, 2009). Women are judged on whether they have children or whether they do not, what age they decide to have them, whether they stay home or return to work, whether they do it as part of a heterosexual or lesbian couple, or as a single mother (Kelly, 2009). While it may seem obvious that mothers are women who have children this is a simplistic way of conceptualising motherhood as it does not capture pregnant women, mothers whose children have left home, and mothers whose children have died. An alternative way of conceptualising motherhood is something that is distinct from mothers and thought of as experiences and practices that can be ‘done’ by either gender (Arendell, 2000). Ruddick (1990, as cited in Ribbens-McCarthy & Edwards, 2011) termed this ‘maternal thinking’ in an attempt to remove the gendered connotations of the word mother. Despite this predominantly feminist work, mothering is still predominantly a gendered role and “gendered assumptions and stereotypes continue to shape experiences and knowledge claims of mothers” (Miller, 2005, p. 7).

The most dominant ideology of motherhood, particularly from America is one of 'intensive mothering'. Intensive mothering assumes the mother is child centred and that mothering is exclusive and emotionally intensive (Arendell, 2000; Currie, 2004; Hallstein, 2004). This ideology assumes that the mother is self-less and is based on the idealised version of the family unit that is two heterosexual parents, living together with their children. While this terminology is still being used I would argue it tends now to apply to mothers with very young children and mothers who stay at home with their children. This has come about as this ideology does not encompass the multiplicity of mothering and the fact that more and more women return to work or do not fit the idealized version of mother, that is, white, middle classed, married women (Miller, 2005).

The other reason why this intensive mothering ideology is problematic is that mothering can be paradoxical. On the one hand mothering can lead to a sense of fulfilment and meaning and on the other hand mothering can be physically and emotionally draining and lead to a loss of identity (Alanne, Laitinen, Söderlund, & Paavilainen, 2011; Gill & Liamputtong, 2011). Interestingly there has not been a lot of research on this paradox. Maybe this is due to the nature of the topic because admitting to frustration and negativity about your role as a mother is not easy (Gill & Liamputtong, 2011). This phenomena has been called the mask of motherhood and is described as the mask that "disguise(s) the chaos and complexity' of women's experiences as mothers and it is this mask that 'keeps women silent' about their lived experiences of motherhood" (Gill & Liamputtong, 2011, p. 4). I believe that the mask of motherhood will apply to some aspects of family health due to stigma of certain illnesses and the morality associated with healthy behaviours. I believe that this research may uncover some of these masks of mothers as they deal with their family's health.

The myths of motherhood persist for all mothers regardless of age, social economic status, or ethnicity. The idea that motherhood is something that is natural, all-encompassing and should be enjoyed at all times has been challenged, mostly by feminist researchers (Collett, 2005; Hager, 2011; Hallstein, 2004). Feminist research was instrumental in identifying firstly that motherhood is an area worth studying and secondly that there is a contested arena between mothering and motherhood (Fox & Murray, 2000; Hager, 2011; Sherriff & Weatherall, 2009). These feminist writers challenged the assumptions and the social processes that framed motherhood in certain

ways. There has been important theorising on women's experiences of mothering and motherhood to encourage research and theories beyond biology and roles of women in society today (Becker, 2010; Hager, 2011; Sherriff & Weatherall, 2009). The labelling of mothers as good or bad, single or lesbian has been noted and challenged through research that explores the complex nature of motherhood as they go about their daily lives. Chase and Rogers (2001) are quoted as saying that "it is only when we pay close attention to mother's everyday experiences are we informed enough to contribute to discussions about how motherhood should be socially constructed" (p. 7). Thus I believe to explore the mother's role in family health it is important to look at mother's everyday experiences and practices.

This section has highlighted that mothering is socially constructed, that it will be subject to dominant discourses or ideologies and that mothering and motherhood can be two distinct areas. I anticipate that the mother's role in family health will be subject to dominant mothering discourses and this will impact on the way mothers practice family health. I will explore these dominant discourses now.

Dominant discourses for mothers caring for family health

Mothers feel a moral and social pressure to conform to an idealized version of motherhood (Miller, 2005). This ideal is one of women aspiring to be good mothers and is a dominant idea from the literature surrounding mothering. This idealized version of mothers is influenced "by socio-cultural backgrounds but also by political discourse and social programs" (Baker, 2010, p. 216). The good mother aims to promote the development and well-being of her children while being nurturing, patient and generous (Barlow & Chapin, 2010). If you have an idealized version of a good mother then of course there is the demonized version of the bad mother, one who is selfish, impatient, and uncaring. While these idealized versions exist they are not useful in capturing the complexity of motherhood in all its forms and leads to maternal judgements or mother blame (Baker, 2010). It also tends to privilege biological mothers and treats maternal behaviours as universal practices, not culturally, socially or politically located practices (Barlow & Chapin, 2010).

The good mother discourse has been found in research on many of the areas within family health such as food provision (Madden & Chamberlain, 2010), smoking (Bottorff et al., 2010), sleep (Maume, Sebastian, & Barbo, 2010), immunisation (Baker, Wilson, & Nordstrom, 2007), health seeking behaviours (Khoo, Bolt, Babl, Jury, &

Goldman, 2008), and breastfeeding (Lee, 2008). In terms of family health the good mother is one who makes moral, responsible and safe health choices (Liamputtong, 2009). The demands of motherhood are used by mothers discursively to explain or justify to themselves when they feel they are not being good mothers. When the mother fails as 'good mother' there is a feeling of guilt. "Mothers always suffer from a sense of guilt as to whether they are doing things right and whether everything has been for the best. There is an awful feeling of uncertainty about being a mother and about what one is like as a mother." (Alanne et al., 2011, p. 4).

The ideology that all mothers are aspiring to be a good mother is problematic. It implies that there is a universal ideal and set of practices that makes a good mother but how do you reconcile this with the diversity of mothers or the diversity of mothering practices. Arendell (2000) suggests that mother know that it is impossible to be a good mother all the time and there is no universal good mother ideal. It is now suggested that mothers are constantly self-surveying, that is, measuring themselves to their own set of ideas as to what makes a good mother (Jenson, 2011). It is very common for modern individuals to become very reflexive and the everyday uncertainty of life means this reflexivity is an everyday occurrence (Moore, 2010). Mothers internally review their own mothering practices in an effort to resist this uncertainty and to reduce anxiety (Keeley, Wright & Condit, 2009). As a consequence of self-scrutiny and self-improvement worry and anxiety has been normalised in mothers (Jenson, 2011). Mothers are shaped by this culture of reflexivity, uncertainty and parenting anxiety so I anticipate that anxiety and worry will extend to mothers and family health.

Mothering is subject to dominant ideologies of 'good' mothering which are located predominantly in gendered notions of intensive mothering. In a modern reflexive society good mothers are also self-scrutinising their own practices. I believe that the mother's role in family health will be subject to these dominant discourses and I will examine this idea with this research.

Family health

There is no shortage of interest, academically, socially or politically in family health. There are journals devoted to family health, health promotion and policies that are targeted at families, and clinicians are recognising more and more that an individual's health is practiced within a family. In New Zealand the importance of family or Whanau in treating and understanding Maori health has been well documented (Durie, 2001).

Family as a construct can be difficult to define but McKie, Bowlby, and Gregory (2004) suggest “family is recognized across many cultures as the setting within which most people, at some point, live and conduct the private, personal aspects of their lives” (p. 596). There has been debate in the literature about definitions of family and criticisms that research has focused on the traditional nuclear family unit. However, the commonly held belief is now that families are multifaceted, complex, socially located and more and more research reflects this (Blaxter, 2010; Ribbens-McCarthy & Edwards, 2011).

There is a complex relationship between family, care, practices and mothering. Family is often seen as the site of care involving love and nurturing and as such care is assumed to be the domain of the mother. Feminist writers have criticised this and suggest that care is socially constructed and consists of work and effort (Ribbens-McCarthy & Edwards, 2011). I believe family health will have caring aspects in both the physical aspects of providing for a family and also the feelings of care, particularly of ill family members. McKie et al. (2004) locates ‘family’ as a site of family care where the maintenance and provision of health are ensured by domestic labour. Regardless of how you conceptualise family and how the family unit is made up, families will impact on family health and family health will impact on families (Lindenmeyer, Griffiths, & Hodson, 2011).

The relationship between health and family is complex and many assumptions are made by much of the research. Firstly, women and mothers are assumed to be predominantly responsible for family health. Secondly, it is common that women will have specific gendered health issues and that they will ‘do health’ differently than men. Thirdly, it is assumed that family health can be measured through health seeking behaviours or health care utilisation. These ideas will be explored in more detail now.

The inequalities in domestic duties and child care are addressed frequently by feminist research and while there is some evidence that men are ‘doing more’ around the home social policy and dominant mothering ideologies still constrain women and mothers (Guendouzi, 2006). Research has shown that mothers still are predominantly responsible for the care of children and for the bulk of the domestic duties within the home whether they work or not (Alanne et al., 2011; Baker, 2010; Maume et al., 2010). Regardless of the issues surrounding the gendered nature of health, mothers are still seen as predominantly responsible for the health of their families and it is widely

assumed their beliefs and practices will be different to that of the father (Maher, Framer, & Lindsay, 2010).

There are very few studies that have considered the role of mothers across the spectrum of health and illness or as I am terming it, family health. Much of the time the parents are studied together ignoring the gendered nature of mothering and health. Or the research focuses on one aspect of either health or illness such food, chronic illness in children or maternal illness. Surprisingly, feminist researchers have largely ignored mothers and family health beyond highlighting and addressing the imbalances in domestic duties (Guendouzi, 2006). I believe this is because so much of the mother's role in family health is embedded and routinized into her daily life and because of the complex relationship between caring as work and caring as love. Kushner (2005) found women thought health was all encompassing and applied to all aspects of personal and family life. While Kushner highlighted the social nature of family health for women, Graham (1993, as cited in McKie et al., 2004) identified the work that goes into managing the health of a family and this is highlighted in Table 2.

Aspects of family health	Tasks include
Providing health	The provision of food, to hygiene in the home, to the development of emotional well-being.
Nursing sickness	Assessing action required on the basis of symptoms and on-going knowledge of family members' health, practical care and emotional reassurances.
Teaching health	Such as teaching tooth brushing, hand washing before eating and after the toilet.
Mediating with health professionals	Such as communication with doctors and nurses, decisions on immunization, filtering health information and accessing services.
Dealing with health crises	Such as assessing seriousness of symptoms and when to call in services; managing the situation until the arrival of help.

Table 2: Work involved in family health
(Based on Graham, 1993, cited in McKie et al., 2004, p. 595)

There has been extensive research into each of these as stand-alone areas such as how families deal with health crisis (Hendry, Beattie, & Heaney, 2005), the gendered nature of symptom recognition (MacLean, Sweeting, & Hunt, 2010), the importance of mothers in teaching health and illness strategies to children (Cantrill, Johannesson, Nicolson, & Noyce, 1996) and the relationship of domestic labour or provisioning to health (McKie et al., 2004). However health and illness are treated as separate entities

rather than 'family health' and it is inherently assumed the mother will be doing all these things as the primary caregiver of children.

Women have particular health issues due to their gender and their ability to reproduce. However, research on women's health, particularly feminist or post-modernist, would suggest that women's health in general is subject to a lot more inequalities than men (Nettleton, 2006). Taking a world-wide view women are significantly worse off in terms of the numbers living in poverty and have lower mortality rates than men but higher morbidity (Lyons & Chamberlain, 2006; Boneham & Sixsmith, 2006). Many of these inequalities are intrinsically linked to the women's role as a mother with gender inequalities for women more evident in non-western countries where women die regularly of reproductive related problems (Doyal, 2000). Research also suggests women construct health differently from men and that they make health related decisions based on these constraints (Kushner, 2005). Women are seen as more caring, bodily aware, more likely to report symptoms, as naggers and responsible for their partners health, and as solely responsible for their children's health (Alanne et al., 2011; Doyal, 2000). What I hope to explore in this study is the relationship between gender and family health as I anticipate there will be aspects of family health that have significant gender components and other areas that the mother may treat as 'work like'.

While the purpose of this research is not to measure family health it is important to understand that this is what a lot of the research tries to do in an attempt to work out how to change it. Quite often the research has focused on health care usage as the benchmark for how healthy a family is (Perälä-Littunen, 2007; Ross, Mirowsky, & Goldsteen, 1990; Schor, Starfield, Stidley & Hankin, 1987). Some of the measures for family health usage in children are vaccination up-take, health seeking behaviours and obesity (Mindlin, Jenkins & Law, 2009). This in itself is concerning. It is assuming that family health is something that is measurable and stable overtime. Also if the family is not healthy the blame must lie with the mother as the primary care giver. Most of this research is also based in Western countries, not undeveloped countries where immunisation, medical care and healthy food are luxuries not a moral imperative.

However, a brief look at family health care utilisation research does give some insights into family health. There are a considerable number of factors that influence the health care strategies within families. Chen and Escarce (2006) state that the following variables influence parents demand for health care for their families; race, ethnicity,

health status, children's age, insurance coverage, finances, time, family income, parental education, knowledge about health and health care and child rearing experience. Janicke, Finney and Riley (2001) suggest that there are additional influences on whether children will be high health users. These are high maternal health usage, parental stress, family conflict, having younger children, low SES, and smaller family size. Family structure, habits and routines have also been shown to impact on family health (Markson & Fiese, 2000). Markson and Fiese (2000) found that family rituals meant different things to each family member and there was the potential for rituals to decrease anxiety. They were looking specifically at asthma management in the children though and not across family health as a whole. Thus it can be seen that research on health care utilisation shows that there are many contributing contextual factors important in family health. It also highlights that research that considers statistics or one health care measure in isolation will not be getting the complete picture of how health and illness are enacted in families.

Family health, as with mothering, is subject to multiple influences and is complex and multifaceted. No single theory, that I investigated, encapsulated the complexity of the mother's role in family health. However, there are dominant frameworks and ideologies that have been applied to family health and mothering that I anticipate will impact on the mothers. I will examine morality, risk, medicalization, and surveillance.

Morality

Health has become increasingly important in Western society (Crawford, 2006). Health is now a moral imperative with healthy behaviours being linked to moral, responsible individuals and unhealthy behaviours being considered immoral and irresponsible (Crossley, 2003). Morality and health at an individual level assumes that you can maintain health by enacting a whole set of behaviours from eating the right food, exercising, and maintaining a healthy lifestyle (Crawford, 2006). The implications of this for mothers are that to be a 'good' mother one must be a moral, health conscious mother for yourself and for your family (Miller, 2005).

Research on breastfeeding and maternal smoking are good examples of the relationship between mothers and morality. Lee (2008) talked to mothers about infant feeding and found that there are strong moral discourses surrounding breastfeeding. These discourses position formula feeding as risky due to the strong moral message of 'breast is best' and breast is the healthiest. Lee found that mother's experiences were found to

include “moral collapse, feelings of confidence, expressions of defiance and defensiveness, and opting to go it alone in response to ‘information overload” (p. 467). Mothers who formula fed had to work hard to maintain a sense of ‘good mothering’. Lee goes on to say that infant feeding is influenced by intensive mothering ideologies and risk-aversion. Holdsworth and Robinson (2008) looking at maternal smoking and found that mothers tended to control the environment to decrease the second hand smoke exposure to their children by having spaces or times that were smoke free. They did this as a means of resisting the immorality and stigma associated with smoking and as a way of practicing good mothering.

Mothers as the main providers of food for families are subject to intense moral judgements around food. Madden and Chamberlain (2010) found that in relation to food and health mothers positioned themselves in constant arena of conflict between moral obligations of staying healthy and moral obligations of being a good mother. Wood et al. (2010) found that mothers from a low socio economic area in Wales knew about what constituted healthy food but the reality was that the mother’s view of the health messages were reworked within their lived environment. ‘Balance’ was seen as more important than always eating well to avoid ill health. Quite often the mother will do the bulk of the purchasing and preparation and the thinking and organising that goes in to family food (Madden & Chamberlain, 2010). Mothers may also provide meals and snacks according to the taste preferences of other family members over herself, which is a good example of the “self-less mother” (Madden & Chamberlain, 2010; Wood et al., 2010).

Mothers as well as being morally pressured to be healthy and have healthy children are also morally bound to be good patients when they are pregnant and moral and responsible administrators of medical treatment for their families (Bessett, 2010). Bessett found that if women did not follow medical advice during pregnancy advice they ran the risk of being labelled bad patients or worse yet bad mothers. Bessett suggests this is a double bind for women. This double bind assumes that women should comply with medical advice during pregnancy and self-survey their own pregnancy symptoms, however, prenatal appointments were treated as routine by the medical professionals and maternal suffering during pregnancy was seen as normal. This led to confusion by the women as to what symptoms to report, what was dangerous and what was due to ‘normal’ maternal suffering. Hager (2011) goes on to suggest that suffering

post birth is normalised for mother's as well and as such this suffering such as pain, lack of sleep, loss of identity is minimised by women themselves and the medical profession. I anticipate that this double bind may exist in other areas of family health where mothers are interpreting a child's symptoms. I also hope to explore the idea that mothers are subject to 'normal suffering'.

Medicalization

Medicalization was a term coined by Conrad to describe how "nonmedical problems become defined and treated as medical problems" (Conrad, 2007, p. 4). Many women's health issues have been medicalized mostly surrounding childbirth. Mothers are subject to an intense medical gaze particularly when they are pregnant and immediately post birth (Bessett, 2010). However, the dominance of biomedical and scientific discourses in health promotion messages, illness prevention campaigns, child rearing and caring for sick children suggests the mother's role in family health is highly medicalized as well (Singh, 2004). Mothers have the responsibility of interpreting, implementing and adhering to health promotion messages (Khoo et al., 2008; Tardy & Hale, 1998). As such maternal health literacy is seen as desirable in order to understand, interpret and implement health and illness information in families (Renkert & Nutbeam, 2001). Maternal health literacy as a concept can be detrimental as it implies that mothers who have little formal education will be worse mothers than those with higher education. It is also suggested that health is still to a large extent measured medically by the absence of illness and fitting within normal ranges of medically determined norms such as weight (Nettleton, 2006).

Mothers do resist medical/expert advice in all areas of family health including immunisation (Nicolson, Fox & Heffernan, 2009). In New Zealand across all ethnicities approximately 82% of children are fully immunised although this is less for Maori with only 69% fully vaccinated (The National Childhood Immunisation Coverage Survey - 2005, 2007). Considering solely the statistics of those not fully immunised, 18% of parents have decided not to immunise in New Zealand. There is limited research that explores the decision making process behind immunisation. Much of the research assumes the mothers are solely responsible for immunisation decisions, it assumes that immunisation is "essential" to good health, and looks at adherence to immunisation schedules. Baker et al. (2007) completed one of the few qualitative studies on immunisation but again the focus was on adherence to immunisation schedules in

Detroit. They found that the barriers to immunisation may include cost, clinic hours, insurance and presence of cold and or a fever meaning the child cannot receive the vaccine. They also found that 26 out of 30 mothers interviewed did not know what vaccine their child was receiving or the purpose of the vaccine. This suggests maternal literacy is not directly related to immunisation uptake and there is a more complex underlying decision-making process going on. I hope to explore the underlying decisions surrounding immunisations and the mother's role in these decisions.

Preventing ill health in families is very much focused on medical discourses around disease prevention and immune systems (Crawford, 2006). There is a huge market for supplements such as vitamins, probiotics, and other natural or alternative remedies that may help prevent ill health. There has been limited research into the use of complementary and alternative medications (CAM) in families with much of it focusing on usage percentages rather than reasons for usage. The reasons parents have given for CAM use in children are fairly consistent though in what little research has been done. The following reasons consistently given are; "to increase well-being, to boost immunity, to decrease the side effects of conventional drug therapy, and because conventional therapy had not met their expectations" (p. 71, O'Keefe, Coat & Jones, 2010). O'Keefe et al. (2010) found that 32% of CAM usage in children was for dietary supplements and vitamins. With the dominant CAM therapy being vitamins it is no wonder that there is an increasing amount of research into vitamin use in children. However, this research still predominantly focuses on statistics. That is, what percentage of children take some form of vitamin (25-48%), what type of vitamin (C and B the most common), what age (applicable to all age ranges), what is the SES of the family who gives vitamins (higher SES, more likely to use CAM), or what is the maternal literacy of the mother (Goldman, Rogovik, Lai, & Vohra, 2008).

The immunity boosting properties of certain foods such as garlic have also been discursively related to prevention of illness (Madden & Chamberlain, 2004). Crawford, Brown, Nerlich, and Koteyko (2010) found that mothers used probiotics in response to antibiotic use but also frequently as they are seen as beneficial for general health and will boost their children's immunity. While this research is useful there is still very limited research as to why vitamins and other therapies are being used, in what context and what has gone into the decision making process behind the use. I believe what the research on immunisation, immunity and vitamin use does illustrate is that aspects of

child rearing and health have been medicalized and that the language around immune systems and boosting immunity has become more common place in mothering discourses. I hope to add to the research on lay discourses around immunity and explore the impact of medicalization on child rearing and family health and how this is talked about by mothers.

Risk

Risk is an important feature of modern society and plays an important part in lay understandings of health and illness (Nettleton, 2006). Beck (as cited in Lupton & Tulloch, 2002) suggests as a consequence of a modern reflexive society, society is risky. As a result of a risk society “individuals are constantly engaged in assessing and managing risks in all areas of their lives” (Backett-Milburn & Harden, 2004, p. 430). Risk is evident in family health in a number of ways. Firstly, individuals are subject to screening programmes aimed at identifying those at risk. Secondly, individual behaviours can be seen as risky as people are aware of risk factors and their relationship with serious health problems. Thirdly, uncertainty over health information means risk/benefits assessments are commonplace (Gillespie, 2011; Lyons & Chamberlain, 2006). The framework of risk has been applied to most aspects of health and illness from medication use (Bissell, Ward, & Noyce, 2001), information seeking (Tardy & Hale, 1998), food (Gillespie, 2011), immunisation (Mindlin et al., 2009), and safety (Backett-Milburn & Harden, 2004). It has also been applied to motherhood with Miller (2005) stating the motherhood journey is one of negotiation of risk and morality on the pathway to being a responsible mother. Miller goes on to explore risk avoidance by mothers and demonstrated this was related to self-control, self-knowledge and self-improvement.

This constant need for reflection and self-improvement can lead to uncertainty over risks, risky behaviours and risk factors (Lupton & Tulloch, 2002). This uncertainty can be due to doubt over ‘expert’ opinions results. This then results in a lack of consensus about ‘facts’ or ‘truths’. Also lay understandings of reducing the risk of serious ill health are difficult because the message is there is “a small chance of great misfortune” (Olin Lauritzen & Sachs, 2001, p. 498). However, while most lay people have knowledge of risk factors and how this applies to their own health, they all have stories of individuals who were healthy despite unhealthy eating or not exercising or know someone who had a heart attack after doing everything right. This randomness or bad

luck means risk is a moving target (Olin Lauritzen & Sachs, 2001). Keeley et al. (2008) looked at fatalistic statements and their link to health beliefs. They found that these statements were not always in direct opposition to healthy behaviours and beliefs but had other roles. These roles were face saving (avoidance of self-blame), stress relief (health is out of my control), uncertainty management (health is unpredictable) and sense making (consequences of prior behaviour) and functioned as a way of negotiating power differentials and as a way to balance priorities (Keeley et al., 2008). While the purpose of this research was to try and predict health behaviours it does shed some light on how lay health beliefs are complex, dynamic and contextual and not always about risk.

Much of the time the research on risk focuses on the individual. However, particularly in families risk is assessed as a family. Backett-Milburn and Harden (2004) talked to all family members about risk, safety and danger and argue that families socially construct risk and risk anxieties in a dynamic and fluid manner. Minimum risk expectations or the bottom line were established but many risk, safety and danger issues had to be renegotiated frequently. They suggest that risk management of the mundane is a dynamic and shifting process (Backett-Milburn & Harden, 2004). While this research was focused on danger predominantly, I argue that risk negotiation within the family will also take place for many other health-related areas. I am also interested in exploring how the mother role in risk negotiation and how talks about this negotiation with her partner and with any older children.

An area of research that has particularly focused on risk is research on medication use within families. Trajanovska, Manias, Cranswick and Johnston (2010) highlight the concerns around cold and flu medications being given to very young children despite limited evidence that they are effective. Another concern identified was parents buying the products without professional consultation and concern over parents giving the correct dosage. However, what has been found even with medications, the decision-making process about adherence or compliance is not just about risk. Bissell et al. (2001) found that consumers stressed their ability to self-manage specific minor ailments using non-prescription medicines. Their confidence in self-management stemmed in part from long personal experience of successfully managing minor ailments. Long term experience, familiarity with use and personal control were important in self-treatment and benefit was found to be more important than risk.

Research into the social practices behind the use of medications in the everyday management of minor ailments and illness in families and in health promotion has been limited. But what this research has shown is that medications have a role in family health that goes beyond simple treatment of ill health and as such are subject to more than just risk. The presence of medications in the home can provide a sense of certainty, reciprocity, and reassurance (Hodgetts et al., 2011). Hodgetts et al. (2011) found that medications were socially embedded objects that were “woven into domestically-anchored relationships and daily health care and maintenance practices” (p. 360).

I anticipate the mother will have a role in assimilating and dissimilating illness information, assessing safe, high quality, cost effective health solutions for their families, and assessing the physical safety of the family. I anticipate that many aspects of family health risk assessment and mothering will be embedded in the mother’s daily practices of caring for her family. This research aims to explore these areas.

Surveillance

The ‘new health paradigm’ is a phrase coined to describe the intensive self -reflexivity and self-governance required to ensure a healthy lifestyle (Moore, 2010). Health, risk, surveillance and medicalization are synonymous in this paradigm at both an individual and institutional level. The new health paradigm requires an individual to monitor themselves against socially, politically and medically determined norms and guidelines in order to maintain a healthy citizenship status (Roy, 2008). Health promotion acts as a form of social control on individuals and the gaze and surveillance of the medical profession on healthy and unhealthy individual’s subjects them to a form of discipline or disciplinary technology (Burr, 1995; Currie, 2004; Hook, 2007). Thus it can be seen that surveillance plays an important role in family health at the individual level, at the level of the mother as responsible for family care, and at the level of the family. This idea will be explored in more depth now.

Families are sites of care and as such are subject to surveillance (Nelson & Garey, 2009). Nelson and Garey report in order to understand families you need to consider surveillance from three sources. Firstly, families are subject to surveillance from external institutions and technology. Secondly, they are observed, assessed and judged against socially determined norms by other families. Thirdly, families themselves are monitoring themselves as a form of ‘border patrol’ where care and control are closely

interrelated. They go on to suggest that surveillance is contributing to and reinforcing social inequalities and will be subject to resistance.

Surveillance medicine has brought about the language of risk factors and signs of disease (Armstrong, 1995). The idea that everyone exists on a scale of health to disease means that normal has been problematized (Olin Lauritzen and Sachs, 2001). Child development is one such area where the screening of healthy babies and young children is a direct result of surveillance medicine (Armstrong, 1995). Ribbens-McCarthy and Edwards (2011) suggests that child development theories have become the dominant paradigm for thinking about children and act as a form of institutional governance over families. This has major implications for families and mothers in particular. Children's development needs have to be met as a moral imperative and part of this requires a surveillance of the children themselves and a surveillance of parenting practices (Ribbens-McCarthy & Edwards, 2011). I anticipate that this screening and surveillance of well children will be embedded into family health practices and will prove both helpful and problematic for mothers.

Blaxter (2010) suggests that hazard identification and a continual vigilance are required at all times to maintain health and avoid illness. Parents, mothers in particular, are advised to immunise, use sun screen, give children nutritious food, boost their immune systems, make sure they get enough exercise, and continually monitor them for any signs of potentially serious ill health (McKie et al., 2004). This requires routinized aspects of surveillance such as keeping children safe in the home by ensuring medications are in high locations to surveillance of bodies for signs of ill health and normal development or surveillance of overall diets and family practices. This leads to uncertainty and anxiety over parenting decisions (Liamputtong, 2009).

Surveillance has also been shown to be important in treatment of ill health. Mothers have a role in symptom recognition and deciding if a family member is ill (Cunningham-Burley & Irving, 1987; Robinson, 1971). They also make decisions on the treatment of ill health and 'wait and see' or continual monitoring is frequently the first 'treatment' option mother's use particularly with minor ailments (Cunningham-Burley & Irving, 1987). Robinson (1971) used an example of bed wetting to illustrate the importance of monitoring by the mother. The mother's constant re-evaluation of the situation went on over a period of two weeks before she decided not to contact a health professional. Many times uncertainty over symptoms and when they are serious enough

to consult the doctor is prevalent (Robinson, 1971). Surveillance has the potential to reassure (all is well) but all has the potential to increase uncertainty (what do I do now) making surveillance of family health difficult.

Surveillance has been shown to be very important in many aspects of health and ill health. I am interested in exploring everyday surveillance by mothers as there has been very limited research on this area that considers both health and illness. I suggest mothers will have a complex roll in family health around surveillance and aim to examine this with this research. This may include surveillance of their children's bodies and behaviours while monitoring their own health and surveillance of the environment including the home. I also aim to explore if the mother resists surveillance and how and why she does this and lastly I hope to explore if the mother is surveying her own practices and those of other mothers or social surveillance. This will be discussed next.

Social surveillance

There has been research that looks at how mothers perceived surveillance of others is impacting on the way she mothers. Mother's discourses suggest they feel judged on how their children are dressed: the child's weight; the child's academic or sporting achievements; the food they eat and so on. Mothering success has been directly linked to their family's success (Collett, 2005). This leads to anxiety and worry over mothering practices in general (Jenson, 2011). This anxiety over social judgement has been found in all areas of family health. Kushner (2005) provided one of the studies that attempted to understand how health was practiced by mothers. Kushner (2005) found that when the child did not meet societal norms that the pressure was felt by the mother and within the family. She goes on to say women recognise and accept that they are responsible for the care and well-being of their families and reports that mothers get a sense of pride from having a healthy family. While the focus of Kushner's research was on employed mothers only, the study highlights the pressures of women to be good mothers from a personal and a societal perspective.

Buzzanell and D'Enbeau (2009), in research on mother's everyday talk about health, found mothers felt they had the right to comment on other mothers mothering skills suggesting that while mothers are subject to social surveillance they are also participating in it. Buzzanell and D'Enbeau (2009) also remarked on how much unsolicited advice is offered to mothers on all sorts of issues including health of themselves and their children, not just by other mothers but also by members of the

community. Blackford (2004) suggests there is an inherent competition between mothers measured by their children's behaviours and health and that their children's behaviour and well-being is a reflection of you as a mother. This process involves a constant self-reflection or on-the-job "performance review" (p. 239). She found that fathers and babysitters are not subjected to the same censor. Collett (2005) suggests mothers as a consequence of social surveillance are on a public stage where the child's successes or failures are open to view. This leads to judgement which is usually reflected on the mother.

Gill and Liamputtong (2011) emphasise the importance of social interactions to the establishment of a woman's identity as a mother. If the mother does not meet up to the socially constructed version of motherhood she has the potential to be labelled a bad mother. They also go on to say that society has moral expectations for mothers and that if mothers feel they are not meeting these expectations then this can lead to confusion around identity as a mother and feelings of ambivalence towards motherhood. While Gill and Liamputtong (2011) were particularly interested in mothers of children with Asperger's syndrome, I argue that mothers in a modern western society do experience a degree of ambivalence and confusion over their identity as mothers and do feel guilty. I believe that family health, identity as a mother and her role within and across these two areas will be subject to discourses around good and bad mothering as both health and mothering are subject to morally laden judgements.

The implications for this study are; that women will have internal and external influences on their mothering practices in relation to keeping their families healthy; that they may feel responsible or stigma from having an ill child if the illness could have been prevented; and that family health and mothering are interwoven in a complicated socially constructed way. This research will explore this idea further.

Mothers and dealing with ill health

I anticipate the mother's role in family health will have common practices across both keeping the family health and dealing with ill health. However, I believe that ill health will prove disruptive and will require extra work. Therefore, it is important to look at research into the mother's role when she is just dealing with ill health.

Ill health can be thought as distinct from disease, in that, it is a socially constructed experience with the wider socio-political context shaping interpretations and meanings (Nettleton, 2006). The illness experience will depend on the seriousness of the event,

the type of illness, whether it is a chronic condition, the treatment of the illness and so on. Ill health, like health, is subject to morality, risk, surveillance and medicalization by those who are ill and those who are around the ill (Nettleton, 2006). It is beyond the scope of this thesis to review all research on all potential illnesses that families may experience. However, I anticipate that certain aspects of the illness experience will be predominantly the responsibility of the mother. These will be: 1) symptom recognition; 2) decisions on whether the individual will take on the sick role; 3) a role in medical consultations; 4) decisions around treatment including medications; and 5) dealing with the consequences and actions of ill health.

Unlike health, ill health is usually unexpected and decisions have to be made about sick roles, treatments, symptoms. Many of the decisions surrounding ill health are made by the mother very quickly using previous experience and products already in the home (Robinson, 1971, Cunningham-Burley & Irvine, 1987). Whether the person takes on the sick role or what treatment they decide on all depend on a number of factors including responsibilities, role within the family, impact the decision will have on the family and so on (Backett-Milburn & Harden 2004; Cunningham-Burley et al., 2006) Mothers are also the ones predominantly expected to sacrifice their time when their children are ill and find it harder to take on the sick role due to their caring responsibilities (Hager, 2011). Robinson (1971) suggests mothers have a differential access to the sick role, which means they felt they could not take on a tradition sick role. “Some people can go to bed almost anytime with anything, but most of us can’t be sick, even when we need to” (Robinson, 1971. p.10). Mothers have unique pressures put upon them to ‘carry-on’ or reduce symptoms that may impact on their ability to care for their families (Tardy & Hale, 1998). There is a strong moral discourse of mothers that “have to keep going” (Cunningham-Burley et al., 2006, p.393). If the children are ill, it tends to be the mother making the decision to authenticate the child’s sickness. Again this is a scale of ill health, for example, where the child may not be fully well but is healthy enough to go to school. This decision is often made very quickly and was related to her knowledge of the child (Cunningham-Burley & Irving, 1987).

The knowledge used to decide if a family member is sick was also related to symptom and illness experience and knowledge. The mother was most likely going to be responsible for interpreting signs of illness. The mother’s look at not just physical signs of illness but behavioural changes such as tiredness, lack of appetite or clinginess

(Lagerlov, Helseth & Holager, 2003; Robinson, 1971). The parents also use previous knowledge of illness to help assess the severity of the illness or what treatment may be needed, that 'wait and see' is quite often the first reaction to illness (Cantrill et al., 1996). The process of symptom perception and recognition is still carried out regardless if the symptom is behavioural or physical. Frequently the action may be 'wait and see' or surveillance, a home remedy such as a warm drink, or an over-the-counter medication. The same complex decision making process goes on for minor ailments as for more serious ailments (Cunningham-Burley et al., 2006).

Symptom recognition and seeking medical attention or additional information to make a diagnosis are related. Research has shown that mothers go through a complex process before seeking medical attention. From trying home remedies, monitoring, seeking lay and other professional advice from health lines, pharmacists, and looking up information in books or on-line quite often these are all tried before making a doctor's appointment (Khoo et al., 2008). Mothers are expected to report to doctors unusual and potentially harmful symptoms in their children to doctors but are criticised for wasting time and resources on minor ailments (Hager, 2011; Hendry et al., 2005). However, the complexity of how this decision is made is quite often ignored and this type of decision is one that parents and mothers have to make very frequently (Cunningham-Burley et al., 2006). Cantrill et al. (1996) found carers were more likely to consult a pharmacy than a doctor for minor ailments. Hendry et al. (2005) reported that the parents in over 50% of cases had consulted a third party before attending A&E and that GP's referred the child to the A&E department in over half of these cases. Hendry also found children with injury were more likely to go to the A&E than children with illnesses. However, this study was limited in that the third party was never defined so it is unclear if it was medical or lay advice. Parents were positioned as over cautious in order to "play it safe with their children" (Hendry et al., 2005, p. 632). Though it was not made clear if they were suggesting parents seeking reassurance and playing it safe were good or bad parents.

An understanding of the mother's role with regards to medications and family health is important. With an increased focus on health and management of chronic conditions being put back on the family, mothers are expected to become medical experts and pharmacists. Regardless of the illness or the medication the decision to give any type of treatment is complex. Cantrill et al. (1996) suggests prior knowledge of the ailments and

knowledge of medications is important for carers when treating minor ailments. Lagerlov et al. (2003) conducted a study looking at paracetamol use in families in Norway. While this was a study looking at fever and medication the findings are consistent with others in that the decision making process behind treating ill children is not a simple one. However, much of the time over-the-counter (OTC) medications are the quickest and cheapest way to treat a family member with a minor ailment as they are already in the home (Allotey, Reidpath, & Elisha, 2004; Cantrill et al., 1996). Trajanovska et al. (2010) found in a study of OTC use in young Australian children that paracetamol is the most common OTC medication given to children under the age of two and 40% of parents have cold and flu products in their homes. Medications are also used by parents for reasons other than treating physical symptoms. Allotey et al. (2004) found mothers use medications for reasons other than just treatment of symptoms. Social use of medications to help settle children, help them sleep, or decrease grumpiness was common.

Much of the research on medications points to the ingrained nature of medication taking in treating all illness. I plan to consider medication use with ill health and what combinations of alternative/natural products are used with OTC and prescription medications. I am also interested to see how embedded medication use is in family health and the role the mother plays in administering, storing, monitoring and purchasing medications.

I anticipate that some of the families in this study will have chronic conditions in the children. Many chronic conditions in children such as asthma involve complex medication regimes and avoidance of triggers. A lot of the time the mother is the one responsible for purchasing, monitoring, administering medications and ensuring that known triggers are avoided as much as possible (Alanne et al., 2011). As monitoring a chronic condition is a daily task all these things become part of the mothers 'work' and routine and have to be managed well to avoid family disruption, lack of medication and flare-ups. Alanne et al. (2011) reports that the stress of managing chronic conditions such as atopic dermatitis or food allergies can be as stressful as managing insulin dependent diabetes and that much of the time this care is left solely to the mother.

With allergies on the rise, or maybe the focus on allergies on the rise, I anticipate this will be an area that affects many of the families. Medications are quite often used in treating allergies alongside a number of other strategies in the home to reduce exposure

to the triggers (Cummings, Knibb, King & Lucas, 2010). Even when the allergy is not life threatening it can involve complex food preparations, avoidance of multiple triggers and can impact on family life. Much of the time the management of a child's allergy will fall to the mother (Alanne et al., 2011). The mother's role within this arena is quite complex as the social implications of allergies has expanded beyond the home into schools, early childhood centres, sporting arenas, and so on (Cummings et al., 2010).

Dealing with ill health has also been shown to be gendered in nature with women seen as more likely to be caring for ill family members regardless of if they work outside the home or not (Cunningham-Burley & Irvine, 2006). Lagerlov et al. (2003) found that the mother believed it was her role to deal with the sick more than the father, and although sickness was also seen as a potential burden on the entire family, the impact on the family was managed by the mother. The sorts of things she would have to manage were the healthy child may be neglected while the sick child is tended to, social or other obligations may have to be changed, and the sick child may have to be quarantined so there is increased isolation for the mother and child (Lagerlov et al., 2003). Robinson (1971) looked at the appropriateness of being ill and found this depended on the situation. The impact of taking on the sick role is considered by the family and influences the decision. The decision whether the family member will take on the sick role will depend on which family member is ill, the context of the illness, the type of illness, and the responsibilities and commitments of that family member (Cunningham-Burley et al., 2006). Maume et al. (2010) found that the anticipation and accommodation of the family's emotional and physical needs have to be managed and these are predominantly managed by the mother.

Mothers have a role in all family illness including minor ailments, chronic conditions and managing serious ill health. Dealing with the impact of illness on the family has also been shown to predominantly be the mother's domain. I hope to explore in this study the role of the mother across all ill health experiences in the family as I anticipate she will have an essential part in the decision-making surrounding illness.

Mother's as educators/modelling health care

Research suggests the family, and mothers in particular, play an important role in how children develop all treatment strategies. Research on adolescents suggests strategies are set in childhood and that young adults use the OTC medications mothers used because they know it works (Gray et al., 2002; Janicke et al. 2001). Other research has found

that mothers are modelling health strategies from food preparation and food preferences (Vereecken, Keukelier, & Maes, 2004) and physical activity (Lewis & Ridge, 2005). Beyond this role of informal teacher, modelling and teaching health is a moral imperative for mothers. Social surveillance of children and families acts as form of social control on mother's ensuring they stay healthy. Other forms of surveillance from institutions and technologies subject mothers to governance of their mothering practices and as such reinforce the dominant ideology that mothers are responsible for family health, including the teaching of healthisms (Heaton, 1999; Lyons & Chamberlain, 2006). Mothers also play a critical role in the teaching of care and management of chronic conditions to children (Meah, Callery, Milne & Rogers, 2009). I will explore the role of the mother as teacher and as model of health through explorations of embedded everyday teaching tasks such as teeth brushing and through more conscious, complex teaching tasks such as teaching children with chronic conditions how to manage their own condition.

Main aims of the research

The main purpose of this research is to explore the mother's role in family health. I believe mothers will have an essential role in family health and anticipate that mothers will feel more responsible, do more practical work in caring for a family, and will have to deal with the impact of ill health more than any other family member. I will interview stay-at-home mothers as they are with their children the bulk of the time and therefore are uniquely placed to investigate as primary carers of family health. There has also been limited research that focuses on this particular group of mothers so research that explores these mother's everyday lives is beneficial. I plan to use multiple methods of data collection in an effort to explore the routinized and non-routinized practices of mothers in the areas of food, sleep, exercise, hygiene and cleanliness, teeth, safety, immunisation, CAM use, and medication use across the spectrum of health and ill health. I will explore how dominant medical, moral, risk, surveillance and good mothering discourses and ideologies are shaping mothers practices in family health. I will explore how the processes of caring for the ill and keeping a family healthy are the same and how they are different. Lastly, I will explore how the mother is influencing family health practices and how the family is influencing the mother's practices.

CHAPTER 2 - Methods

Theoretical Framework

This research has been conducted within the framework of feminist social constructionism because I am exploring the daily life of mothers and their role in family health. Motherhood, health, and illness are all socially constructed, are all intertwined and are all open to social, political, cultural and historical influences. Social constructionism is based on the following propositions; Firstly knowledge is socially constructed through interactions according to social, cultural and historical practices; Secondly, the focus is on language as a site of knowledge production; and thirdly, where there is knowledge there is power and thus the potential for power inequalities (Burr, 1995; Kahu & Morgan, 2007; Willig, 2000).

All feminist research has the aim of “seeking social justice, enhancing women’s voices and exploring alternative ways of understanding the world through women’s experiences” (Gergen, 2008, p. 280). Feminist research has brought to light the following ideas that shape all understanding of modern Westernised mothering. These ideas are that firstly, motherhood is shaped by social and personal meanings. Secondly that deeply held cultural assumptions around motherhood can be disempowering to women. Thirdly, motherhood can act as social mandate to all women where deviance can lead to discrimination. Fourthly, mothering as a practice can be distinct from gender (Sherriff & Weatherall, 2009). Mothers as primarily responsible for family health are subject to inequalities in terms of power and imbalances of domestic duties and child care. Also women’s health in general is subject to more surveillance and inequalities than men’s health. Therefore, in order to explore the role of mothers and family health I believe you have to consider the culture and society in which she lives and how these are impacting on her everyday life.

Language is important in feminist social constructionism and the analysis of discourses is a key element to this framework. Burr (1995) defines discourse as “a set of meanings, metaphors, representations, images, stories, statements and so on that together produce a particular version of events” (p. 48). Discourse can be used to provide meaning to objects and our identity can be constructed by the discourses available to us. Discourses are embedded in power relations and therefore have political effects. Social constructionism and feminism are not limited to an interest in discourse because social practices, social structure and their associated discourses are all part of the same

phenomenon (Burr, 1995). There are many ways to analysis discourse within the framework of feminist social constructionism and the justification for my method is outlined below.

The analysis for this study was loosely based on Foucauldian Discourse Analysis (FDA). FDA is based on the assumption that “discourse plays a fundamental role in meaning and subjectivity is largely structured through language” (Willig, 2008, p. 126,). Willig (2008) claims FDA does not aim to produce one absolute truth but rather to understand the social, psychological and physical effects of discourse. Amigot and Pujal (2009) explored the impact Foucault has had on feminism and suggest while there are some tensions between them Foucault offers some useful ways of analysing power, gender and freedom. I believe FDA is the most suited to this research not as a specific process but rather because of the focus it has on subjectivities, agency and power.

Thus it can be seen that the appeal of feminist social constructionism to this research is predominantly this. If knowledge is constructed this allows the possibility of dominant discourses surrounding mothering and family health to be challenged, resisted and ultimately disrupted. In order to do this you must first understand how women, or in this case, stay-at-home mothers are constructing their identities and practices within their everyday social contexts. This framework would allow me to explore the potential power imbalances for stay-at-home mothers from within the family, from external institutions and other mothers. It also allows me to explore the contradictory positions offered to mothers in terms of problematization between the mother as a caring, loving provider, and disciplinarian of family health.

I made a number of assumptions in this research which will impact on the theoretical framework and as such are important to state. Firstly, stay-at-mothers are with their children the bulk of the time and as such I anticipate they will be the dominant carers of family health. Secondly, the mother’s upbringing, health history, her social networks, and her own life experiences will impact on the way she practices and talks about health and illness and this will change over time (Ribbens McCarthy & Garey, 2011). Thirdly we live in a health conscious society that places responsibility for health on individuals and families, and thus mothers as the overseers of families will be subject to moral judgements based on their family’s health (Crawford, 2006).

Ethics

Ethical approval was gained through Massey University's ethics committee. I anticipated that, although the focus of the research was on the everyday nature of health and illness, participation in the study may bring up emotional and sensitive subjects. This was due to the wide nature of the potential topics. I thought there may be emotions around areas that concern just the mother in terms of her well-being (such as depression, stress, role conflict), or that concern the children (social adjustment issues, food), or that concern the family (demands of family). However, it was anticipated that these discomforts were unlikely to be extensive. I did bring with me to each interview a sheet of contact details for support organisations for mothers but did not have to distribute it to any of them. I did have to stop recording at the request of one mother, which I complied with and only started recording again once I had her permission.

The participants were made aware in the consent form, information sheet and by me personally, that all topics discussed and all information provided would be confidential and that they would not be able to be identified in any publications except by me. Immediately following participation in the research, each participant was thoroughly debriefed on their participation which included: re-explanation of the purpose and aim of the research; and conversing with the participants to relieve any emotional anxiety that might have resulted from their participation.

Approval was given by the ethics committee and by the Department of Psychology for each participant to receive a \$30 koha for their participation. This was due to the time commitments for this study, which involved two interviews and completion of a health diary.

Methods

Participant Recruitment

Having a number of community networks and being a stay-at-home mother has allowed me to meet many women who are mothers, some who stay-at-home with their children. Consequently while I did not invite close personal friends to participate I did ask them if they knew of other women who may be interested in participating. Two friends distributed information sheets for me and these mothers then contacted me if they were interested in participating (see Appendix A for information sheet). Other times the participant mothers asked friends of their own and then these mothers contacted me. By

using this 'snowballing' technique ten women indicated to me that they would be happy to participate.

Maori/Pacific Islander or mothers from other cultures were not excluded from the study but were not actively pursued for this study. It was anticipated that if there were any participants from other ethnic backgrounds then a cultural advisor would be consulted and included in the interviews as needed.

The aim was to invite mothers to participate in the study who met the following criteria:

- They were not engaged in paid work outside the home
- There were two adults within the home
- There were two or more children living in the household who were aged 12 years or less
- Mothers who only have children aged older than 12 years were excluded
- The children lived within this home more than 50% of the time
- The mothers could speak English
- The households were located on the North Shore of Auckland
- The participants consented to participate in this research.

There were three main reasons for only talking to stay-at-home mothers. Firstly, stay-at-home mothers are with their children the bulk of the time and as such I anticipated they would be very much involved in family health. Secondly, I anticipated that mothers who worked outside the home would be less available to be interviewed due to restraints on their time and the time demands of this study. Lastly, research on mothers tends either to group all mothers together assuming a universal set of mothering practices or focuses on working mothers. The reason for the age requirement of the children was I anticipated that over the age of twelve children tend to take on more of their own health responsibilities and the role of the mother changes. I also anticipated that more mothers of older children would work outside the home more and would not be available to interview. I required English to be spoken as that is my first language. The location of the participants was important only to ensure proximity for travel purposes. The reason for small subject numbers is due to anticipated saturation of the data and the time constraints of transcribing two interviews per participant.

The research was completed within a predominantly white middle-class area of Auckland. These mothers are not subject to the same inequalities mothers in lower socio

economic areas of Auckland or as Maori mother's experience (Durie, 2001). This may be seen as a limitation to this study as it will add to the bulk of research on mothers which is within these demographics. However, it may also be seen as a strength as there is limited research on mothers who stay at home with their children in urban areas that would be classed as upper middle class. It could be said that this group of women is a minority in itself due to the pressures on women to return to the work force after having children.

Data Collection Process

I anticipated that many of the practices surrounding care of family health would be embedded into routine mothering practices that would be difficult to explore without the use of multiple methods. Maps, timelines, health diaries and semi structured interviews were used in an effort to uncover the routine and non-routine aspects of family health. The process of collecting the data is described in Figure 1 and each area of the process is explored in more depth below.

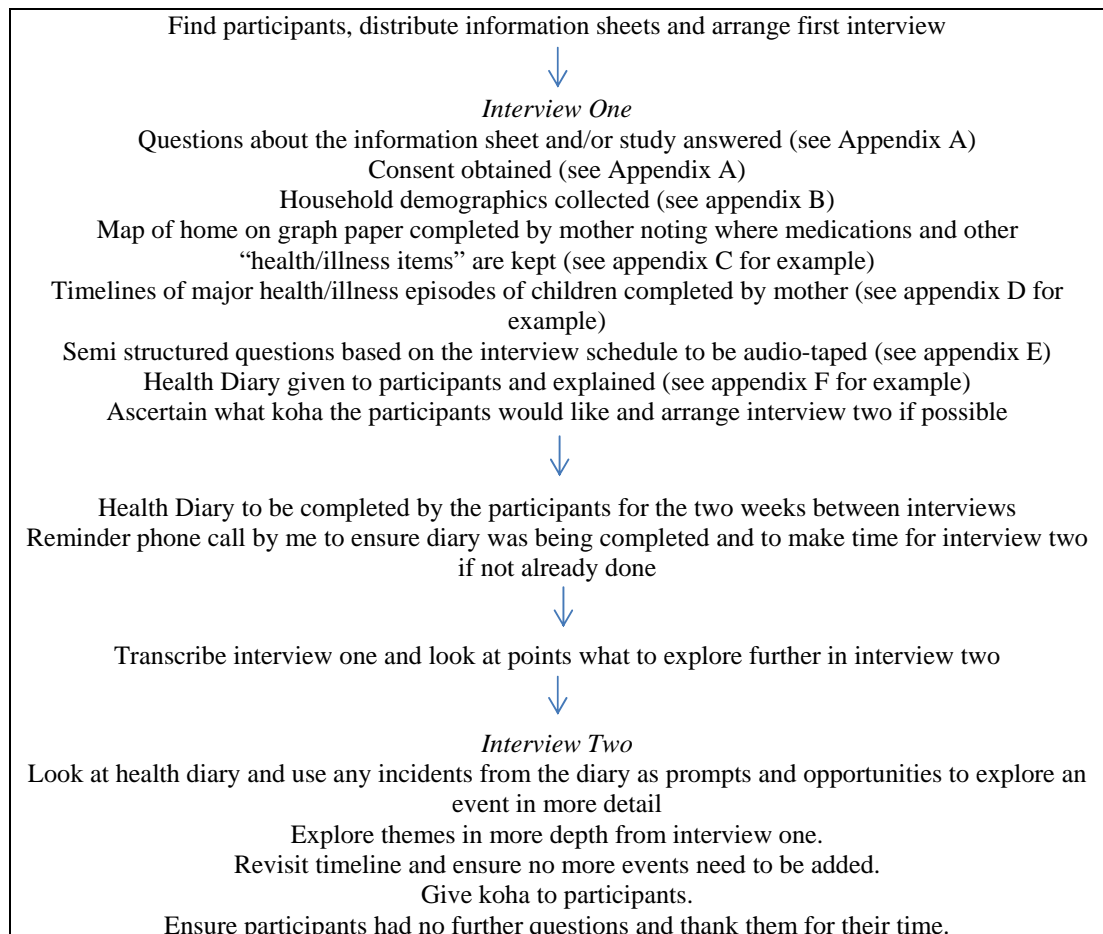


Figure 1: Data collection process

Arranging interviews

Once the mothers who were interested in participating contacted me I explained the study to them. I ensured they knew that the process would involve including two interviews in their homes and would involve completing a health diary. If they were still interested I arranged a suitable interview time for the initial interview. I arranged the time for the second interview at the completion of the first interview or called one week after interview one. I conducted the interviews within the participant's homes as the focus of the study is on the health/illness practices of the mother within the home and also because the home is the site of the material aspects of health and illness (Hodgetts et al., 2011). The first interview took on average between 1½ to 2 hours. The second interview took between 1-1½ hours.

The rationale for two interviews was to gain a more complete understanding of the complex nature of family health. The mother's role can include a wide range of activities that could not be fully explored in one, one hour interview. The two week gap between interviews also allowed me to start data analysis and look for key areas that need to be explored further in the second interview. It also allowed the participant mother to complete the health diary and be thinking about health-, and illness-related issues which might aid recall of events.

First interview

Each interview was conducted in the participant's home at times convenient to both the mother and me. All of the interviews, apart from one which was conducted in the evening, were conducted during the day while children attended school, kindergarten or while young children were having afternoon naps and while the husbands were at work. This was to ensure confidentiality and ease of talking without interruptions.

At the start of the first interview I ensured the information sheet and consent form were understood and signed and I got the mother to complete the household data sheet (Appendix B). I reminded the participants that the interview would be recorded, that only I and my supervisor would see, hear or have access to the transcript and that all information provided would be confidential and unidentifiable except by me. Once I had ensured they were comfortable with this the recorder was switched on. I ensured it was on before the mother did the map or timeline to capture the talk around maps and timelines.

The first thing all the mothers did was draw a rough outline of their house on graph paper (see a sample map in Appendix C). The purpose of the map was to get a household map of where medications and other health related items were stored, to give a starting point to the interview and to focus the initial part of the interview. The maps worked remarkably well in doing these things, particularly focusing the talk on health and illness. However, it did lead the mothers to believe that medications were the only thing I was interesting in talking about until I re-directed the questions to other areas.

The use of visual representations has been shown to help participants focus their attention, help understand the scope of the research, and help make the mundane or routine unfamiliar (Hodgetts et al., 2011; Manny, 2010; Sheridan, Chamberlain & Dupuis, 2011). It has also been show that use of graphic elicitation alongside interviews has the potential to enrich the talk into layers of past and present that may not be found in interviews alone (Sheridan et al., 2011). In this research the use of maps and timelines did exactly this, it focused the talk, aided the understanding of the research project and abled me to get stories of the past and present around family health.

Drawing of the household map allowed the mother to think about specific medications, why she has them, what are they used for, when were they used and who purchased them, thus exploring the routine and non-routine aspects of some medications. This allowed me as the researcher to explore how the mother talks and explains medication use in her family, her role in medication distribution, administration and purchase and her role in her decision-making process when using it. Medications for the most part are stored, used and bought into homes. However, they also leave the homes, go with the mother, father, and children on holiday, to school, and to work. I anticipated that the mother would ensure the efficient 'mobility' of medications for the children in particular. The process of drawing the map bought up incidents and stories around the mobile functions of medications as discussions was focused on the medication and where it goes, who is responsible for this and so on.

Timelines were completed by all mothers (see Appendix D for a sample). Major illness events were recorded for the children starting from their birth to the date of the interview. The timeline worked very well as an aid in recalling major illness events. It focused the talk on one child at a time and in all instances began with the birthing story of the child. The mother ignored her own health, for the most part, when doing the timelines except for health during her pregnancies and birthing stories. However in one

household (#4) the mother has had serious on-going health issues which we talked about in depth but interestingly she did not mark these issues on the timeline, only those of her children. Leaving the timeline in sight during both interviews allowed both the mother and I to refer to and we could add to it as necessary.

The main aim of using the timeline was to provide instances and examples where the mother had had to manage a complex illness event. These events tended to be very serious such as hospital stays and were very clear in the mothers mind due to the seriousness of these events. So while these stories were subject to recall bias I felt the seriousness of events aided the recall of these times. I was also more interested in the mother's management of the event as the overseer of family health, rather than specific details of what occurred. So for this, the timelines worked extremely well.

An interview schedule was taken by me into each interview (see Appendix E). Once the maps and timelines had been completed and talked about then I referred back to this schedule to ensure any areas that had not been covered in the mapping and time lining process had been covered. The topics that tended not to be covered by mapping and time lining were related to health, healthy lifestyles and preventing illness. Illness events were explored well using the other methods.

At the completion of the interview I asked what koha they would like (they had a choice of grocery or petrol voucher to the value of \$30) and then explained the health diary and asked if they would be happy to complete it and what this would entail. Once the participants said they were happy with completing the diary I gave it to them and thanked them for their time. I then attempted to make a time for the second interview if it was possible.

I called or e-mailed the participants one week after the first interview. The purpose of was to check if the health diary was being used and if they had any questions. If a time has not been made for the second interview I asked the participant what would be a suitable time for the second interview and confirmed the appointment time.

Health Diaries

The use of health diaries has been shown to be effective in eliciting information that is temporal in nature and may otherwise be hard to obtain (Willig, 2008). If completed correctly diaries can allow specific incidents to be explored from start to finish in real time. This can be very difficult in other methods which rely on recall of past events

(Willig, 2008). While the use of health diaries can be time demanding for the participants and can require a high level of commitment, this did not prove problematic in this instance. All the mothers interviewed fully engaged in this task and were very happy to complete the diary in all instances.

The health diary for this study consisted of a booklet in which one page was completed for each day of the week for fourteen days (see Appendix F for sample). A space was available to comment on any medications administered, any illness incidents from any family member. I emphasised I was interested in the role of the mother in any incidents and the impact the incident had on her personally and on the family. I anticipated the health diaries would take five to fifteen minutes a day and the mothers reported this was an accurate estimate. In fact in some houses it would have been even less than this. Households with chronic conditions that had the same daily medication routine were told they could just write the regime once and only note changes, however all of them wrote down the medications each day.

Health diaries varied in complexity from one entry to multiple entries each day. The content was based solely on what had occurred during that time period and to what extent the mother was happy to complete the diary. The households with chronic illness had more complex dairies. The health diary was very effective in producing really rich and detailed information about specific minor ailments and the management of chronic conditions. One of the questions in the diary was about the impact of the incident on the mother and this provided some excellent discourse on the mother's role in every day instances of health and illness. In this way the health diaries allowed an in depth look at a two week period or a cross section of data.

Second Interview

Before the second interview I had transcribed interview one so I had areas, themes and incidents I wanted to talk about further. Before I explored these I started by going through each page of the diary and getting more complete details and talk for each instance written in the diary. The recorder was turned on before the diary was discussed to ensure all the talk was recorded. I then went on to explore any themes that may have come out from the initial data analysis.

At the conclusion of the interview I debriefed the participant by asking them if there are any outstanding issues or concerns after which I closed the interview. I gave them the koha that they had requested and thanked them for their participation.

Data storage/Participant confidentiality

Access to audio data and transcribed notes was restricted to me and my supervisor. The audio from the interviews was destroyed after analysis was completed. Transcripts and tapes were stored in a secure and locked cabinet unless being transcribed. Transcribed interviews were kept in a locked cabinet in my home office. Consent Forms were kept separately in a locked cabinet in The School of Psychology. The health diaries, maps and timelines were stored with the transcripts. A summary was given to participants at the completion of the study if they had requested it on the consent form.

Extreme care was taken to ensure that any information that could identify families or participants was not reported. Participants and their family members were given first name pseudonyms when the tapes were transcribed and these were then used in any subsequent reporting. All other names, places or identifying data were removed.

Participants

There is a summary of the households and their demographics in Table 3.

Family	Name and age of mother	Ages of children	Name and age of father	Occupation of father
1	Sarah	Addisyn 7 years Joe 5 years Talani 9 months	Chris	Air traffic controller
2	Michelle (43)	Chloe 17, Amy 7, Jacob 5	John (47)	Registered Valuer
3	Leanne (36)	Sophie 5, Belinda 2	Richard (37)	Construction/Importing
4	Jocelyn (41)	Rebecca 7, Andy 5	Luke (41)	General Manager
5	Charlotte (35)	Georgia 8, Samantha 6, Lucy 4	Edward (36)	National Business Development Executive
6	Lexi	Steve 5, Tymone 3, Byron 2, Michael 5 mnths	Eli	Organisational Development Consultant
7	Lilia (43)	Louise 9, Jim 6, Bob 6	Mitchel (38)	Currency Trader
8	Stephanie (37)	Thomas 5, Andrea 3	William (37)	Teacher

Table 3: Demographics of households

One participant (Lexi) identified as Maori and her children as Maori/Chinese, while the rest identified as New Zealand European. The mothers of eight households were interviewed. I completed fifteen interviews. Due to scheduling and family illness, in my and her family, I only completed one face-to-face interview with Lexi. She did however complete the health diary and I asked her several questions via e-mail about the health diary and interview one. All the mothers involved met with the criteria stipulated in participant recruitment. While income data was not collected the occupations of the husbands and the decile rating of the local primary school indicate that this area of Auckland is predominantly upper middle class. The decile of this school is a 10. The Ministry of Education (2011) defines decile as the following:

“A decile is a 10% grouping. A school’s decile rating indicates the extent to which it draws its students from low socio-economic communities. Decile 1 schools are the 10% of schools with the highest proportion of students from low socio-economic communities, whereas decile 10 schools are the 10% of schools with the lowest proportion of these students”

(<http://www.minedu.govt.nz/NZEducation/EducationPolicies/Schools/SchoolOperations/Resourcing/ResourcingHandbook/Chapter1/DecileRatings.aspx>)

Reflexivity

Reflexivity, particularly in feminist social constructionism, is emphasised due to the social nature of construction of knowledge and the awareness of the power imbalances between researcher and participants (Gergen, 2008). Fox and McBride Murray (2000) describe reflexivity as “self-conscious reflection about the part one plays in the generation of knowledge” (p. 1161). Fox and colleague go on to suggest that taking a self-critical stance and being reflexive then allows the idea that subjectivity is as valid as objectivity in research and allows the researcher to be co-producers of knowledge. The power of knowledge and the supposed expert stance of the researcher are then not as evident. Important in this is the ability to be self-critical at all phases of the research. These have been the goals that I set for myself as the researcher. Being aware and self-critical at all phases of the research and also being aware that I as a mother will bring to the research a different viewpoint than a woman who is not a mother or a male researcher.

The feminist theoretical framework and the social constructionist epistemology were taken into consideration when planning the methodology. There are many methodologies that I could have used within this framework, however, I was interesting

in exploring the mother's lived world and how this was impacting on family health and how family health was impacting on the mother. I anticipated many of the practices of mothers in family health would be embedded into their role as mother and considered 'routine' for these mothers. In order to explore these ideas, and the relationships between mothers and family health, I carefully reflected upon which methodology would be the most useful.

Tardy and Hale (1998) in research with mothers found that the researcher was seen to be more knowledgeable and approachable once it was established she was a mother also. An insider status may be claimed by me the researcher as I am of a similar age to the mothers being interviewed, my children are similar ages, and we all have at least one child attending the same primary school. The advantages of being 'researcher near' or mother talking to mother is that the participants may feel comfortable with me in sharing the stories that may be open to judgement otherwise (Mannay, 2010). My ability to empathise or potentially share stories from my own mothering should decrease any feeling of judgement and encourage the 'mask of motherhood' to be revealed (Gill & Liamputtong, 2011). However, the disadvantages are that they will potentially see me in the community, at school, at the grocery store and while confidentiality will be maintained the knowledge that I have heard intimate stories about their mothering may discourage some talk.

I was also very aware at all times that I am a mother and as such have a role in caring for my family's health. I found myself at times listening to the mothers and thinking I "that is a good idea, I will try that" or "I am glad that they do that too" or "I don't think that is a good idea". A constant and heightened awareness that I had an internal voice around the issues we were talking about assisted me in keeping my experiences separate. However, it was impossible for me to remove myself as a researcher from the experience or from the analysis. At times I was asked how I managed certain aspects of my family and I would give examples. This was done with the aim of keeping the interviews more informal. However, the focus was always brought back to their experiences and practices. The ultimate aim was to be non-judgemental and sensitive to the participants and I believe I succeeded in that first and foremost.

I asked all the participants how they had found the study process. One mother said it had made her more aware of how much she does do and gave herself a mental 'pat on the back'. Another mother at the second interview said she had felt guilty about not

having an activity for her then nine month baby outside the home, felt guilty and then had been to a toddler group with the baby. This was based solely on me asking about her children’s activities. For me the question was about gaining information but she had internalised this question. As well as highlighting to me how careful I would have to be in framing questions it made me aware of how much guilt mothers have. However, I do believe that overall these mothers felt listened too and valued as mothers because of the interview. Being in a traditional mothering role is not easy at times and being interviewed allowed them to verbalise all that they do, the sacrifices they have made and talk about the good and bad aspects of stay-at-home mothering. I believe the fact that I am a mother aided me in eliciting natural talk and also made me aware of how much I do as a mother caring for my family’s health.

Data analysis

The data analysis was loosely based on Foucauldian Discourse Analysis and the procedural guidelines set out by Carla Willig (p. 115-117, 2008). These guidelines include a six stage process, which is detailed in Table 4.

Each tape-recorded interview was transcribed verbatim by me and typed into a Word document. These transcripts included all talk around the maps, timelines and health diaries. I re-typed the health diary information verbatim and put this into the start of interview two’s transcript.

Stage	Analysis Process	Aim of this step
Stage 1	Discursive constructions	What is the discursive object? How are these constructed in the text both implicitly and explicitly?
Stage 2	Discourses	How do the discursive objects differ?
Stage 3	Action Orientation	What is gained from constructing the object in this way at this point in the text?
Stage 4	Positioning’s	Look at subject positions – a location for the persons within the structure.
Stage 5	Practice	What is the relationship between discourse and practice?
Stage 6	Subjectivity	What is the relationship between discourses and subjectivity and what are the consequences of taking up these positions?

Table 4: Procedural guidelines used to base data analysis

The process of analysis was a recurrent, on-going dynamic process where the transcripts were read multiple times. I made extensive notes looking at each household, each

mother and then across each family to all the families. I initially looked for the different areas that made up family health such as food, sleep, exercise, medications, immunisation, hygiene and cleanliness, illness prevention such as sunscreen, and supplements. I initially was interested in determining what the mother's role was in each of these areas and then within health and then within illness and then across family health.

I will use food* (I could substitute medications, exercise, or any other area of health in here) as an example for the analysis process but a similar process was used for all areas of family health. I looked for such things as who does the cooking, grocery shopping, provides snacks, packs school lunches, does menu planning, writes lists and who has overall responsibility for food in each family. Once I felt I understood who was doing what at that time I could ascertain why it worked that way, when did it work differently, how had the mother negotiated with the family who was doing what, how was food* provision and monitoring related to the mothers identity as a mother. Once I had analysed each family individually I then looked across the families to see how food* was 'done' the same or differently. Was it something unique to one family or common to all, and why was this?

Stage two was to see how the different areas of family health were the same or different across health and illness and then across family health. Again using food* as an example I was interested in how food was used in keeping the family healthy and how it was used when dealing with ill health. The sorts of questions I looked for were the practices the same across health and illness, how did food differ when one family member was ill and the rest healthy, and why did the mother take on the role of food for entire family, just the ill, just the healthy? Again this was done within and then across mothers and then families.

I moved on next to see what was gained by constructing the talk in a specific way and think about how the mother was positioning herself with regards to the discourses she had produced. In the example of food*, I could see if she talked about food as her overall or shared responsibility and why she took this position, what did she gain from positioning herself this way, how did it empower her or constrain her, and what did it mean across health, across illness, and across family health.

Then it was important to think about and theorise around these positionings. I looked at how the mother was actually practicing mothering and the justifications and the impact

it had on her practices across family health. In the example of food*, I went back to the theories I had proposed would be of importance to family health and looked at the relationship of the discourses around food, mothering, and family health in terms of these theoretical accounts. Was food* subject to morality, risk, internal or external surveillance, or medicalization when keeping the family healthy, preventing ill health or dealing with ill health? If the answer was yes, I asked why, when, and for what purpose. If the answer was no, I again asked why, when and for what purpose.

There are always consequences of taking a specific subject position which I explored in the next phase of analysis, looking specifically at ideologies and power and its relationship to the mothers. Again in the example of food*, if the mother positioned herself as the overseer of family nutrition then what was the consequence for her, the family and the wider society? How did this influence her mothering practices across and within family health?

It is important to realise that although I have outlined these as a series of steps that are consequential the actual data analysis was not so clear cut. I went back stages, jumped steps, and re-worked the analysis many times. This was an on-going process and involved many discussions with my supervisor on the different steps, clarification on different areas, and required extensive time to arrive at the findings. The findings will be split into two chapters solely for the purpose of this thesis. Family health consists of both of these areas and the role of the mother may encompass both these areas at one time. The first findings chapter will focus on the mother's role in keeping the family healthy and on preventing ill health. The second will focus on ill health.

CHAPTER 3 – Keeping the family healthy/preventing ill health

The multifaceted nature of the mother's role in family health was difficult to encapsulate in a single word but the discourses all suggest that mothers 'oversee' family health. While all eight mothers had different activities and tasks that they identified that they had sole or joint responsibility for with regards to family health there were common areas that were identified during analysis. They talked about food, hygiene and cleanliness, sleep, exercise, well child checks for eyesight, hearing, height, weight, and monitoring of behavioural childhood milestones, dental health, boosting immunity, avoiding certain foods and environmental risks, use of sunscreen, and immunisation. They also mentioned mental health in terms of types of activities, socialisation and happiness. The discourses around these areas were grouped together for the purposes of this chapter as keeping the family healthy which includes 'doing health' and preventing ill health. Doing health is the way I will frame all the activities and practices the mother's did in order to maintain their family's health. Dealing with ill health will be dealt with in the next chapter.

It is important to note that every family member had a role to play in family health but the focus of this particular study is on the role of the mother. While descriptions and summaries of the roles of the mother are interesting and point to the complex nature of family health the main purpose of my analysis was to go beyond descriptor of roles and responsibilities. The focus of the findings is not on the 'who does what' in each household but rather gaining a greater understanding of the mother's role as the overseer of health. The analysis revealed three main processes discursively constructed relevant to the mother's role as overseer of family health: 1) surveyor and monitor of family health; 2) provider of health; 3) and teaching and modelling health. The purpose of these was ultimately to reduce the risk of ill health and to maintain a healthy family lifestyle.

Mothers as surveyors of family health

A key finding from the analysis revealed that mothers survey and monitor family health. There were four process identified that were relevant to this role of surveyor. I will explore the way these were discursively constructed within theoretical ideas of surveillance medicine (Armstrong, 1995; Gillespie, 2011), and Foucault's ideas of

disciplinary technologies and community surveillance (Hook, 2007), and a postmodern feminist idea of self-scrutiny of mothering practices (Jenson, 2011).

- 1) Surveying children's bodies and behaviours
- 2) Surveying the mother's own health
- 3) Mother self-surveying her mothering practices
- 4) Surveying the environment and goods and services of health for the family

Surveying children's bodies and behaviours

In terms of keeping the family healthy the mother was continually surveying her children's bodies for normal development and for signs of ill health. The rise of surveillance medicine means that children are screened and measured against medically determined 'norms' (Armstrong, 1995). This dominance of medicine on normal development means mothers as the primary carers of children are aware there is a potential for abnormal development. This creates a culture where experts are seen as necessary for mothering (Lee, 2008). This medicalization of motherhood and the rise of surveillance medicine mean children are measured for height, weight and length on growth charts, on their normal development of eyesight, hearing and age appropriate development of other physical attributes such as teeth and then on behaviours such as socialisation (Chase & Rogers, 2001). For these mothers, surveying of normal development was an on-going practice and was embedded in the mothers daily lives until something out of the ordinary happened that initiated an action or further surveillance. Jocelyn talked to me about the process of her noticing that her daughter needed glasses. The seriousness of her poor eyesight was also stressed through numbers or medical jargon suggesting the dominance of biomedical discourses surrounding 'normal' development.

Jocelyn: I think I told you but we were driving along and she said Mum look at that cat in the driveway and it was a plastic bag and I thought that's a bit odd. And then she reads everything, when she was reading signs she would say I can't see that. So then I kind of made the connection, plastic bag, can't read road signs, maybe I should have her eyes checked. She was negative two when we got her tested. And they said that was quite severe for her age as a six year old.

The surveillance was an on-going process over a period of time for Jocelyn, not something she noticed in one day. The link between surveillance and child development meant surveillance was an on-going process and as such became routinized as part of mothering children. Lexi has four sons, all under the age of six years and her eldest son

was diagnosed with autism four years ago. The process of diagnosis was drawn out and required on-going surveillance by Lexi, her husband and her extended family before she identified there may be a problem. She initiated a professional consultation which proved unsatisfactory and so it took even longer before she received a specialist diagnosis.

Lexi: So I ended up going to my plunket nurse and I said I am concerned about my son, I think he might have autism and I went to see her and she's like it's expensive to go and she pulled out like a milestones form for what they should be doing at his age and he was doing everything so it didn't catch the things I was concerned about. Developmental milestones you know. And if by the age of two they are not talking it is not such a big deal cos there are kids who don't say a lot. But I knew, mother's instincts, I knew something was happening. So um she was just trying to convince me not to go, she just didn't want to write the referral.

In Lexi's case screening did not highlight any problem but rather it was her sense that something was not right or 'normal' with her son. Her mother's instincts were related to her unique knowledge of her son. This expert mother position allowed her to keep seeking advice, help and a diagnosis for her son. This process and her expert mother knowledge heightened her awareness of the issues that may indicate autism and as a consequence the surveillance of her other children. Based on this previous experience she was worried her third son may be exhibiting similar behaviours and was sensitive to what needed to be surveyed and as a result took him to the doctor. The doctor reassured Lexi that her son was developing 'normally'.

Lexi: I took my Byron to the doctor because he had, his speech isn't developing that great, he's two and a half. He didn't try to speak or communicate, until a couple of weeks ago, verbally, a few months ago.

The dominant discourses surrounding motherhood and childhood development assume the mother has the knowledge of the child that is required to make a diagnosis or decision regarding any problems and that they will raise this when necessary (Bessett, 2010). This places them in a contradictory position at times because most women when they become mothers are not experts on child development but learn as they go. So on one hand the medical profession assumes mothers will seek help when they need to and not waste their time on minor delays and on the other hand mothers are not expected to have specialist medical knowledge (Nettleton, 2006). This was evident in consultations with medical professionals and other situations where the mother acts as an advocate for the child. The mother trusts her instincts and knowledge of her family but needs to seek

expert medical advice at times. However, while the medical professional may have the medical expertise they were seen as not having the intimate family knowledge.

Lilia: One thing I will say about having children that have slight problems with their health is that the doctors don't take you seriously enough. The doctors, you know there is something wrong with your child, you want a certain action.

In New Zealand, Plunket¹ does the bulk of this screening for very young children. Michelle's daughter did not walk until two and a half years due to a problem with her ligaments which Plunket identified as a problem in a routine check-up. While this was helpful to Michelle it was also difficult as Plunket thought the walking delay might indicate other developmental delays. On one hand screening was seen as useful for picking up any potential problems, but it also had the potential to make something into a problem where there was not one.

Michelle: They came to the house. She had developmental um, stuff as well. There was a lady from plunket who came and did puzzles and stuff with her. I think they must of thought that, cos she wasn't walking that something else might have been wrong. And I knew! That she was fine, I just knew she was fine. I mean she could talk and everything else, she just couldn't walk. They were a bit worried she was, that there was something else going on.

This problemization of normal has been demonstrated as a consequence of surveillance medicine where we are all seen as precariously situated between health and illness (Heaton, 1999). Michelle had adhered to medically and politically determined screening schedules and as such had done the moral thing, but she also retained the expert knowledge of her child. She 'knew' that her daughter was developing normally, except for her walking, due to her reaching other developmental milestones within normal timeframes. She remained confident in her knowledge of what was normal for her child. Maintaining an expert mother position was one way of discursively resisting the medical/child development expert while still allowing for medical intervention and help. In these examples the mothers are discursively positioning themselves as the experts in their children and as good mothers. She was someone who knows something no one

¹ "Plunket is a national not-for-profit organisation, community-owned and governed. We provide a caring, professional well child and family and whānau service. Plunket sees more than 90% of newborns in New Zealand each year. Plunket offers parenting information and support as well as developmental assessments of your child. Our nurses provide support through home and clinic visits, mobile clinics and PlunketLine, a free telephone advice service for parents. 24 hours a day, 7 days a week. Plunket also organises car seat rental schemes, parent groups, parenting education, toy libraries, drop in centres, play groups and education in schools – most of which are available nationwide and free of charge." (Plunket, 2011). <http://www.plunket.org.nz/what-we-do/>

else does about the child or as I term it the 'mother expert'. The mother expert is an expert in her family, their health, and their illnesses within a social, cultural and historical context.

As well as surveying the children for normal child development the mother also physically checked the children's bodies for signs of ill health, such as nappy rash, eczema, head lice and so on. This was considered particularly important in children who were very young or had limited vocabulary to explain they were unwell or something was not normal. The mother's also talked about surveying the children's behaviours for anything out of the ordinary. Extra tiredness, grumpiness, being off their food or wanting extra food could be a sign of an illness or something 'normal' such as teething, general tiredness and so on. How the mothers dealt with ill health once they noticed something was wrong or abnormal will be unpacked in the next chapter. However, much of the time it led to further surveillance and monitoring.

Kathryn: So is the grumpiness and tiredness an indication they are not up to full speed?

Jocelyn: Yeah, but in saying that Andrew is usually grumpy and tired when he gets home from school. Because he finds school really hard anyway. It's not necessarily an indication of his health but because he's miserable.

As the quote by Jocelyn suggests, the child's body and identity were surveyed with an expert knowledge of family health. This is important in the surveillance process because what is normal for one child may not be normal for another. Certain children were seen as being prone to certain illnesses and certain behaviours and the mother retained this knowledge of her children. As the child grows older from baby to toddler and so on this health and illness knowledge is obtained by the mother on her children. Fox and Ward (2008) suggest individuals have a health identity that evolves and changes over time. This study would suggest that the mother takes on the initial ownership of the child's health identity, she retains this knowledge, and she learns how to care for that child with their particular health identity. Jocelyn talked about how her daughter is a frequent vomiter and as such this is not something to be unduly concerned over. This was just one example where the health identity of family members was talked about as all the mothers talked about their children being 'prone' to certain illnesses.

Jocelyn: No, he's fine. Rebecca is quite healthy but is our expert vomiter. She has had lots of tummy bugs and she has vomited lots, and lots and lots and she probably has a vomiting type of sick episode a couple of times a year apart from when she was younger

when she used to have it all the time, six times in one winter, when she was going through her whole antibiotic ear infection thing. So she's a really good vomiter. (laughs)

Two of the mothers had young babies and their discourses suggested the baby had not established a health identity yet and also that children's identity would continue to change as they grew. This required continual surveillance by the mother in order to stay current, aware and prepared for any changes in the child's health history. Sarah's husband suffers from hay fever so when her daughter starts complaining of itchy eyes she uses this family knowledge to help decide whether it is hay fever or an allergy to long haired cats. This will require on-going surveillance in order for her to decide.

Sarah: She's had it on other occasion where she wasn't round cats where she said she has itchy eyes. And she's been rubbing them. So that makes me wonder whether it is something hay feverish or something of the like because she hadn't been near any that day so (indicating diary). And we do have a family, well Chris gets hay fever. So I did wonder whether that kind of thing is coming out.

K: So is that just a matter of keeping an eye on it?

Sarah: mmmmm . It will be interesting to see if it goes on (//) over winter because predominantly you don't get hay fever in the winter. It's just the change of season so it will be interesting to see if she's not around people with cats whether she still complains of itchy eyes kind of thing and time will tell.

Liamputtang (2009) suggests that the embodied child and health are intertwined with the "mothers' presentation of themselves as responsible for the health of their children as 'worthy' parents" (p 211). Roy (2008) says that the body is now a site of physical and moral health and as such mothers as the prime carers of women are subject to the surveillance of their children's bodies and their health and physical appearance. Foucault (1984, cited in Roy, 2008) would say this surveillance is points to disciplinary power. Disciplinary power suggests that there is a new self-regulated form of self-governance through a new set of norms that guides and regulates the body towards good health. This research would suggest that mothers have a form of control or disciplinary power over their children's health. This raises interesting issues for these mothers as while they position themselves as in control and having control of the child's body through surveillance they acknowledge that is a paradoxical position between morality, good mothering ideology, surveillance medicine and love of the child. On the one hand the good mother surveyor is very vigilant in order to notice 'abnormal' and then take action and then on the other hand she is aware that the child's body and her own are open to surveillance themselves. This leads into the next section that considers that

while mothers are surveying the children's bodies they are also surveying their own health.

Surveying the mother's own health

Mothers are subject to intense medical surveillance and monitoring during pregnancy and post birth (Bessett, 2010; Nicolson et al. 2010). For most women, even before they get pregnant there is a heightened awareness and consciousness they are responsible for normal foetal development (Nicolson et al. 2010). Post birth mothers are surveyed seemingly solely for their ability to feed and care for their babies. This immediately reinforces the dominance of intensive mothering, one who selflessly cares for her family and one of maternal blame (Lee, 2008; Roy, 2008). Then as a moral healthy citizen under the gaze of society the mother should be doing health for themselves (Currie, 2004). So how do mothers negotiate contradictory pressures to be healthy enough to mother and healthy enough to maintain moral status as a healthy citizens. Discursively they pulled and pushed against both these positions. Comments such as "mums don't get sick", or explanations of why they did not exercise due to the time pressures of being a mother indicated a strong good mother position, one that puts family first. However mothers do get sick. This will be discussed in greater detail in chapter 4 when I discuss dealing with ill health.

Charlotte: Mums don't get to be sick. Dad's get to be sick and go and spend a couple of days in bed or grizzle about it and even I felt like I was going to come down with what Lucy had this week and hubby's first comment is but you can't I've got to go to Wellington this week and I gotta .. and it's like it's too inconvenient for the Mum to be sick because they are too busy for you to take a couple of days to be sick in bed. So you're more likely to just take the tablets to clear everything up and get you through the day and keep going.

Reducing stress was seen as one way of negotiating the difficulty of mothering in a health conscious society where healthy children are seen as a reflection of parenting practices. Doing things to reduce stress on the mother, or making it easier for her were talked about as being necessary to be a good mother, one who is patient and kind. Mothering in this case was difficult and hard and as such mothers needed a break from the intense demands on them. Sometimes it was things such as chocolate or alcohol, both 'unhealthy' but necessary to get through the mother's day. Again this was difficult was taking time out for yourself was selfish but potentially has health benefits for the mother.

Lilia. I walk to school and try and get as much exercise as possible, eat healthily unless I am bingeing. Drink healthily and have a good network of friends so that you can talk to your friends so that the stress doesn't build up too much.

Both positions did require the actual process of surveying and caring for the mother to fit in with family commitments. If you joined a gym then it needed to have a day-care or you went when the husband got home from work. You either take all the kids with you to the doctor to get a smear done, wait to the weekend, or get someone else to watch the children. Currie (2004) found that exercise programmes outside of the home provided a space for women to get relief from the burdens of being a stay-at-home mother.

However, the exercise class itself led the mother to self-survey and compare her own body with the others or feminine ideals of fit, healthy and athletic women. This will be discussed in the next section alongside self-surveillance of mothers.

Self-surveying mothers and family health

There are competing discourses for surveying family health. The discourses of the surveillance, medicalization, the discourses of the good mother and discourses of the morality of health are all evident. These competing discourses makes the work of the mother more difficult as in reality you cannot survey all the aspects that go into health all the time due to constraints on such things as time, budget, physical or emotional resources. Thus it is impossible to be a good mother, a moral health provider and keep your children healthy all the time which makes the job of overseeing family health challenging. Part of this is the culture of surveillance that opens mothers up to surveillance from others, either medical professionals or friends or even strangers who feel they have the right to comment on your child particularly around health issues such as weight, sun burn, diet, bed times, discipline and so on (Blackford, 2004). The self-surveying mother is very aware of social surveillance by family, friends and the community (Stearns, 2011). Maintaining your own identity as a good mother, while being subject to social surveillance, is difficult and dynamic. Jenson (2011) suggests that worry and anxiety have been normalised for mothers in all aspects of mothering from health choices through to choices around toys, schools, activities and just about everything surrounding child rearing. This certainly was the case in this study, with guilt and worry being expressed on choices the mothers had made or had yet to make throughout all the mothers talk about health and ill health. Stephanie talked here about the guilt she has of not taking her children to the park enough when they were little and guilt that they are not doing swimming lessons at the moment.

Stephanie: And I have a vague idea and this is guilt from the early days of not taking them to the park enough all that kind of a kind or I am not making enough of an effort, so in the back of my mind I think in the holidays, right you know we must find a space for them to go to the park, or there is the guilt that they don't swimming, so we must do that at some point. I know all the all the good stuff that happens at the park, but sometimes I have to consciously make that happen.

Medically determined parenting practices also had power over the mother's sense of competence and this was frustrating and worrisome. I argue that uncertainty and anxiety is very relevant for these mothers. Part of this was framed as mistrust of health promotion messages and partly personal guilt over certain mothering practices based on social and personal surveillance or what I termed internal and external 'performance review'. Both are intertwined and connected though in the messy everyday world of these mothers. These areas will be discussed under the frameworks of uncertainty management and a culture of self-improvement.

Many health promotion messages, parenting manuals and discourses behind well child screening programmes suggest there is the potential for great misfortune (that is, ill health, injury or death) and assumes that we live in a risky society (Bissell et al., 2001). This has led to a culture of mothers that are constantly managing risk and have to be super vigilant in surveying the environment, the body and practices of health in order to manage this risk (Backett-Milburn & Harden, 2004). It also means that mothering and health are uncertain and at times you cannot trust in the decisions you have made for your family and at times you cannot trust the advice you have been given. There were examples talked about by all the mothers where they were uncertain over medical decisions such as immunisation, mothering practices such as how to deal with picky eaters, or uncertainty over other expert advice. Sarah talks about her uncertainty around her decision to immunise with the MMR vaccine.

Sarah: So you go and do it. And then they turn around and they tell you they are stopping the programme and it's not that effective anyway and then you think oh my god I've just exposed my kids to being guinea pigs to something or rather that they're not sure of and make you feel guilty if you didn't do it.

Jocelyn's son had reflux and her frustration with the advice she was getting and how to actually mother with that particular advice which positioned her as responsible for her son's tummy problems due to what she was eating.

Jocelyn: Honestly with Andrew he was just diabolical. I was tearing my hair out, he wasn't sleeping, he had sore stomachs, he has itchy skin and I was going through plunket

and they were saying you have to stop eating tomatoes, you have to stop eating this, you have to stop eating that. Cos they thought it was all coming from my breast milk.

One way of decreasing the uncertainty of the mother's decisions was by doing extensive research either on-line, in books or via lay networks. For some of the mothers expert knowledge of family health was power, power over their partners/husbands, medical professionals and other mothers. They are economically privileged in this study as they have access to these resources and have the time to do the research.

Leanne: So if I come across something that I don't know much about I research it. I'm on the internet, I google it, I talk to people, I ring healthline, I just get as much information as I can. I have always been like that. Like to get a handle on it, just //

Of course knowledge in itself can be uncertain and not all knowledge is treated with the same degree of trust, power or relevance to them (O'Key & Hugh-Jones, 2010). The mother saw it as her role to survey the information and then implement it in to her family's health. However this responsibility led to guilt over many mothering and health related decisions from what you are feeding your children to what activities you take them to. Self-improvement and a culture of never knowing enough about health or mothering means there is a culture of mothers who judge other mothers based on their children's appearance, behaviour and attitudes (Jenson, 2011). Miller (2005) suggests there is a moral imperative to be a good parent and this leads to anxiety and heightened self-awareness. I argue that this extends from 'parenting' to all aspects of health and illness as mothering and family health are connected and intertwined. However these mothers do not feel guilty all the time either. They do make decisions and discursively justify these decisions. They are aware that mothering is hard and you are blamed for a lot but sometimes you just have to believe in yourself and your ability to make the best decisions for your family.

Leanne: ...so every morning she is doing something. But no paid activity which I feel a bit guilty about.

Kathryn: tell me more about that.

Leanne: Yeah, that's just what I was saying about Belinda, she should be attending something, some prearranged and like I drove past Jumping Beans and I looked in there and I thought for god sake just let them crawl around your furniture it is that same thing, do some roly pollies on the carpet you know. I feel bad about it and then I see what the class entails and I think come on take your kid outside to a jungle gym and you know. I'm sure it is good for when it is raining, that type of thing. Yeah I give myself a hard time but really I am doing the best that I can.

Leanne first starts off telling me she feels guilty because her two year old does not attend a paid activity which she perceived as something she should be doing but then discursively works her way around to 'what I am doing is actually ok'. Managing risk and uncertainty are also tied to surveying the goods and services of health and this will be discussed next.

Surveying the environment and goods and services of health for the family

The mother in all cases surveyed the goods and services or provisions of health for the entire family including the husband. While they might have shared duties such as grocery shopping or cooking the mothers positioned themselves as the main surveyors and monitors of the overall provision of health including food and nutrition, amounts of exercise, amounts of sleep, environmental safety, dental hygiene, personal hygiene, and household cleanliness. Monitoring and surveying of family members was seen as an on-going daily job and was embedded in mothering practices. The surveying of everything that goes into health meant that healthy lifestyles were maintained, the goods of health were purchased and replaced as necessary, and illness and injury were potentially prevented. By doing they were ensuring the efficient provision of health and the safety of the family while maintaining the good mother identity.

While all aspects of family health were surveyed by the mother on a daily basis, food provided the most talk. The link between food and health has been reported in lay accounts of health and the mother's role as the main provider of food has also been explored (Wood et al., 2010). Healthy eating messages are targeted at mothers and it has been suggested the mothers mistrust some nutritional messages (O'Key & Hugh-Jones, 2010). What this research highlighted was that the mother positioned herself as the overall monitor of the family's nutritional needs even when she was not the one purchasing the food. How much processed food the family eats, how much sugar, salt, fat, vegetables, fruit, types of meat were all surveyed and then menus, snacks and other events were planned for, provided and then monitored, all by the mother.

Leanne: Richard does the grocery shopping, he takes the girls in the weekend. But in terms of what we need to buy I probably have more say. We'll agree on what we are going to eat that week but I am the one who says make sure you get fruit and vegetables. If he just went shopping without me saying anything to him, he's not big on fruit so he probably wouldn't get that. And he would probably just get broccoli, mushrooms or just the very basic vegetables. So I will usually write a list for him.

Stephanie: So, in terms of processed stuff, we get rice wheels or seaweed crackers or sesame ones because there is more kibble in the sesame ones, rice wheels they have some stuff that some of the other chips have. But then I look for the salt on the crackers

The excerpts above show how embedded some food health messages are to these mothers. Fruit and vegetables were seen as universally healthy, and foods high in fat, salt and sugar were seen as ‘unhealthy’. Other nutritional messages were not as clear cut and were mistrusted and as such had to be re-worked into the family, usually by the mother. The scientific nature of food discourses and the ‘expert’ talk on food suggests that food surveillance is bound to medically and scientific determined norms and social rules. Talk around food provided another example of how much of child rearing has been dominated by the medicine and science and how uncertain this can be.

Lilia: I hate going to the supermarket and buying the fat free food. Cos what is in the fat free food. I don't have full fat milk but I don't like buying for my children necessarily, the fat free luncheon sausage which is probably crap anyway, or whatever it is, what do they put in when they take the fat out. Have they put more sugar in? Sugar is aging and hardens the arteries and all that sort of stuff.

Allergies and food intolerances have added complication to the surveillance of food. The mother in one household has to manage a severe peanut allergy in her daughter and ensure that the community takes on the responsibility for her daughter when she is not at home. The mothers were very aware of the food safety and risk associated with some foods such as peanuts. Discourses on breastfeeding, scientific warnings and medically determined schedules for the introduction of food for babies have increased the discourses around allergies and the role the mother has in potentially stopping the development of them (Cummings et al., 2010). Food safety, such as choking hazards, is also embedded in the provision of food to young children. However, I suggest that discourses surrounding food allergies and the risks associated with them are also part of good mothering ideologies and means the mother has to be very vigilant in monitoring food safety in their own home and outside of it as well. This means any potential sharing of food requires mothers to be hyper vigilant when having other people’s children back for play dates or shared lunches or having people over.

Michelle: And when it's practice on Tuesday after school everyone brings fruit, crackers, biscuits, and we just have this big share before, during and after. Because it's like I'm hungry, I'm thirsty. But it's quite funny actually watching them, normally always before because they are quite hungry after school which is fair enough, and um I try not to bring biscuits cos I know Jacob would just scoff the lot and so would Amy. But other parents do bring biscuits and others don't cos they don't want their kids to eat sugary things.

There's a couple that don't bring biscuits. And it's the same with Amy's netball. Whoever gets player of the day on Saturday gets to bring treats and oranges. But no one's got any allergies.

Surveillance was also about reducing the risk of ill health (including injury) through safety and risk reduction both in the home and out of the home. Baby proofing houses through the use of safety gates, locks, baby monitors, swimming lessons and water safety in baths and nanny cams were just some of the things that were done to keep young children safe. Information seeking was also related to reducing risk in the environment and keeping the children safe. Things such as which car seats were the safest were important considerations. Reducing the risk of injury was particularly important part of gaining information and being prepared. Safety was particularly important for young children and sometimes a minor injury acted as a prompt for a mothering practice change. Again these mothers are in a position where have the economic and physical resources to research safety ratings and buy the safest products on the market. While this is a privileged position in some respects it also heightens information uncertainty due to consumer choice.

Jocelyn: We had a camera in his bedroom so as soon as he came out of his cot, we would have a monitor set up outside his bedroom and we would sit there and watch him, walk in and put him back in his cot, cos it was so bad.

One could argue that the use of these safety measures means the parents have to be less vigilant in surveying their children as their home is 'safe'. However, it also could be argued that the focus on safety means parents are now extra sensitive to the blame that would be attached to them if their child is injured or hurt while under their care. In the example below Leanne justifies her good mother status when her child got hurt.

Leanne: So that was that day and then Sophie fell over a buggy onto the carpet, stingy ankle, weight bearing. So being a physio I always do the can you point your toes, can you, check all the function, can you stand on it, but really she just needed a bit of a cuddle. Kiss and a cuddle. And what that made me think about was that we need to keep all the moving toys, buggies, ride on toys away from the main living area. Like they need to be, like we keep moving them down there, onto the deck but the kids keep bringing them up. It's just a rule but they are just young. They're not, you know how it is.

Mothers monitored the safety and locations of the goods and services needed for health. This was particularly relevant for medications but also things like poisons, cleaning products, sunscreen, treat foods, and anything that may need to be limited or kept out of reach of children. This was a process that was on-going and needed continual surveying as the children got older, started walking, or climbing.

Stephanie: So with the exception of my iron pills which are just in the pantry just behind something, this has only been recently, before that we have put them in a drawer underneath all these tea towels, panadol and that sort of thing, we thought oh god, that is not very safe, if they, not that they go through the kitchen but if they could. So they are in the bedroom in the wardrobe up high. So they are not locked away but they are up high behind stuff. So for the moment it is ok but not ideal if you know what I mean.

Surveillance included the amounts of sleep the children were getting as sleep was important for normal growth and development in children.

Sarah: Do I want a miserable, grumpy, grouchy, screaming, crying child the next morning. No, you're going to bed between 7 and 7.30pm - see ya! It's about getting through the next day! But they are young and they do need a regular amount of sleep. They are doing heaps and they still are growing. They do need sleep. But there is always flexibility with a family of three. You go out, you know.

Mothers also surveyed how much exercise the children and family was getting and the activities of the children to balance these with their health and social needs with the family commitments. Things such as screen time were seen to be something to be limited with exercise and fresh air being seen as healthy and something to be encouraged.

Leanne: For me, for Belinda taking her to the park a couple of times a week, playing with friends. She self exercises, she's two I am not that concerned with her. Um, I just let her do what a normal two year old does, basically. With Sophie, swimming is really important to me. ... Um and in terms of exercise she does enough running around, we take her bike riding, to the park, she's always asking to go to the park. ... I think they are fine, they aren't overweight, they are happy. They need fresh air.

Personal hygiene such as hand washing or bath times were surveyed and monitored. House cleanliness was also something to be surveyed as a sign that you are a good housekeeper and for illness prevention reasons. Even the household cleaning products they used were considered and surveyed due to the potential risk of ill health based on family health identities and the mother's expert family knowledge.

Kathryn: Do you tend to use certain laundry detergents or cleaning products or do you not mind?

Charlotte: No we stick to the eco store stuff. Georgia was starting to, she started having an allergic reaction on her skin and we found it was where her singlet's and knickers were so we thought well um, she had been fine with things like Persil and that previously but all of a sudden, whether they changed something in their formula you know, you don't know. So you know, we got some cream from the doctor to help with it but I found switching, switching helped straight away. So it hard to know whether it was the cream or the powder but certainly it hasn't come back since switching powders and with

Georgia's asthma it's easier just not to use air sprays, like air fresheners or ... and she will start coughing if she is around someone who is smoking or whose got lots of perfume on so it's just easier to use something that doesn't have any smell in it.

The mothers talked about monitoring health as a dynamic and fluid process that would change according to context such as the age of the children, family commitments, or certain times of the year. Winter and the cold months were consistently dreaded by the mothers and this led to increased monitoring and vigilance in preventing illness. Older children were monitored less closely than babies and family health was something that could change in an instant. Surveillance as a practice is risky and uncertain for these mothers. Watching and supervising your children are part of modern discourses surrounding safety, health and illness. This implies that if you watch your children closely enough you can prevent all accidents, all ill health and can be prepared for every eventuality. It also reinforces dominant ideals that the stay-at-home mother is the one most suited to care of her children as she will survey and monitor more closely than a day care facility or even the father.

Being the primary surveyor of family health is a however, a position of power for these mothers. With power comes responsibility, responsibility for family health and policing this, and punishing those who are not being healthy (Foucault 1977, as cited in Cheek, 2008). Primarily it places the mother in a position of controller or disciplinarian over the father/husband/partner and the children. They must survey health and everyone in the house to maintain this position. Husbands/partners are positioned as less expert, less involved and less invested in family health. Children are inexperienced and irresponsible and need to be taught health.

Leanne: But in terms of teeth he is a bit but he won't be hands on. It's one of our things, it just makes me furious. They just can't, they don't have the capacity to brush their own teeth at the age of five or two. So he'll be standing there saying that's good, so I get a bit bossy so I say "Richard brush her teeth" so I end up doing it. I make sure that I brush their teeth once a day at least. If he does it at night and I can't be bothered checking up on him I just let it go, but most, sometimes I do both, brushing their teeth morning and night but I try and get him to do it too. I think a lot of families have that problem. It's more than having toothpaste in their mouths. Teeth that is a huge thing.

Thus the mother's role in family health is to survey environmental risk and reduce it where possible, survey the children's bodies for signs of ill health, survey and monitor food, sleep, exercise, sunscreen, and all the areas that construct family health and survey her own health. In addition to surveying the areas of health the mother also surveys and

monitors the actual levels of the goods and services of health. This is done so that things such as food, groceries, supplements, and sunscreen are replaced when they run out. This has the effect of making the mothers super surveyors and hyper vigilant. This is linked to the next main area that the mothers have a role in, the provision of health or the goods and services needed for keeping the family healthy.

Provision of health

Food, sleep, exercise, hygiene/cleanliness, sun screen, well child checks, and health information are surveyed and monitored by the mother for the purpose of positioning herself as a good mother, and as part of the new paradigm of health, one of self-governance and family responsibility for health. Provision or the work of keeping the family healthy was a shared family responsibility in all the households but predominantly the mother's domain and included anticipation and planning, purchasing, policing and administering health. Maher et al. (2010) used the framework of maternal responsibility and provisioning to look mothers and obesity or "conflicted discourses of maternal plentitude, self-sacrifice and social contribution through (almost limitless) nurture, while asking women to simultaneously supply and deny children food (p. 306).

Provision of health while dominated by biomedical discourses and healthisms was complex for these mothers. Much of the provision of family health was tied directly to domestic work. I use the term work on purpose as the mothers themselves termed overseeing family health as their job. Maher (2005) suggests that "being a mother was composed of a set of activities that needed to be done" (p. 26) and theorises and conceptualised motherhood as a set of activities rather than an identity. This allows the mother to be flexible and reinvent her own good mothering practices regardless of social pressures. Maher et al. (2010) goes on to frame mothers as central to social 'provisioning', that is, the labour that secures the necessities of life. The provisioning framework captures paid and unpaid work, social setting and policies allowing for in-depth conceptualisation of the conditions mothers negotiate as they provide for their children. If you consider that health and illness involves provisioning then Maher and colleagues (2010) framework is helpful in understanding the messy world of these mothers where mothering is work but also about showing love. The mothers used strategies to discursively negotiate their lived world. These strategies included

1. balance,

2. care of the mother,
3. showing love, and
4. anticipation and preparation.

It is important to reinforce at this stage that this is occurring as part of a whole process which includes provision, surveillance, and teaching health. The mother is surveying as she provides and teaches as she is providing as she surveys and so on.

Balance

Balance has been shown to be important for mothers in food provision for them to discursively justify immoral or bad food choices for themselves or their families (Madden & Chamberlain, 2010). Food in this study also provided good examples of where the mothers talk about having to constantly balance nutritional needs, family preferences and allergies, family activities and commitments with time, cost, ability to cook and societal pressure to be 'seen' to be healthy. The sheer amount of talk generated around food and health suggest this is the most obvious health measure that these mothers thought of. Food provision is something that you can be judged on due to the social nature of food and the morality of healthy food. However for the mothers in this study balance was more than just balancing diets and nutritional needs but about the balance of certain aspects of health. For example, taking the child to afternoon swimming lessons means the family has takeaway for dinner that night so food and exercise as two aspects of health are being balanced. They are balancing the family commitments with time, budgets, and physical and emotional resources. This balancing act and the discursive positioning here suggest this is not an easy position. The good mother is always prepared with band aids in her hand bag, hand sanitizer to prevent illness, has nutritious and healthy snacks on hand for the fractious child after school and who puts the children first at all times. Of course this is unrealistic so the times when you buy ice creams, forget the wipes or the nappy or get takeaway because you have not done the shopping are explained as something that is unusual, not common, and part of the balancing act of being a busy mother.

Charlotte: We are a bit naughty on a Tuesday and we will get fish and chips purely because it is on the way home from swimming. Um but otherwise the only other stuff we will get is Pita Pit so it is a pita pocket with some meat and some salad in it or Thai. So it's a take-away for us but its rice, and meat and vegetables you know. And you don't have to cook it.

Provision of health had to be flexible and the mother frequently catered to preferences of the different family members. It involved altering and changing diets, avoidance of certain foods, changing patterns to be flexible to family commitments and available resources. Lexi's son who has autism has oral sensitivities and family meal preparation is a complex task of balancing his nutritional needs with his preferences with the family's needs and preferences, all this while caring for four children under the age of six years.

Lexi: Sometimes I cook it separately. For instance protein's a big deal cos he won't eat meat yet so I give him eggs and stuff which he'll have or he'll have mince sometimes for iron and that but um, because of his sensory issues he doesn't like bits in it so he won't eat it with everything in it so I'll just make two batches. Fried rice, I won't put any vege's in it. Because otherwise he just won't eat it. He'll just pick them all out anyway. Or just give him something on the side. So yeah, I have to do that for him.

Care of mother

Healthism would suggest the mother as an individual woman should be doing health for moral and social reasons but intensive mothering discourses suggest children come first and their needs outweigh the mother's needs including her health and well-being. These mothers were obligated to provide care and health to their children but also felt obligated to care for themselves at times. These mothers discursively positioned themselves as fluid with regards to obtaining a balance between mother and individual. The children's health needs did come first at times especially while the children were very young but certain practices were about caring for the mother either physically or emotionally.

They positioned themselves as self-less mothers at times whose job it was to sacrifice their own needs over the children's. Both Leanne and Sarah sacrifice their sleep regularly and saw it as their 'job' to let their husband sleep at night uninterrupted for safety reasons. Sarah's husband is an air traffic controller so the responsibility ensuring he is rested fell to Sarah.

Kathryn: So you get up in the night if they need someone

Leanne: Oh yeah. Always. I see that as my job, he's working and he's quite often doing that you have to be mentally on to it so having him tired is kinda of not safe sometimes. He also drives quite long distances sometimes so I rather I did than have him tired and then I have a bit of// a crap day than him crash the car.

Sarah: Yeah, he's a shift worker so he

Kathryn: So you see it as your job to let him get good sleep?

Sarah: Yeah so I'm kinda balancing the sleep thing with the rest of the family type of thing.

Other ways they demonstrated a selfless sacrifice was working her health around the family's needs. Appointments were scheduled around everyone else's schedules.

Charlotte: Yeah (laughs). I remember the last time I had a smear done it was because I had had to take one of the kids in cos they were sick and the doctors room was empty so I thought I will take her home and I'm going to run down, cos I know it has been a while. And you get told off all the time and I'm like I know that there is no-one there, I'm not going to have to wait so I dropped her off home and said I am going back, run in, done (laughs).

At other times being 'selfish' or looking after yourself physically or mentally was seen as important to maintain the good mother status. For Lexi and Lilia time out from child minding with the use of day-care was seen as an imperative for their health and ability to cope with the demands of stay at home mothering.

Lexi: I have got it to the point where I get some time out for me where the kids are at crèche one afternoon. And my Mum the other two during the day or in the weekends so that Eli and I can go out or something, depending on what it is so.

Lilia: Zoe went over to um child care across the road, three days a week, for six hours and I just went home and slept and cared for the boys cos I couldn't have dealt with her as well as the boys.

Thus, the mother is balancing her duties and responsibilities of mothering and taking care of herself. This was used discursively to justify a lack of mothering resources with self-preservation. By this I mean where the actual physical aspects of care work are balanced with stress reduction for the mother so she would not be a bad mother. In this case the bad mother is one who yells, is impatient and is not enjoying the mothering work. Either of these positions was not comfortable for these mothers.

Stephanie: So we are actually really busy with lots of things, so just kind of aware of putting a boundary up and that is for me and for them but um, if I am honest then maybe it is more for me. Maybe it is more for me but maybe it will have a trickle down effect and they might be less stressed because I am less stressed so I do think my motivation comes from me, it's not totally selfless, when I think about their sports and things then it is about them but then there is my stuff.

Sarah: I kinda go, they really need to, they really need to be in bed between seven and seven thirty. They are busy, they do lots of things, um, and they do actually need sleep - to grow. And I really don't what to have to deal with a grumpy, grizzly child the next morning. Actually you know it probably about my own self-preservation as well. (laugh)

If they had a husband who was actively involved in childcare, domestic work and family health, they felt guilty they were not fulfilling the stay at home mother ideal. Stephanie talked to me about taking care of herself and having worked out family routines so that her stress and health does not suffer.

Stephanie: I felt like he was doing a lot, more than most other Dad's. Like I know, most other dad's maybe they need, maybe they could do more. But I thought maybe William did a lot. And he would seem tired and stressed but I was tired and stressed too. It's always hard to find a balance.

Showing love

Provision of domestic duties has been linked to mothers showing their love for their families (McKie et al., 2004). I believe there is a contradictory position for these mothers who use some aspects of health as a means of showing care for their family such as treat foods for special occasions, late nights as a reward for good behaviour and so on. This has to be balanced with the policing aspect of family health. As mentioned in surveillance of family health part of being a good mother is being a good surveyor, and part of good surveillance means ensuring the provision of health through saying no to requests for food, late nights and so on. For example, mothers were in conflict at times between showing love through food and showing morality and responsibility through policing or refusing certain foods at different times. Pressure to eat and restriction of intake are also two aspects of the provision and surveillance of food (Vereecken, Keukelier, & Maes, 2004). Michelle talks about a bedtime routine in their family where her husband has initiated an 'unhealthy' snack before bed and the rules around this ritual. Her husband is positioned as 'soft' and not a good disciplinarian of this rule.

Michelle: Um and then about six thirty, this is John's ritual, and he's always done it, milk and cookies. They will have a little bit of milk and a biscuit. Or a piece of fruit, like half an apple each or half an orange each and a drink of milk. That's their bedtime routine. And she loves that. So if she doesn't eat her dinner then there is no milk and cookies. And then she's like. But we always tend to, especially John, he's so soft, he always tends to give in, even if she hasn't eaten all her dinner.

As well as food there were other things that the mother policed and monitored such as bed times and dental hygiene. This policing was sometimes of the father who again was positioned as inexperienced, not invested in the children to the same extent as the mother and would not be around the next day to cop any fall out due to a late night or too much junk food.

Charlotte: Yeah, with a committee meeting, you think they are all ready for bed, they are in their jammies, they've got half an hour to do stories and into bed and then the next morning they are tired cos Daddy turned a programme on and pulled out some lollies. You know cos they grizzled a little before bed and because of that they got to bed an extra hour and a half late. You know. Yeah and he goes off to work in the morning and you are left to get them ready.

Anticipation and preparation

Anticipation, purchasing and planning are an important part of providing health. By this I mean the mothers had to anticipate food requirements for the week, anticipate future ill health, anticipate future requirements of the family that may affect their family's health and then plan and purchase the goods needed for good health accordingly. Interestingly food and medications provided the most talk in this area. Medications will be discussed in the next chapter but the complex nature of family food is discussed below.

Sarah: me, well it depends. Like today um// I said (to Chris) //let's do a meatballs, you can take some to work for tea so he's taken some to work for tea, the kids and I won't eat all of it so they'll be enough left over for the kids, a kids amount left. So some nights we might have, umm, Chris might be at work, I can't be fagged cooking, I'm just happy to have spaghetti on toast but I still feel like the kids should have something a little bit more decent then I can just whip out a small meal for them to just that will take 10 minutes to cook, as much as it is to cook pasta, and you're done pretty much.

Lexi: Yep. Although I need to get a better system at that you know. It's just, it's a huge thing in my family, it's huge, if I haven't done the shopping in time or know what I am going to cook then it's going out to the store with all the kids or getting takeaway, it's not pretty. Eli's really good, he's a good cook and stuff and he's quite, he's very left brained. It's easy for him to create a menu out of nothing whereas I find that hard. So we are trying, just leave it to me.

Fathers interestingly again were seen as inexperienced preparers. Charlotte talks here about how her husband would forget snacks for outings but might remember sunscreen or he might remember to pack panadol for the family holiday, but forget the band aids.

Charlotte: And he'll just grab what he can see and he hasn't got everything. And um or he'll get the food and he'll forget the drinks or he'll get the drinks and a couple of muesli bars but it won't be enough for a four hour drive, you know.

Mothers also said they felt responsible for administering good health. Whether this was physically giving a vitamin tablet or applying sunscreen this was tied to surveillance. The continual surveillance of the children by the mother ensured that the clock was watched in order to 'give health' at the appropriate time.

Teaching and modelling healthy lifestyles

Another part of the mother's role in family health was modelling and teaching health to your children and sometimes your husband/partner. There has been research suggesting mothers' play an important part in what medications children will use as they grow what food they will eat and how much exercise the children will do later in life, in fact mothers will influence the healthiness of the child as an adult (Gray, Cantrill & Noyce, 2002; Janicke et al. 2001). This research agrees with this but goes on to say that the mother's role is twofold. Firstly, to teach the children actual tasks such as how to clean their teeth and what are society's rules about healthy foods and what are unhealthy foods, that exercise is important, and that sunscreen protects you from the sun. It begins with actually doing the task for the children and then moving on to teaching and supervising the task. This is all part of the child's increased independence and working towards getting the child responsible for their own health. It is also directly linked to the mother's role as a good mother. I argue that a key aspect of family health and mothering is that there is a moral imperative for mothers to raise children who will not be a burden on society through ill health and also to teach the rules, norms and obligations of what being and doing healthy means.

Jocelyn: What I tend to do is they clean their teeth in the morning and I do theirs at night, well Andrew. I don't supervise Rebecca anymore. At some stage they have to take responsibility for their own teeth. We try and teach them how to do it.

Another area that was important for these mothers was to be seen to be doing health and modelling wellbeing and good mothering. By this I mean the mothers talked about part of their role being one of model. Modelling good health was important but problematic as then unhealthy practices have to be justified not just to people outside the home but to your children and partner where the old adage 'do as I say, not as I do' was applicable. Also when they are sick and cannot mother as they would wish this was worrisome. One mother is having on going health issues and was very concerned about the message that sick mummy was sending to her children. It was also impacting on her ability to care for her children in a culturally and socially defined way.

Leanne: .. it has had far reaching //consequences - the spinal surgery. I mean if I hadn't had the complication it may have been a bit better. But who knows, who knows? But the kids, it's really but Sophie still is, I mean if she is drawing a picture of the family and we are all mermaids and daddy is the merman or whatever, then mummy is the mermaid sitting on the rock or sitting on a chair. I am not frolicking in the water with them.

Kathryn: Is that how she sees you do you think?

Leanne: Yeah, that's how she sees me. So I am desperate to change that but now with this thing the doctor's just said. So in my mind, as their care giver and there, you know keeping them well I want them to see me well and then that will reflect in them so it's really important that I try and do that for myself in front of them. So I'm starting to do, that's a big thing for me, I don't want to be seen as the sick Mummy which I have been for a long time.

Preventing ill health

Up until this point the focus has been on how the mother talks about keeping the family health by surveying, providing and teaching health. However, the mother also has a role in surveying, providing and teaching her family how to prevent ill health. She surveys the child's body for any signs of ill health or deviations from normal, she provides the goods and services necessary for illness prevention such as immunisation, hygiene and cleanliness, food, sufficient sleep and she teaches and models these things to her family. While you could argue that keeping the family healthy and preventing ill health are one and the same I argue that they are similar but have distinct differences. Keeping the family healthy is part of being the good mother in a health conscious society and maintaining a healthy lifestyle. Illness prevention is more about managing the risk of immediate or long term ill health. However in saying that, many of the practices in keeping the family healthy are about preventing illness. Leanne talks here about preventing ill health in her girls. This illustrates the relationship between health and illness and how intertwined they are, both in practice and in lay beliefs.

Leanne: Vitamins, multivits, fish oil. Sophie loves them but Belinda doesn't like them. I'll do things like I will make sure they are warm when they go outside or make sure they have a hat when it is windy. Make sure they are eating, try and get fruit and vege into them as much as I can, I see that as prevention. What else do we do? I was into hand sanitizer when they were babies but now I think bugs are ok. I do every now and again make sure there is hand washing, that they are actually doing it properly and I ask her if she has washed her hands after she has been to the toilet. She is pretty fastidious but I do just check up on her every now and then. Belinda is still in nappies so not such an issue for her.

Kathryn: Things like sunscreen?

Leanne: Absolutely, hats in the summer, and I buy... I spend quite a lot of money on good sunscreen that will stay all day. I will do the day long one or sun sense. And washing powders I will get the Persil sensitive and I just try and minimise. I mean I know they are all full of chemicals but I try and minimise perfumes and dyes and I try and use green kind of stuff.

From the findings on surveillance of children's bodies and mothers health it became clear that there were a number of reasons why preventing ill health was important. Firstly, ill health was seen as an added burden for these mothers. If they were the ones sick it made the job of caring for your children and family harder, and if the children were sick, it added extra chores to the day and the behaviour of the sick child may change and this would impact on the mother. Thus the mother does all she so she does not have to deal with ill health. This idea will be discussed in the next chapter.

In other instances it is about negotiating risk. There were times when mothers avoided potential situations, places or environments that were seen as risky. Other times it was seen as beneficial to expose the children to certain illnesses as childhood was a good time to build immunity or experience certain illnesses such as chicken pox. In the quote below Jocelyn had been explaining to me that they had a trip overseas planned and a friend came over to her house with her son who happened to have a 'green' nose. She asked the mother to reschedule the play date as a consequence which was not taken well by the visiting mother.

Jocelyn: And I said are you sure it's not an infection because we are going to Rarotonga and I don't want my kids sick. I obviously didn't do it very tactfully and she hasn't been around since. (laughs). So if we have something planned like that then I will avoid situations but most of the time I will expose them because I think that they are better to be exposed but I did vaccinate against chicken pox, Rebecca did have them, only a mild case and I've done all the other vaccinations and the flu vaccinations because I figure if you can then why not.

Immunisation and the concept of immunity and boosting immunity is a medical concept and talk around immunity was embedded in lay discourses of health for these mothers. The child's body is seen as vulnerable on one hand as their immune systems are weak and need to be developed but on the other hand children were seen as more robust than adults and recover from illnesses quicker as demonstrated in the quote from Sarah.

Sarah: But I would far rather that they got, any of that childhood things, I quite happy for them to get it when they are young, in fact to the point of running over and trying to get them exposed to it.

There was a lot of talk around immunity from all the mothers suggesting that boosting the immune system of children is part of the mother's role in family health. There were discourses around immunity with food, supplement use and hygiene and cleanliness also.

Jocelyn: Yes Rebecca picks up things at school all the time cos she sucks her fingers. BUT the good thing about her sucking her fingers is she probably has quite a good immune system.

Sarah: and they get sick and you're not going to avoid it and you could spend your whole life to avoid illness and still get it anyway. Anyway, so no I'm not wrap my kids in cotton wool, not a um. I am not a over the top. I do sometimes use hand sanitizer if we are out in the park so I do have the hand sanitizer, so I do have it but I'm not an obsessive user of that type of thing. In a lot of ways my view is probably of that sort of thing is get amongst it cos that's the way they'll build up their immunity. The more you try and protect them the more they'll get a bit sick. So, yeah, I'm not. That's my view and that's how we operate really.

Lilia and Charlotte talk about how feeding the family goes beyond ensuring healthy food is given to boosting immunity and preventing illness. The use of foods like garlic was seen as being good for the family and may prevent potential illness.

Lilia: So I suppose in the food that I do for them as a preventer, last year I did a spoonful of manuka honey, the umf manuka honey every day, they used to have vitamin tablets everyday but they cost a fortune and if I'm doing food for us it's garlic, I try and put garlic in, when I am doing lasagne I always put load of garlic in, tomatoes, always use tomatoes when I am cooking. And always try when doing beef patties, they have to have two or three cloves of garlic in and tomatoes cos they are high in antioxidants and antibacterial. And that's about it really.

Charlotte: Well if we have nachos or something then I will put garlic in, just cook it first before I put the mince it. Because I think it is really important for the kids to have it health wise.

Preventing ill health was subject to similar uncertainties as health. Knowing when to trust expert opinions and when not. This was evident in talk around immunisations. Of the eight households, one mother has made the decision not to immunise three of her four children. There was also uncertainty around the MMR vaccine for one other mother who had done it and then regretted it. This also happened with flu shots and the chicken pox vaccination.

Lexi: Steve is fully immunised, but I chose to not immunise my other 3 sons. With Steve being my first child, I just went with my doctors recommendations to immunise. But, I did not like the way Steve reacted to his immunisations - swelling, fevers, grizzly. I didn't really sit right with me, so I did some research about the pros and cons of immunisation and I felt strongly that I should not immunise my children. For me, the possible risks of immunising my kids with some pretty hazardous substances far outweighed the need to immunise against diseases that are highly unlikely to have serious impacts on their long term health. The only high risk disease is meningitis, but there is no solid evidence that these immunisations actually decrease the incidence of the disease.

Immunisations were seen as traumatic for mother and child or a disruption and as such required extra planning, surveillance and support from the family, much like illness. Managing the fall out of injections rather than the risk of the potential illness framed much of the talk around immunisations. Immunisation was not seen as universally safe and necessary by the mothers in this study. However what was universal was that the process of immunisation was one to be managed. The planning and organising shots involved getting husbands to take the child to get the shots because the child will get upset, or arranging for the favourite toy to come along, even arranging the appointments in the school holidays so both parents can go and deal with the potential fallout. The fallout was not seen as a reaction to the shot but more crying, screaming, holding the child down for the shots and the emotional and physical distress of an injection. As a result the immunisation schedule was changed frequently for many reasons, not just the risk of the shot or an illness in the child about to receive the vaccination which is what previous research has found (Baker et al., 2007).

Jocelyn: I can't, can't hold Rebecca down and I can't force her because it will damage our relationship so. Andrew I split his, //so there was measles going around the kindy so I gave him the measles part of the vaccination just after he turned four and the rest of it just before he started school. So I decided to split them which I know most people didn't but I just thought that was the sensible thing to do.

Kathryn: Why was that?

Jocelyn: Because I had done some reading and it said it was probably a good idea to have them vaccinated and I called the doctors said should I do his four year old shots now because there is measles going around and they said split them.

Stephanie has always gone with her husband to get their children's shots to help all of them cope. She positions herself as a bad mother for not doing it by herself, guilty that she has used her husband for support, but then justifies the decision with the fact that waiting a few weeks will not affect the immunity properties of the vaccination and she is lucky to have the support of her husband in a stressful situation.

Kathryn: In terms of shots – will you take them?

Stephanie: The way it has worked out, again I feel like I am taking advantage of a lovely husband, but it's worked out that we do it in the holidays. For injections if I can wait for the holidays, I might have waited two or three weeks longer than the due date so that we could do the holidays except for the last one but all others have been in the holidays. So for Andrea's 4 year old ones I am already thinking maybe I will wait till October, it's only a few weeks and then we can both be there to handle the screaming. It just works out that way, it's been lucky. I could of coped doing it myself but I've been lucky.

This research suggests decisions around immunisation involve risk assessments but that it is more than this. The decision is tied to the health history of the child, fear of needles, and a family health philosophy. In New Zealand the chicken pox vaccination is not part of the official immunisation schedule but parents can chose to have it done and pay for it themselves.

Stephanie: Ok, with the chicken pox thing, I was thinking I would not want the worst case scenario to happen to them because I knew that was preventative, you know, I would want to prevent that, you know, we went down that route even though there are complications with having the injection type of thing, later on. So I didn't want the worst case scenario to happen so in terms of that but in terms of health generally I don't worry about it.

The other reason that preventing ill health was important was tied to notions of being healthy enough to do your role. If you are healthy then you can go to school and complete your role as a student, if you are healthy then you can go to work and earn the money for the family. Rest was seen as particularly relevant for this. Getting enough rest so you would be able to function well the next day.

Michelle: I know people who don't eat till seven and then they don't go to bed till about nine and they're only seven years old! I couldn't do, she wouldn't be able to function, if she went to bed at nine each night (talking about Amy who is seven years). That would be horrendous; a late night for her is eight o'clock. Even in the school holidays I try and get them into bed at the same time.

As mentioned with immunity part of preventing ill health was selective avoidance, limitation and exposure to germs and certain diseases. This was relevant to all other aspects of health, in particular food. Again the scientific nature of the mother's discourses around food suggests much of talk around health is still to a large extent medicalized. However, risk and balance become important too. Charlotte gets migraines when she eats onions but will still cook with them for the health benefits for her children. Also food generally was seen to be risky. Things like preservatives, specific coloured dyes in food, additives, hormones, pesticides, cholesterol are some of the things that mothers talked and worried about. Add this to food intolerances, allergies and general food preferences it is no wonder that food is such a contested space.

Charlotte: So it hard to tell cos some brands have taken it out and some haven't. So I just avoid them all now cos you get a tomato soup and there will be something in it that makes you react. So you just don't know. And the only thing that we just try and avoid is um is orange food colouring if anything.

Kathryn: Oh really?

Charlotte: Samantha in particular will just go nuts on it. If she has rashums or burger rings or something.

Preventing ill health was also linked to beliefs around the control of health as these mothers knew it was impossible to prevent all illness and anticipate all the needs of a family's health all the time. Fatalistic statements about luck and health being out of their control were discursively used to explain good health or the potential for bad health. Planning ahead was seen as a way of reducing stress on the mother and the family, decreasing disruption and reducing uncertainty of the potential for serious ill health later in life and was also directly linked to good mothering practices.

Family health philosophy

The mother's role in family health was complicated and while family health was overseen by the mother it was practiced as a family. While universal health truths were held by all the mothers, health was practiced differently across families through a family health philosophy. The family health philosophy was a unique, dynamic, changing set of beliefs and practices based on historical and current knowledge of the family's medical, cultural, and social beliefs. The mothers had the most influence and input into how the family health philosophy was maintained and practiced due to their mother expert status but the father and children had an input. Backett-Milburn and Harden (2004) found that families continually negotiated safety rules as a family. This study would suggest that all aspects of family health are open to negotiation and it highlights how family health is not static but continually changing. Leanne's quote highlights how the philosophy has to be flexible and open to change.

Kathryn: Do you buy organic food?

Leanne: I did for a while but it just got too expensive. I do look on the back of packets and if it's got MSG and.. I try and avoid MSG, I think the less ingredients the better. No so worried about food additions and that type of thing. Home cooked is always better, that is my philosophy.

Much of the time 'doing health' was part of this philosophy and was reflected in the family at that time. It was used to discursively explain differences in the provision of food, exercise, sleep, and immunisation and so on. Stephanie talks about their family philosophy for meal times and Sarah discusses her decisions to enrol her children in many team sports which was for health and social reasons.

Stephanie: Yes. I remember in terms of feeding with Thomas, cos he wasn't gaining weight initially I think I put pressure on him, like come on, I feel like was pressuring him, didn't realise that he would tell me when he was full. So that is evident in my philosophy now, they don't have to eat everything on their plate. They um you know, they have to try everything, that sounds like I am a lax parent but I can't say that I was like that with Thomas in the early days when I was worried.

Sarah: They don't have to play them forever but as long as they understand what is involved to be part of a team then, the other people in the team, there are social sports they can play. I think New Zealand is a very sporty country and I think you would find it hard as a child if you didn't have some sport that you could connect to the other children playing. So that's kinda my philosophy behind that one.

Summary

For these mothers the surveillance, provisioning and teaching of health was complex. It had to be worked into the lived world of the family. Health was overseen by the mother's and embedded in to mothering practices and care of the family. The mother's positioned themselves as the mother experts who retained the expert family health knowledge. Practices around keeping the family healthy and preventing ill health were based on a family health philosophy. Up until this point I have focused just on the health side of family health. The mother's role in ill health will be explored in the next chapter.

CHAPTER 4 – Dealing with Ill health

Ill health whether it was minor or serious was a disturbance to the ordinary, everyday lives of these mothers. While preventing ill health was an embedded part of managing a family, dealing with illness represented disruption, additional uncertainty and work. Chronic ill health and the management of this in children by the mother represented an interesting area due to symptom free periods where the child was considered well or healthy and then symptomatic periods that were treated as illnesses. The disruption of all ill health was managed predominantly by the mothers within the context of the family health philosophy and this will frame the findings in this section.

As with keeping the family healthy the mothers all identified the same areas that they had to deal with in regards to dealing with ill health. These included: providing food for the sick which may differ from the rest of the family; ensuring the sick had enough rest; purchasing, administering and monitoring medications; watching hygiene to help prevent other family members getting ill and to aid recovery of the sick; making appointments and taking children to medical consultations including doctors, physiotherapists, specialists, plunket; consulting with other medical professionals such as pharmacists or chiropractors; managing chronic conditions; dealing with the impact of ill health on the mother, sick family member and the family; monitoring the recovery of the ill; and having general first aid knowledge. Some entries from the health diaries in Figure 2 illustrate the complexity of dealing with illness while caring for the family. Some are minor ailments, some part of managing a chronic condition and some were more serious sudden events such as croup. These entries are typed verbatim directly from the diaries.

Mothers at times took on the role of doctor, nurse, pharmacist, overseer, teacher, decision maker and manager of family ill health. Each family member took on different roles with sickness depending on who was sick, what the illness was, and who was physically present and this varied from household to household. Again the purpose of this chapter is not to explore who does when a family member experiences ill health but rather gain a greater understanding of the mother's role in dealing with ill health. So what does this mean for these mothers who are dealing with ill health? They positioned themselves as the family health overseer and expert mother, as they did with health. They knew the family genetic history, the family member's health identities, and provided and surveyed health and illness within this context. Ill health however,

represented extra work in terms of provision of care and extra surveillance. The discourses around this were similar to health in that surveillance was required of bodies, environment and materials aspects of dealing with ill health from food, medications, first aid equipment and so on. Also, as with health, dealing with illness was an uncertain business, maybe more so than health as the risk of ‘getting it wrong’ was higher than not doing health. This meant discourses surrounding self-surveying of mothering practices and knowledge was common when they talked about ill health. These ideas will be unpacked now.

Day	Person	Incident and action required	Role of Mother	Medications
Day 1 – house 7	Child 1	Headache, sore mouth (ulcer), sore throat. Asthma	Gave pamol, bliss throat guard, bonjella.	Pamol for headache, bliss throat guard for sore throat and bonjella for ulcer. Ventolin/Flixotide
Day 12 – house 6	Mother	Recovering from kidney infection.		Antibiotics and probiotics and canesten vaginal thrush treatment.
	Child 2	Scrape on top of foot	Applied plaster	Healing balm
Day 6 – house 4	Mother	Cracked skin on hands – requires good barrier cream	Applied cream	Barrier Cream
	Child 1	Woke up worse than yesterday with croup. Kept home from school. Burnt fingers on toaster, applied cold running water	Kept home from school. Did chores in the morning so she could rest in afternoon. Kept fingers under water and applied cream once cooled.	
	Child 2	Cold continues, eczema continues	Applied barrier cream and sent to school with tissues	
Day 10 – house 2	Mother	Sore throat	Painkillers	Panadol and neurofen
	Child 2	Fell on hip while dancing	Applied ice pack and then arnica	Arnica
Day 2 – house 5	Child 1	Bronchiectasis. Physio twice a day plus medication and exercise	Do physio with her, give her medicines	Ventolin and seretide for asthma. Butacort and amoxicillin to prevent chest infection
	Child 3	Fever – starting to reduce. Fell over and grazed her knee.	Comforting and monitoring her temperature. Wants different food to rest of family.	Panadol

Figure 2: Complexity of the mother's role in ill health

Surveillance

Surveillance of bodies, behaviour, and environment takes on an added importance when dealing with ill health. If the family is well then the surveillance is routinized and part of the mothering work of keeping the family healthy and preventing ill health. However, surveillance of the sick required more conscious thought as there may be medication or other health care regimes to follow, different food may be provided, more fluids might be necessary and so on (Cunningham-Burley & Irvine, 1987). Surveillance was used in monitoring a child who experienced a minor ailment through to more serious ill health recovery and was essential in all aspects of chronic health management by mothers.

The health diaries illustrated that much of the mother's role in dealing with family ill health was dealing with the everyday cuts, scrapes, insect bites, bruises, and aches and pains of her children. Monitoring and surveillance were an essential part of the care of minor ailments and the child. For the purposes of this study I included any incidents that required treatment but did not require a formal medical appointment in the category of minor ailment. Much of the research on minor ailments has found that 'wait and see' or monitoring is used in the treatment alongside the use of over the counter medications that are already in the home (Cantrill et al., 1996; Gray et al., 2002). Figure 3 shows that the surveillance is of the child's body, their behaviour, the treatment and the recovery.

Leanne: After a while they were both still going ow, ow, ow so I gave them some pamol, put an icepack on Sophie's arm and then just gave them a cuddle. And then just watched them.

Monitoring and surveillance was essential to mothers as they were the ones deciding if the child is becoming ill. This concurs with previous research on the process of becoming ill (Cunningham-Burley & Irvine, 1987; Robinson, 1971). Mothers made decisions on current surveillance and knowledge of the immediate incident and the mother's historical family health knowledge and individual health identities or her expert mother knowledge. Surveillance was also important in determining if the treatment the mother chose was working, whether this needed to be modified or whether extra assistance or information was necessary. Many times alongside folk remedies, natural remedies and medications, cuddles and soothing were the treatment. Regardless of what the treatment was it had to be surveyed and could lead to changes in how the illness was dealt with.

Day/house	Person	Incident and action required	Role of Mother	Medications
Day 5 – house 6	Child 1	Insect bites on shoulder	Determine what it is and figure out medication to apply	Ferrous phosphate tissue salt cream (homeopathic medicine) to relieve inflammation and itchiness (applied 3 times) Healing balm (calendula, nettle, comfrey) to soothe and heal rash as well as protective barrier (applied 3 times)
	Child 4	Nappy Rash	Determine if it is thrush or just a common nappy rash	
Day 2 – house 4	Child 1	Fell at brownies, grazing hip, knee and elbow. Left to heal overnight Complaining of sore throat after school	Monitor Monitor and asked child if too sick to attend after school activities and gave her a drink.	Paracetamol
	Child 2	Eczema round mouth	Applied barrier cream, am and pm. Worse than usual cos of cold	
		Sprained foot (occurred wed evening 1 week prior) Woke up grumpy from cold, comfort and paracetamol given for headache	Collected child from school at 12.30 for 1.30 physio apt. Kept child home for rest of the day as tired. Gave cuddles and pamol prior to school, cancelled after school play date. Gave more pamol at bed and rubbed on baby balm to aid sleep	

Figure 3: Surveillance in everyday ailments

Surveillance was necessary in the process of treating an illness particularly with timely delivery of treatments. Watching the clock for the time to reapply ointments, give paracetamol, administer antibiotics or ensuring the child is drinking enough mean the mother was also surveying time and treatment. While this was important for antibiotics and other prescription medications it was also important in reapplication of alternative treatments as well.

Michelle: If they are sick, on antibiotics then I will make sure they have it. I am also looking at the clock making sure I know when things are due.

Surveillance was also required of the environment for the same reasons as with health, to ensure the safety of the environment and to ensure the replacement of core household medications and other treatments. These houses had some universal medications such as paracetamol and first aid type equipment and these tended to be routinely surveyed and

purchased as part of the family grocery and health needs for the week. Then there were medications and equipment specific to certain conditions, certain family members and certain times of the year that required extra thought, extra work and extra surveillance. This were all monitored, purchased and kept in safe places, predominantly by the mother.

Jocelyn: And if I go to the doctor for me I get a prescription for paracetamol tablets. Basically if we get the flu or something so we have them as a backup type of thing. So we don't have to go out to get them and it's much cheaper to get them from the doctor.

Monitoring and surveillance were key parts of managing a child with any chronic condition. Effective management of conditions such as asthma, eczema, food allergies and hay fever mean surveillance of the child's body for signs that they are staying in a well phase was important. This alongside surveillance of the environment to ensure triggers are minimised or avoided and surveillance of medications levels were all aspects of dealing with chronic conditions. Medications were given as part of a routine of care and surveillance was embedded in daily mothering practices. In some cases the surveillance becomes a source of difficulty though, especially when the child is asymptomatic for a long period and the risk of flare up's has been lessened over time. Michelle's daughter had a blocked bowel in 2010 and as such Michelle is monitoring her daughter's fluid and fibre intake and the number of bowel motions on a daily basis. She states that the continual monitoring is difficult to maintain though and she must get back on to it again.

Michelle: dehydration that was a big thing. She does not drink enough, doesn't drink enough water and she still doesn't. I even, I mean I have to sometimes threaten her, remember that Starship place. You'll end up there again if you don't drink enough water. Oh I don't want that go back there, again. I'll have a glass of water. But in saying that though she'll still not regular if you know what I mean. I must get on to that again actually cos don't want it to get that bad as it did. Wouldn't be good.

Surveillance by the mothers of children with asthma was embedded into their daily routines of care alongside the administration of medications. At certain times such as winter months, if the child got a cold or starting coughing or was going to exercise this surveillance was heightened or made more conscious. As a result of this routine and conscious surveillance the mother would change medication regimes usually without any medical consultation. Lilia has two children with asthma and both are on the preventer flixotide and also on ventolin. Surveillance of this required filling prescriptions before the repeats expired, ensuring the school had a supply of this

medication, and surveillance of the family's activities to ensure medications went to netball or soccer, play dates, holidays and so on. The mother expert position discursively was a difficult one at times as the triggers for asthma were not consistent and medication use was so routinized that it was forgotten. So on one hand they were expert enough to change medications but on the other hand they talked about being unsupported by the doctors in asthma management.

Lilia: Take them off the flixotide preventers during the summer time, give their bodies a break. And you don't generally get asthma attacks during the summer time. And then you can start doing it in autumn. And then you start doing two in the morning and two at night so in total four shots of flixotide. And then ventolin when you need it.

Lilia: Yes, I am the sole manager. Maybe it's because I am too close to the doctor, cos he's my uncle. He says oh you know what to do with, when she's having an asthma attack. Yep I do know what to do, give her six puffs and then keep her on her preventers, two on the morning, two at night sometimes four puffs at one time, of flixotide just to keep her boosted. Um but no one has actually said to me, right we'll see her, you're supposed to come back in three days' time, no-one's ever rang up and said Zoe's had an asthma attack would you like to come down and we will see how she is doing.

Lilia also has a daughter with a stage 4 allergy to peanuts. Avoidance of nuts and Zoe's other allergens are embedded in the family and reflected in the family health philosophy. Management of this also requires a medicine bag to go with her daughter, Zoe, at all times. This bag contains an epi pen, antihistamine, asthma medication and an action plan. The management of this bag of medicines has been routinized to a large degree where strategies are put in place to ensure the bag is not forgotten and the epi pen is replaced when it expires. Lilia is very conscious of is the surveillance and monitoring of her child when she is out of the home and when others are responsible for her. This in turn leads to anxiety or as she termed it "make sure she comes home alive".

Lilia: The thing I find really, really difficult um, before I had a nut allergy in the family I was a bit blasé about it but now I am so constantly aware of it that the thing that gets me worried is sending my child off to camp, um, sending a child off to a play date. ... It's trying not to make // adults, when Zoe goes on a play date worried and concerned about Zoe having an attack of some sort, either allergy or asthma related cos they get very worried about it. But aware of the fact of if you give her certain things then something will happen to her.

For one family, surveillance is vital to maintaining the health of the eldest daughter, Georgia. Georgia suffered for months with on-going respiratory and chest infections

finally leading to a diagnosis of bronchiectasis² in 2011. The management of this requires at least twice daily physiotherapy, a complex medication regime, and certain lifestyle changes such as regular exercise and hygiene to prevent respiratory infections. The mother in this case told me she felt that she was solely responsible for surveying the child's body for signs of infection, surveying the environment for potential contaminants and surveying the clock to ensure medications and physiotherapy were administered at the right times. The aim of the physiotherapy was to make the child cough up phlegm or sputum. The mother has to look at the colour of this phlegm and then decide how to treat the child for the day.

Charlotte: Yes, it should normally be really, really stringy, a bit like spit, really really clear, maybe a bit stringy. Even now even though she is normal she will still get a globby bit but it is still white, fairly light coloured or white which is fine. So then we're told if it starts to go yellowish then straight on a full course of antibiotics, straight away, a long course, two weeks. So now when she is on antibiotics it always has to be two weeks, always, she doesn't get a little course ever. Um, and if it goes green then you have to up the antibiotics, or if the antibiotics don't get rid of it within a couple of days then you're into Starship (Children's hospital).

This is part of keeping the child healthy and reducing the risk of her condition worsening and partly if the child gets an infection it means she has to spend two weeks in hospital on IV antibiotics. This is something to be avoided because of the complexity of managing this within the family as she has two other children and for the health of Georgia. Surveying by the mother and managing this places her in difficult position. On one hand she is an expert in her daughter's condition and thus a good mother, however, also means she is reinforcing that she is the only one expert enough to care for her daughter properly. The father was very much positioned as inexperienced in this case.

Charlotte: Edward doesn't check if she has had her antibiotic for the day. He can do her physio if I say, can you two sit down and do it because I'm busy with the other two. He, he can do it. But if I come back late from doing grocery shopping, he won't have thought I have missed physio or I need to do the physio. You know, you have to ring and remind

²). "Bronchiectasis is a condition in which some of the bronchi have become scarred and permanently enlarged. During the disease process the cilia are damaged so that they are unable to effectively sweep away the mucus. As a result, mucus accumulates in parts of the lung that are affected and the risk of developing lung infections is increased. Recurrent infections can then cause further scarring and bronchial enlargement thereby perpetuating the condition." (Health Resources, 2011)
<http://www.southerncross.co.nz/AboutTheGroup/HealthResources/MedicalLibrary/tabid/178/vw/1/ItemID/206/Bronchiectasis-Causes-symptoms-treatment.aspx>.

him, can you do it for me. And he'll do it. So I can't rely on him to do medicines. It's not on his radar.

Dealing with ill health, as with keeping the family healthy, was filled with worry, guilt, anxiety and uncertainty. Self-surveillance of mothering practices and social surveillance of children was as much part of family ill health as with keeping the family healthy. The stigma and morality surrounding certain illnesses was talked about extensively by the mothers. This quite often placed the mother in a conflicting position, one where the child may still be unwell but is sent to kindergarten, school, or playgroup. The good mother would keep them at home but then the mother who is feeling overwhelmed dealing with the sick needs a break.

Stephanie: And the whole contagious period, being conscious of other mothers. Because William or me might forget to ask the doctor or the health line for, how long are they contagious for because you need to know. One because you don't want to give it to other kids and you care about having the play date options for your own sanity. You know the selfish things and the not so selfish reasons. The contamination thing. And some people care more about that than others, the whole friend thing.

Provision and care of the ill

Ill health is complex and the provision of care for the sick is not as simple as care, doctor appointments and medications as treatment. There is a process involving symptom recognition, decisions on whether the family member will take on the sick role, treatment, and medical encounters (Cunningham-Burley & Irvine, 1987; Robinson, 1971). Previous research has shown the important role mothers play in each of these areas (Cunningham-Burley et al., 2006). As primarily responsible for ill health, mothers positioned themselves as the mother expert. This was important in all aspects of the provision and care of the ill.

Provisioning was important in ensuring the goods and services needed to care for the sick were available. Ensuring that the necessary items are purchased to deal with ailments for the whole family requires on going surveillance, monitoring and preparedness. What was interesting to note and different from keeping the family health was that the all the mothers except one took on sole responsibility of medications, including natural and complementary medicines, over-the-counter (OTC) medicines and prescription medications. This included monitoring levels of medications, purchasing them, filling prescriptions, monitoring safety, deciding on what type of medication to use and watching the clock to ensure timely administration. In one house the husband

does all the grocery shopping except for the baby's food and medications suggesting there is a gendered aspect to medications and care of the ill that was not evident in the health side of family health. However, I believe this is too simplistic and it had more to do with mothering work and care of the family, which is not necessarily gendered, and the fact that medication use was also related to the family health philosophy and practiced within this philosophy.

Sarah: I am the primary care giver in terms of that health thing. But if I'm unsure about something I'll always bounce it off him. His response will be "take it to the doctor" (mimics his voice) and I'm always like hmmm. I don't know. So many things are just viral and you wind up taking them to the doctor and they say it's viral, can't do anything for ya, go home and wait it out. Out of the pair of us he's probably more quite conservative //thing when it comes to health and when to taking them to the doctor type of thing. Whereas I am more of the lets just wait it out, wait it out a bit longer and see. I'm probably more on the relaxed side and he's probably more on the up-tight side so we kind of get it, you know, more in the middle. So ...

The expert mother position was important in the notion of medications. She retained control of the medications through expert knowledge of family health such as allergies, likes/dislikes, if the child can swallow pills or requires a suspension medication, preferences for flavours and what remedies work and what do not work. Lay expert knowledge of non-prescription medications has been found to be part of a taken-for-granted aspect of self-treatment, and void of risk assessments (Bissell et al., 2001). I would argue this was true for some medications as well such as panadol³ and even some prescription medications. These were considered safe and routinized in practices of care by these mothers such as in asthma management and some antibiotics for 'normal' childhood illness such as ear infections. Medications and strategies used in treating ill health are strongly tied to the mother's practices (Trajanovska et al., 2010). This research would suggest that this was the case here.

Illness represented a lot more uncertainty and worry than health which at times placed the expert mother position in jeopardy. While they retained expert knowledge of their family and their ailments, chronic conditions, and the family health history they were not medical experts so they had to seek medical information and help at times. The medical profession were seen as not always supportive of the mothers and the mothers were treated as inexpert by doctors. Michelle is talking here about when her son had

³ Panadol, paracetamol and pamol were used interchangeably even with the same households. All contain paracetamol. Panadol and pamol are two brands of this medication.

pneumonia and how the doctors did not trust her 'expert mother' knowledge of her son and how hard serious ill health in children is on the mother. The mother has to keep acting as the child's voice, their advocate until they get the answers they seek.

Michelle: oh cos he was sick for so long, like for weeks and weeks and I had him. One particular week I had him at five different doctors. They all told me there was nothing wrong with him. One doctor even told me to put him in the push chair and take him for a walk by the beach. // and um, yep no he's fine. He was having major temperatures, like in the 40's. And I just didn't know what to do. And one morning he woke up, it was a Saturday morning. Raging, another raging temperature. And it was like seven o'clock in the morning and I said to John, that's it I'm taking him to Starship, I can't stand this any longer. He was so sick. Of course, took him straight there, X-ray and he had to be hospitalised because it was so bad. I said that I had him at five different doctors and not one of them knew what it was.

Michelle: He was extremely clingy. I couldn't even walk out of the room without him. Cos that's another thing is it really gets you down you know. Like what's wrong with this kid? Couldn't do anything with him. Couldn't do anything with him but um that's why I took him to Starship cos I was just exhausted. There is definitely something that is not right, you know and I said I am not leaving here till you find out what it is.

On the other side of the coin the medical profession had the power to reassure the mother they were doing a good job and they had to power to heal the sick family member. Thus, there was uncertainty over when to follow and when to trust the medical profession and biomedicine and was applicable in decisions over symptoms, treatments, and in medical encounters. This uncertainty never seemed to be alleviated which required on-going uncertainty management (Brashers, 2001). While some mothers reduced their uncertainty by seeking as much information as possible such as Leanne, others found this was a stressor in itself. Stephanie talked of the internal conflict over when to trust herself and when to trust the expert. This did not always apply to ill health but issues of health as well.

Leanne: So if I come across something that I don't know much about I research it. I'm on the internet, I Google it, I talk to people, I ring health line, I just get as much information as I can. I have always been like that. Like to get a handle on it, just //

Stephanie: That's how I feel. To take away some of the voices, to focus on the one. People often go for credentials or qualifications so that can be a reason, good or bad to go for that. But the whole thing about mothering is the whole internal anchoring yourself and your heart. You know what I mean, there is the other idea that the answer is inside you. But with the medical stuff, or medication we find that we have to look outside ourselves. Because all these people have done all this research and it becomes all sciency.

Family and health identity were tied up with treatment plans, medications and other folk remedies used by the mothers. As with keeping the family healthy a family health philosophy was important where the mother's history and knowledge of medications took precedence over the fathers. Fathers were either positioned as 'not as good' as the mother or more worried about the children. This again positions the mother as the expert carer thereby constraining her into this position.

Lexi: Mainly me but Eli's very, he's very worried about health and stuff like that. One of the boys just has to cough and he's like take him to the doctor kind of thing. He's worrying so he alerts me to things that I might you know, or take them to the doctor because he really wants me to. But I'm like they are just going to give him paracetamol and send him home, which they do. I'm like it's a waste of money, gosh.

Charlotte: When I was in starship with Georgia he was pretty good at trying to look after Samantha, when she was getting wheezy, he was pretty good at doing her asthma meds and stuff. Um and trying to remember to get them to everything. But I don't know, they are just not as focused on the kids // that way. They're more there just to interact with them and have fun and stuff, you know, rather than do that sort of thing.

The other aspect of provision was the provision of care and love for the child or family member who is ill. All dominant ideologies of good mothers have the notion of nurturing and caring as part of the make-up of the good mother (Arendell, 2000). Ill health and care of the ill was linked to the work of mothers and to good mothering ideologies of the mother responsible for the ill. One way to show you care is the care given to the ill by showing love through the provision of food, cleanliness, cuddles, first aid, and medications. Caring for the sick can place the mother in a position of difficulty when children are forced to accept treatments that are unpleasant. For example taking children for immunisations was seen as traumatic and some treatments are very traumatic. Lexi and her husband at times have had to administer suppositories to their son when he becomes constipated. This involves the father holding the child down while the mother administers it which is hard on all involved.

However, while the mothers all agreed that good mothers love their children, the discourses surrounding the care of the sick were not as clear cut. While the mother assumed responsibility for care, there were substantial differences in the provision of care from natural to medical solutions, differences in sick philosophies or how the sick should be treated (child in bed, it's not a fun day but a day to rest, through to making the child feel special through treats while sick), and differences in what constitutes ill health.

Stephanie talks here about how she and her friend differ on how to treat their sick children.

Stephanie: Yes, um there's a part of me that thinks yes and no. If they are ever, I mean friend thinks I do this well, if they are sick and home then I am all, I want them to know they are loved and they get extra sort of stuff when they are sick. Not like a party or anything but I really do want them to be cared for when they are sick. You do go back to that place when they are babies, oh something is wrong, you know. And I want them to know that I will be there and all that sort of thing. And my friend has the other sort of approach that I think is kinda good too. She doesn't want it to be too fun or good for them. And she wants me to feel good too, and says I think you are being really nice but she obviously does her approach because she thinks that is good. Um, so yeah, when they are sick I really want to be there for them.

Model/teach illness strategies

Another part of the mother's role in dealing with ill health is modelling and teaching. Teaching was sometimes a conscious decision and something the mothers knew they were doing and at other times embedded in the practices of mothering. Tasks such as teaching personal hygiene, ways of treating minor ailments, which medications are safe, and how the ill are carer for are routinized into family health. Sarah talks about her seven year old daughter using optrex for an allergic reaction to long haired cats. She initially showed her how to do it but now she is getting to an age where she just needs watching and reassurance.

Sarah: I'm just there to make sure she's doing right but not only that I think she just wants the reassurance of someone else is there.

However, teaching took on added importance for mothers managing chronic conditions in their children as the ultimate aim was to teach independent management of the chronic condition. Chronic conditions over the life course of the child go through a similar process of the parents administering the medications, teaching them to care for their specific condition on their own (Meah et al., 2009). Mothers were aiming to get the child to independently care for their own health and manage their own bodies. There were quite different views on the age that a child had to be to be independent and differing strategies for teaching the child to care for themselves outside of the home in places such as school. For the mothers of children with chronic conditions the management of the condition outside of the home, such as liaising with schools, brownie leaders, netball coaches and teaching them how to care for their child was the sole responsibility of the mother. She acted as the liaison and teacher of the child's

medical history to ‘outsiders’. The child depending on their age would be also be coached as to what to do if something was going wrong.

Modelling was important particularly when the mother got sick. The mothers were very conscious of how they were modelling self-care and healthy lifestyles and the morality surrounding ill health. However, it was also related to her identity as a mother and the message she was sending the children. Thus making teaching and modelling of ill health and all that goes into this area difficult at times due to the contradictory pressures of mother and healthy citizen.

Dealing with the impact of ill health

In these households the mother was doing the bulk of the domestic work so if a family member was ill they would manage this alongside the rest of the domestic duties. Ill health is quite often something that cannot be anticipated, so even minor illness, had the potential to disrupt routines, change roles, and create change (Lyons & Chamberlain, 2006). The mothers saw a large part of her role when dealing with ill health was to manage these changes within the context of her own personal resources and family commitments. Ill health could lead to changes that would be felt by the entire family but the mother’s said the impact of ill health was felt predominantly by them and had to be managed by them. How do you provide a meal for a family of six when the baby has had a cold and wants to be held all day? It had to be managed across all the areas of family health including surveillance, provisioning and modelling family health. In the two weeks that Charlotte completed the diary her youngest child was quite ill and she had Georgia’s on-going treatment for bronchiectasis too. A note from the diary explains how she manages both one day.

Charlotte: Day 1 – Child 3, I needed to spend most of the day comforting and cuddling her since she didn’t feel well. Had to wake her from a sleep to pick her siblings from school, and carry her around while her sisters had their swimming lessons. Child 1, Need to have family ready for school early to allow time to sit down and do her physio breathing exercises before school, and before her swimming lesson. I have to constantly check the colour of her sputum after physio to notice any changes that show a chest infection. Have to have her active every day to keep her lung function healthy. Her siblings need to be taken with us when do fitness activities and join in or wait for her to finish. All have swimming lessons that day.

Planning ahead and anticipating the needs of the entire family are essential if she wants to follow the treatment regime and still get everything else done. The complex regime

has become integrated into the daily routine of the family and as such is monitored, planned for, and surveyed along with the rest of the family's health needs. This routinization of chronic conditions happened with all the chronic conditions such as asthma, eczema and severe peanut allergies. The management of these is difficult at times and requires expert knowledge by the mother and the family but the process of care becomes embedded into family health and the family health philosophy alongside health related knowledge such as food preferences.

Charlotte: (the physio takes) 15-20 minutes but it depends again if she's really tired, and if you have netball practice at eight o'clock in the morning, I mean it's not too bad if it's Samantha's practice cos we can sit there and do it on the side of the court so it's not so much of a rush or sit in the car like we did the other day in the rain. If it's hers, if she's going to do netball practice then you need to do her physio beforehand otherwise her chest is going to start going and she's going to be stopping to cough up stuff every couple of minutes cos she's exercising. And it's like if we have swimming after school instead of leaving it to dinner time then we have to come home and do it before we go to swimming cos otherwise she is not going to be able to hold her breathe and swim as good or it's going to irritate her and she's going to have to keep stopping to cough stuff up in front of everyone you know so..

Planning, organising, monitoring, and anticipation were ways the mothers talked about to reduce stress of ill health on the family. Ill health was seen as a source of extra work, worry, stress and therefore was a driving factor in preventing it. They did this in a number of ways, reducing the risk of cross contamination, being prepared, and being knowledgeable. Ill health was also directly linked and intertwined with mothering. Ill health in children could impact on their behaviour which in turn impacts on the mother. Also if the mother was ill this impacted on her ability to mother in the way she defined as 'good mothering' and as such could be used to discursively justify bad mother moments.

Lilia: I don't know, I don't get sick myself, I do get stressed, the things that stress me, all of my back and neck and that type of thing is really tight and stressed, and headaches that's what I find and when I've got from what's happening in the family then I am really grumpy and horrible to my children so it's just a circle that goes around.

Kathryn: Yes?

Lilia: But also if you have got medical issues, and I am sure you have found this out. But if you have major medical issues then you are more laid back with your kids because you think their behaviour is impacting on the way the children are or whether they are more uptight about it. //Yeah but again there is the whole guilt about being a good parent or a bad parent or whatever.

Ill health was also used discursively to justify immoral health choices and could be seen as a time when good health could be relaxed. This was framed as health reasons though. When Georgia is well then juice, milk and water are deemed healthy but when she is sick then energy drinks are fine to have for health reasons. Normally they are avoided due to added preservatives and colours in these drinks.

Charlotte: Yeah, when Georgia gets sick she can't just drink water it just doesn't have enough vitamins in it, when she gets sick she is so skinny, that she just has to have an energy drink to drink.

Sudden, serious illness events are very disruptive and required the whole family to be involved. There were stories of the household having to alter very quickly to adjust to this. This was applicable regardless of who was in ill. But while serious, sudden ill health is a disruption the disruption is routinized over time. While completing the health diary Lexi got a serious kidney infection which required an overnight stay in hospital. These notes from her health diary indicate the impact this had on the family.

Day 8 – husband had to cancel business meeting to take me to hospital, quickly found babysitter, husband informed work he would be taking day off on Tuesday, pack a hospital bag for me and baby –had to take baby in cos he is still fully breast fed.

Day 9 – husband had to take time off work. Other children a little unsettled with changes.

Day 10 – my mum came over at midday to watch the children while I slept for 3 hours. She also picked Steve up from school. Household disorganised. My mother prepared dinner.

Day 11 – house sill in disarray, Steve late to school and Tymone late to kindy. My Mum came again while I slept for 2 hours. She also made dinner again.

Day 12 – my mum came to watch kids again and I slept for 2 hours at midday. House still in disarray and simple dinner.

As Lexi's diary notes illustrate when the mother is sick this presents the most disruption for the family. Taking on a traditional sick role for these mothers required organisation and planning so others could take over the care of the family. Lexi indicates that even when she returned home she was not able to mother in the way she normally could and this was reflected in the state of the house, the mood of the children, and in the quality of the meals. This position again reinforces that the mother is the expert in managing all aspects of her family.

The other aspect of disruption was the mother's role in events that were disruptive but not illness related. Mothers in this study took on this role of family health overseer in

these situations as well as a good mother expert should. Packing medications for holidays, ensuring a first aid kit is in the car, being prepared for trips to the park was very much left to the mother to manage.

Charlotte: He packs for himself and then he's done and he's like what's taking you so long, what do you mean you're up, it's one in the morning, how come you are not in bed cos you are still doing the kids and then things like Georgia now you have to think well we are going through customs and stuff and we're going to be on a long plane ride and she can't do her liquid antibiotic, you can't take liquid on or if you want to take the liquid medicine then you have to take this, this and this.

Family illness philosophy

The family practiced ill health within a family health philosophy and this unique set of beliefs and practices influenced all practices of care for minor ailments, chronic conditions and serious ill health. The mother had the most influence on the philosophy in all areas of family health including medication use, when to seek medical help, how to treat certain illness, and how illness was experienced in the family. However, this was flexible and advice and reassurance was sought in response to uncertainty. In this one example, Sarah talks about her philosophy over chicken pox. While some of the other families had their children vaccinated for chicken pox Sarah had not, believing it is a 'normal' childhood illness. Her philosophy was to expose her children when it was going around the school to make sure they got it as a child. The philosophy was also important in where she would take the sick child as they recovered.

Sarah: I think what you become aware of is // not the impact necessarily on the other children because my philosophy is that basically you're going to get it no matter what, they'll get it sometime anyway but my philosophy is more about older people. What happens if you exposed an elderly person and they got shingles then I kind of think ahhh. School I don't mind so much and don't so get so up tight with, kindy I'm not so uptight with but // look with chicken pox you're infectious before you come out in spots so like I don't get particularly... I did feel uptight about taking not him out to places like shopping malls but schools, kindy's psst. Public places where we might come into contact with other elderly people or .. I avoided taking him to those type of places. Because of that, you know. You'd have to be pretty selfish to think that about schools and kindys but the fact of life is they are all infectious breeding grounds running around infecting everyone else before they even have a sign of it.

There were many examples to illustrate that family health was practiced as a family and the constant work that goes into maintaining and updating the philosophy over time. Mothering was framed as a dynamic, changing and challenging journey that required

on-going education and negotiation but over time aspects of the philosophy and family health practices are routinized over time. This was particularly relevant when a child had a chronic condition to manage. Lexi's son has autism and she talks about the journey and how aspects of his care that were very hard to cope with to begin with are becoming second nature or routinized now. This has been shown in previous research on chronic conditions (Meah et al., 2009).

Lexi: It's been a real journey for us with Steve. // We understand Steve now, it's just preparation, making sure we prepare him, prepare him for change. Remember too that he has autism so if he's like you know. I was getting really upset with him the other day and Eli called out, he was just about to hop in the shower and he called out, remember our son has autism hon. And then he goes and gets in the shower (laughs). I'm like Ok, (deep breath). So it's trying to find that balance, we don't want to let him get away with stuff but also understanding that some things are really hard for him to cope with so you can't be lazy you know (laughs). Which you want to do all the time. You just have to be mentally on your game all the time. But now it's just becoming, what's the word? //Second nature now.

Summary

Mothers again were primarily responsible for all aspects of ill health. While many of the processes of keeping the family healthy and dealing with ill health are the same illness represented disruption. Even minor ailments had the potential to disrupt routine family health practices. This disruption was left predominantly up to the mother to manage in these households. Chronic conditions were also left predominantly up to the mother to manage. The mother retained her expert health knowledge of her family and this influenced and impacted on how ill health was dealt with as a family in all areas from symptom recognition, care of the ill, treatments, medications and interactions with health professionals. This expert status was maintained within the family but was contested outside the family by medical professionals and other families making it a difficult position to maintain. Ill health was practiced within the family health philosophy, as was health, truly indicating that family health is an interwoven and messy place consisting of both health and ill health.

CHAPTER 5 - Conclusion

Stay-at-home mothers have a complex role in family health. The mother played an important role in all aspects of family health involving keeping the family healthy, preventing ill health and dealing with ill health. The main finding of this research was that while the mother had a key role in overseeing family health, it was practiced as a family in a messy and intertwined way. I termed this the family health philosophy. All practices within family health for the mother and the family were governed by a set of dynamic, changing and fluid beliefs that were unique to that particular family. The mother was the primary agent of the philosophy. The philosophy is built out of experience, practice and knowledge over time within the household. Certain health related decisions were negotiated as a family which allowed the father and children to have an input into family health. The philosophy was used in all aspects of family health to discursively justify the different ways that family health could be enacted, challenged and re-worked in to the reality that is family. The philosophy had to be flexible, dynamic and open to change. This suggests that as 'family' can be thought of as a unique set of practices so too can 'family health' (Ribbens-McCarthy & Edwards, 2011). There is more and more research exploring the relational nature of family and how many decisions are negotiated as a family (Backett-Milburn & Harden, 2004). The goal for future research would be to explore the relational nature of family health and the role each family member has in the negotiation of its family health philosophy.

Family health, while practiced as a family, was for these mothers the primary responsibility of the mother. In an exploration of the power of mothers in family health I found that, in order to resist patriarchal power, mothers positioned themselves as the 'mother expert'. The mother expert retains the specialised health and illness knowledge of her children. This knowledge comes from embodied experiences such as pregnancy or breastfeeding, historical family knowledge including medical history and genetics, and mothering experiences. This mother expert position empowers and constrains these mothers. They were empowered as stay-at-home mothers as they are the experts on their children and this gives them the power of specialised family health knowledge. Fathers were seen as inexpert family health carers and as a consequence less powerful. However, paradoxically this position also constrains these women into the position of family health carers as they are positioned as the only ones capable of caring for their families with any real expertise. The family health philosophy was used to discursively justify

unhealthy practices, resist medical advice, and reinforced the expert mother status. Looking at this mother expert position in households, where the mother works outside the home, single mothers, adolescent mothers and so on would be the next step in ascertaining whether this is a dominant ideology for all mothers or is unique to mothers who stay at home with their children.

Family health was practiced within a unique family health philosophy that differed across families but there were still the same processes being performed by all the mothers. These processes were surveillance, provisioning and teaching. Aspects of all these areas were routinized into mothering but certain aspects required a more conscious process. This finding is consistent with Graham's research into the work of family health (cited in McKie et al, 2004) but extends this concept further to include surveillance and to explore the routine versus non-routine aspects of family health. I also argue that the processes, while split between health and illness here for analysis purposes are interwoven, and quite often were performed in conjunction with each other.

Surveillance played a major part in family health. The extent of this was a finding I had not anticipated. Nelson and Garey (2009) suggest surveillance is important to families in three areas: external to the family; across families; and within families. I have extended this idea to family health and found that the same three areas apply. Firstly, surveillance medicine and the dominance of biomedicine act as an external control on mothers and family health, through screening of well children and adults, discourses surrounding prevention of ill health, medical advice for the sick, and health promotion. Secondly mothers compared themselves to other mothers and their families and judged their own success as a mother on their children's health and how healthy their family was. This led to guilt, self-scrutiny and anxiety over mothering and family health practices. Thirdly, surveillance by the mother within the family acted as a form of control over the family. She was the disciplinarian of family health, restricting and monitoring access to 'unhealthy' areas administering treatments that were unpleasant.

The mother's role in provision of family health was a complex process involving the often contradictory tasks of balancing health with family commitments, showing love, assessing risk, monitoring, taking care of the mother, organisation, all while dealing with the impact of any illnesses. Many aspects of provisioning were embedded into the mother's daily life, such as food provision, getting the children bathed, or administering medications to children with chronic conditions such as asthma. However, when illness

disrupted families, this required extra work. The impact of family illness on the family was managed in all cases by the mothers. Managing disruption had to be done within family commitments, personal resources, and budgets.

Teaching was the third aspect to emerge. This involved physically teaching tasks to the children, modelling how to deal with illness and modelling a healthy lifestyle. While modelling health was a moral imperative, teaching was more embedded into child rearing and mothering. The ultimate aim was to teach the children how to 'do health', care for their own health including managing any chronic conditions, and be healthy citizens.

The mother's role in family health is complex due to the interwoven nature of the mothering work involved in family health combined with the nurturing, caring aspects of mothering. Rothman (2000) would argue that positioning mothering as work is unacceptable as it devalues the "intimate, joyous, terrifying, life-affirming experience that is motherhood" (p. 7). Maher et al. (2010) conversely suggests that considering mothering as series of tasks or work removes the gendered aspect of the general care of the family. I would argue that the mothers I talked to do feel like parts of mothering and family health are 'work-like' and not particularly pleasant but that elements of nurturing and love made this 'mothering'. I also argue that this paradox increased the uncertainty and worry over mothering practices and family health practices. As the focus of this research was more on the family's physical health rather than mental health or well-being I believe this may have contributed to why some aspects of family health were considered work including the domestic duties, provisioning and surveillance. Further research that considers these issues in the context of both physical and mental family health would be beneficial.

The gaze of academic research, policy and social agenda in a modern Western society has complicated motherhood and its practices in family health. The ideology of the good, moral, responsible mother who produces well-mannered and healthy children who grow up to be productive and healthy members of society has been critiqued, and rightly so. This ideology is unrealistic, damaging and culturally limited to white, middle-classed mothers. However, I argue that there can be a just as damaging an ideology of inherent judgement, competition and sense of injustice between all women, mothers or not. This was evident in the mother's role in family health. The awareness of social surveillance and judgement of mothers as carers of children led to guilt, anxiety,

and uncertainty over family health practices. Self and social surveillance impacted on all aspects of family health. While maintaining expert mother status within the family was one way to resist this, this was problematic as mothers are not usually medical experts, only experts in their family at that particular moment. Practicing family health through a health philosophy that allowed input and negotiation by all family members as well as lay and medical professionals outside the family was the main way these mothers justified family health practices. The family could resist, challenge, accept, and discuss how family health would be enacted.

One of the restrictions of this study was the women all lived in a middle class area of Auckland and only one woman identified herself as Maori, all the rest as New Zealand European. The women were all in a relationship with the father of the children and lived in the same house as that person. So the research was with predominantly white middle class mothers in a nuclear type family unit. While this is a limitation it is also a strength as the group was homogenous and it could be argued stay-at-home mothers in this area of Auckland are in the minority. Regardless of whether this is a minority group or not I would argue that all mothers are very focused on health and illness and that the processes that these stay-at-home mothers go through on a daily basis could be applicable to all mothers. I argue this not from a role/responsibility viewpoint but from a process viewpoint. By this I suggest that most mothers would consider themselves experts on their family's health and they are practicing health within a family health philosophy, regardless of whether they work outside the home or how the family is constructed.

This research gives us a rich understanding of the role of the mothers in family health and this could be of interest to mothers, women, health providers, policy makers and any organisation that cares for children or deals with parents. Mothers are doing, practicing, and living family health partly through routinized aspects of mother work, partly in response to illness disruption but always through the love and nurturing aspects of mothering. Mothering and family health are intrinsically linked and constrained and empowered by dominant mothering ideologies, moralities of health and illness, surveillance of both the normal and ill, dominant medical discourses surrounding child rearing, health and illness, and uncertainty and risk management. The two main ways the mother forged a way through these often contradictory positions was as a mother expert and practicing health and ill health as part of a family health philosophy. This

information may help us understand the complex contextual nature of a mother's everyday lived world and the decisions she is making around her family's health.

APPENDICES

Appendix A – Information sheet and Consent form

INFORMATION SHEET

Researcher Introduction

My name is Kathryn McGuigan. I am a student at Massey University enrolled in a Masters of Science within the School of Psychology. As part of my degree, I am conducting a qualitative study into the role that mothers play in managing the health of their families under the supervision of Professor Kerry Chamberlain.

Project Description and Invitation

Within many families much of the responsibility of keeping the family healthy and dealing with everyday ailments and illnesses falls to the mother. I am interested in your personal story as a mother and what your everyday experience is of managing your family's health. For that reason, you are invited to participate in this research.

Who can participate?

Mothers

- of two or more children who have a partner/husband/significant other adult living in the household, and
- who have at least two children who are 12 years or younger and who live with the mother more than 50% of the time, and
- who are not in paid employment.

What would you have to do?

If you agree to take part in this research, I will need your written consent to participate in two audiotaped interviews two to three weeks apart. These interviews will last no longer than 1 - 1½ hours each. At the first interview I will ask you about all the medications in your home, and to draw a rough plan of your house and locate on it the places where you keep medications. We would also like to see the range of medications, and related things like pill organisers and inhalers, that you have in the house, but only those things you are willing to show us. I will then ask you to complete a timeline, for you as the mother and for the children, of any episodes of illness and related events you can remember and that you are willing to disclose. I will then ask you about these episodes in more detail.

I will also ask you to complete a health diary in between the two interviews. This requires making quick notes each day on any medications you or your family has taken and any illnesses or health complaints you have dealt with. This will **only** take 5-10 minutes per day. The interview will take place at your house, as the focus of the study is what you do when you are at home with your family. It is important that the interview location is private and quiet. Also, please note that I am not a medical professional and I am not qualified to provide medical advice.

What are your rights as a participant?

You are under no obligation to accept this invitation to participate in this research, but if you do I can assure you the research will be conducted according to the ethical principles that support university academic research. If you decide to participate, you have the right to:

- decline to answer any questions or talk about any issues;
- ask for the recorder to be turned off at any time during the interview;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used;
- withdraw from the study anytime up to two weeks after the second interview;
- be given access to a summary of the project findings when it is concluded if you request this.

In addition, I assure you that all research materials will be treated with great care. All the information you provide is confidential and any identifying details, such as names, dates and places, will be removed and pseudonyms will be used, if necessary, in reports. The information you provide will be carefully stored and be available only to me, and my supervisor. After the research is completed, a summary of findings will be made available to you if you request it, and the transcripts and recordings destroyed.

A small koha (a gift of petrol or grocery voucher to the value of \$30) will be provided to you in recognition of your support for the research and the personal contribution you have made.

Who can I contact if I have questions about this research?

After reading this information sheet, if you would like to participate in the research, or have any further questions or concerns about this investigation, please feel free to contact me and/or my supervisor, Kerry Chamberlain. Our contact details are below:

Kathryn McGuigan

Professor Kerry Chamberlain

Ph: (09) 476 7991 or 0212386704

Ph: (09) 414 0800 ext 41266 (Massey University)

E-mail: mcguigan.kathryn@gmail.com

E-mail: K.Chamberlain@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 10/083. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 9570, email humanethicsnorth@massey.ac.nz.

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I would like to participate in the proposed study and be interviewed about my experiences as a mother managing my family's health. I understand that I can decline to answer questions and stop the interview at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:

Date:

.....

Full Name - printed

.....

I would like to be provided with a summary of the research findings. YES ____ NO ____

If you have requested a summary of the research findings, please provide contact information below:

Either: Your address:

.....
.....

OR: Your e-mail address:

.....

I would also like to seek your permission to release the household map and the transcript section of your discussion covering comment on medications in the home to the Medications Research Group at Massey University, as this group is conducting a major project investigating the location and meanings of medications within the home. This group's research is conducted under ethical approval from Massey University Human Ethics Committee Northern (Approval Nos 08/054 and 08/067), and they would treat your information with the same care that I have assured you of in this project.

I agree that my household map and the relevant section of my transcript can be released to the Medications Research Group for further analysis.

Signature:

Date:

.....

Appendix B – Household Data Sheet

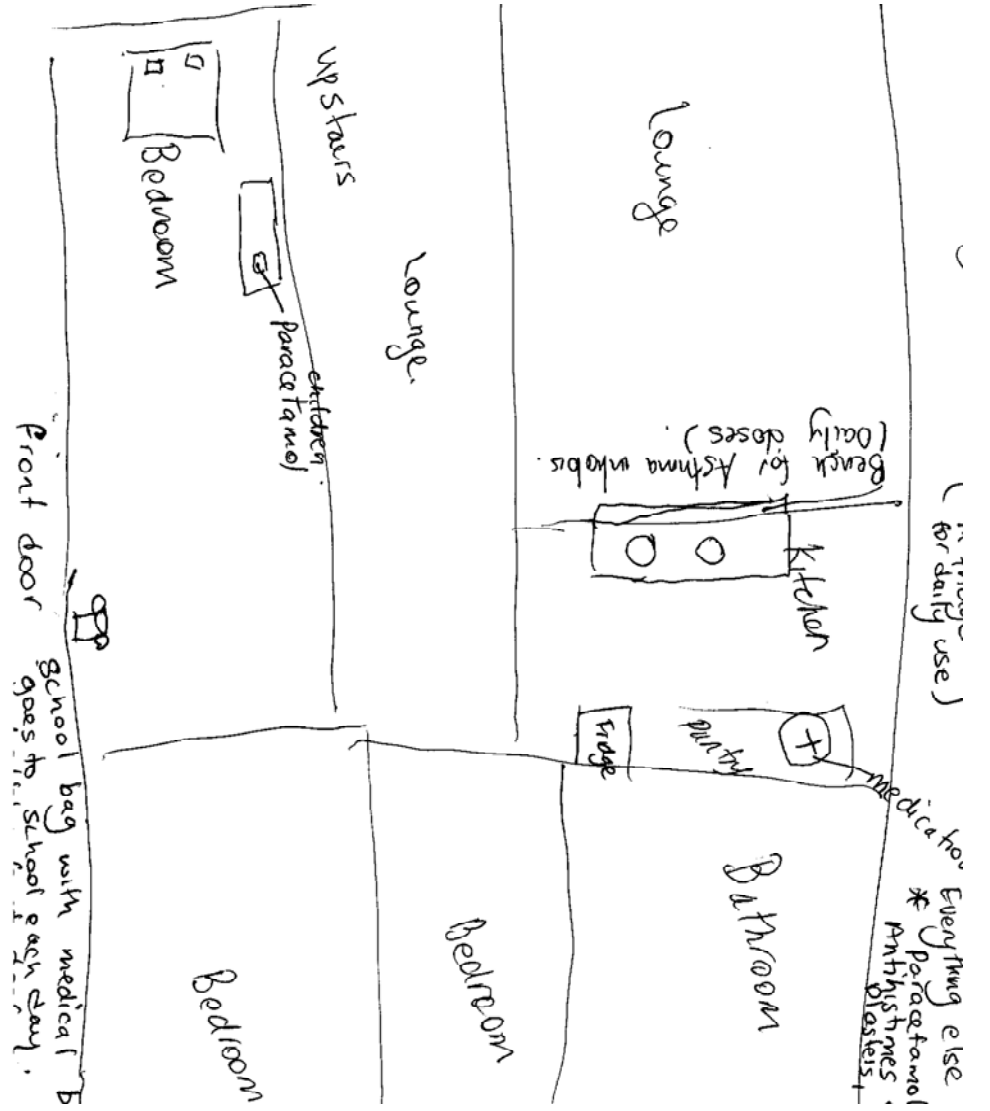
Household Data Sheet

Name	Age (years)	Gender	Relationship

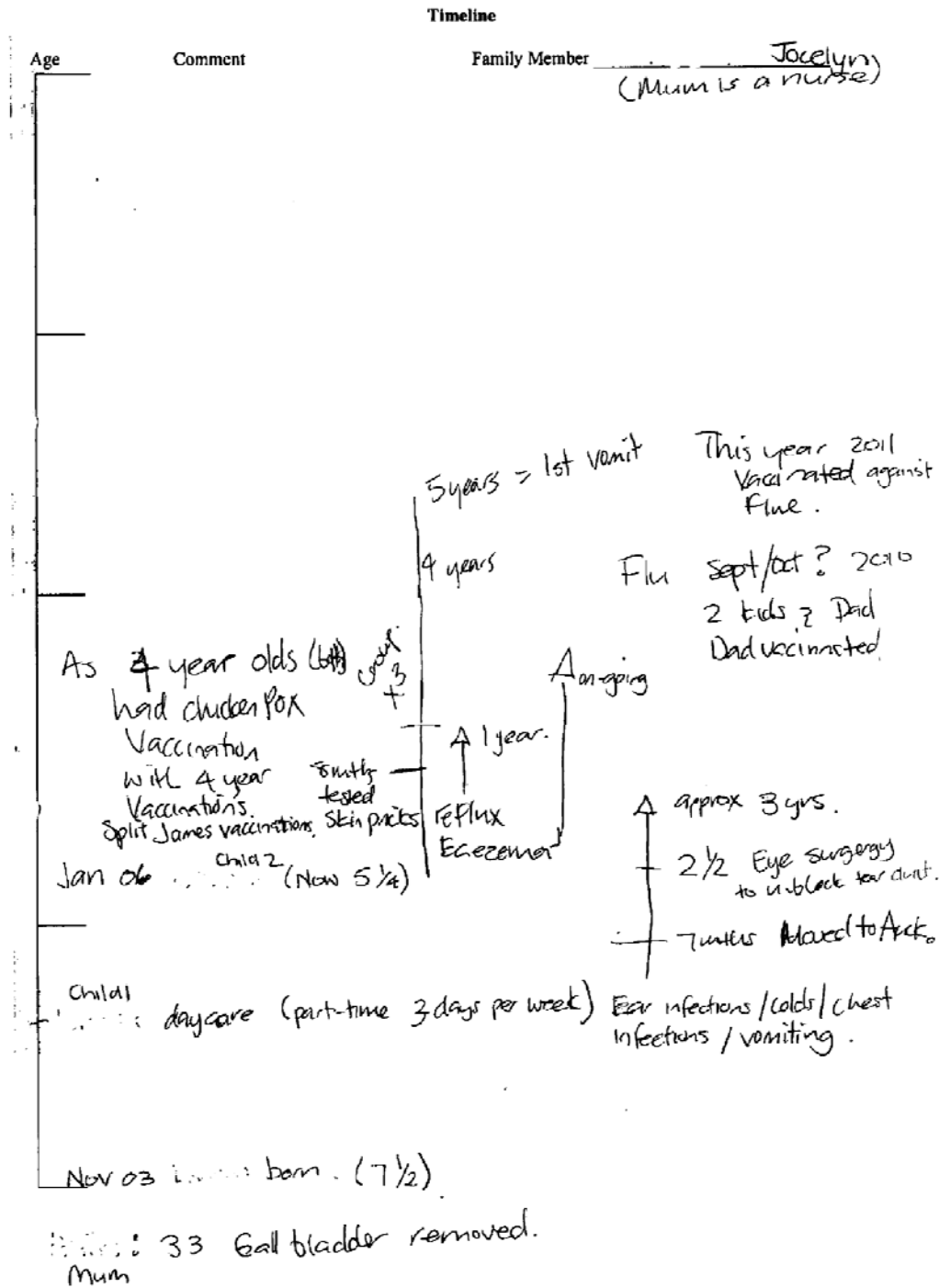
Occupation of Partner/Income Earner

Other comments

Appendix C - Map



Appendix D - Timeline



Appendix E – Interview Schedule

INTERVIEW ONE (1½ -2 hours)

KEY QUESTION	FACTORS REQUIRING EXPLORATION
Tell me about your family	<p>Ethnic and religious background</p> <p>Any other demographic info (income of house, level of education)</p> <p>Structure of family (make up, proximity of other family members who may need care)</p> <p>Number of children (ages and sex)</p> <p>Relationship with partner (married, de factor etc.)</p> <p>Role of the mother within home (duties, who is responsible for what)</p> <p>Role of mother outside of the home (voluntary work, memberships, regular commitments, social support)</p> <p>Interests of children and mother (sports, hobbies)</p>
Health timeline for children and mother	<p>Major health incidents for children and mother</p> <p>Any chronic illnesses</p> <p>Gives lead in to later questions about specific health issues</p> <p>Minor recurring health incidents</p> <p>Uniqueness of each family members health identity</p>
What does health mean for you and your family	<p>Understanding of the word health</p> <p>What are the health priorities for the family (food, exercise, activities, safety, cleanliness)</p> <p>Immunisation or other health prevention measures</p> <p>Society and Gender stereotypes</p> <p>Risk/threat of harm (reduction of harm) e.g. Exposure to smoking, alcohol use.</p> <p>Consumer society</p> <p>Pressure for healthy families</p> <p>Family/genetic risks (e.g. Tendency to have high blood pressure)</p> <p>Constant surveying</p> <p>Home as source of risk or benefit?</p> <p>Pharmaceuticalisation</p>
Tell me about you becoming a mother, what has this meant for you	<p>Gender roles</p> <p>Feminist ideals</p> <p>Health inequalities</p> <p>Family Burden</p>
What happens when one of the children gets ill?	<p>Self-treatment strategies (not medication)</p> <p>Medication use (OTC and CAM)</p> <p>Activity restrictions for mother or child</p> <p>Who does what within the incident – role of mother</p> <p>Sources of information – lay networks, health lines, internet, pharmacist etc.</p>
When do you seek professional medical help and why?	<p>How does role of mother or other duties influence these types of decisions?</p> <p>Time commitments, needs of other family members</p> <p>Normativeness of health concern (a childhood illness versus something new)</p>
How has this changed since you have had children or as they grow older	<p>Constantly changing over time</p> <p>Own historical and medical background important in how the mother will act</p>

	Gender stereotypes Age of children – as they age health requirements decrease or change?
Can you tell me about the last time you were ill?	Cause of illness Strategies for management Feelings Stress Role of mother with competing demands
Explanation of health diary and what is required	
Make next appointment	
Anything else you would like to add	
	Thank you

Health Diary to be completed by the mother (see Appendix 5) in the interval between the two interviews

The purpose of diary is to explore medication use and obtain information on what illness events may have taken place during the two weeks

INTERVIEW TWO (1- 1 ½ hours)

KEY QUESTION	FACTORS REQUIRING EXPLORATION
Review of health diary	Look at what has happened during the 2-3 week break Clarify any information
Explore any important incidents from the health diary	Role of mother within the incident Probe key factors that have arisen from narrative
Review of what we discussed previously	Highlight any events that have come to mind in two weeks and explore these with the mother
Anything else you would like to add	
	Thank you

Appendix F - Health Diary

	Mother	Partner	Child 1	Child 2	Child 3
Ailment and action required			Bronchiectasis -Physio twice a day plus medication and exercise		Fever
Role of mother in incident			Do physio with her, give her medicines		check temp throughout day and night. Try to determine the cause.
Medications taken (include medication and reason for medication use)			Ventolin severe for asthma. Buteo cort + Amoxicillin to prevent chest infection.		Paracetamol as required to bring temp. down
Any additional notes			Swimming Lesson Day for fitness.	Swimming Lesson Day	Swimming lesson day. Wants diff food to rest, family.

Consequence of event for mother/family

(3) I needed to spend most of the day comforting and cuddling her since she didn't feel well. Had to wake her up from a sleep to pick up her siblings from school, and carry her around while her sisters had their swimming lesson.

(C1) Need to have family ready for school early to allow time to sit down and do her physio/breath exercises before school, and before her swimming lesson. I have to constantly check the colour of her sputum after physio to notice and changes that show a chest infection.

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