'I'm Always on the Lookout for What Could Be Going Wrong': Mothers' Concepts and Experiences of Health and Illness in Their Young Children

Sydney Health & Society Group Working Paper No. 1

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Abstract

Mothers in contemporary western societies are expected to adhere to the principles of intensive parenting, spending a great deal of time and effort caring for their children, protecting them from risks and promoting their health, development and wellbeing. This paper draws upon research involving indepth interviews with 60 mothers of infants and young children living in Sydney. The discussion focuses in detail on three major topics discussed in the interviews: how the interviewees conceptualised good health and illness in their children; the role of diet and physical exercise in promoting children's good health; and space, physical safety and bad influences. The study found that the interviewees reported that they 'read the signs' of their children's bodies and had to 'know' their bodies intimately in order to do so. They also interpreted the signals of their own bodies – their 'gut instincts' – as part of the process of maintaining careful surveillance of their children's health state. They represented diet and physical exercise as the most important dimensions of promoting their children's health, and were very concerned about the risk of obesity in their children. Notions of space and judgements about the bodies within these spaces were also important to some of the women's concepts of protecting their children's health and wellbeing.

Key words: children's health; mothers; concepts of health in children, children's embodiment; sociology; intensive parenting; biopolitics; risk

Introduction

The role of parents in caring for their children in late modern societies has become the focal point of much discussion and advice. Some researchers have begun to use the term 'parenting culture' to describe the sociocultural context in which parenting takes place, including the network of advice that both surrounds and assists in constructing the experience of contemporary parenting (Faircloth and Lee, 2010; Lee, Macvarish and Bristow, 2010). Others have described 'intensive parenting' as denoting aspects of parenting culture which focus on the accompanying responsibilities and obligations, including the expectation that parents will devote a great deal of time and attention to seeking out information about how best to parent and acting on this information in the interests of the child (Hays, 1996). Children are represented in contemporary societies as precious and valuable, requiring the highest level of parental attention and care and constant work to ensure that they achieve their potential (Zelizer, 1985; Beck and Beck-Gernsheim, 1995; Wall, 2010).

The Foucauldian concept of governmentality (Foucault, 1984, 1991) and Beck's thesis of the risk society (Beck, 1992) intersect at the pivotal site of the family. From the governmentality perspective, in the neoliberal context of late modern societies parents are encouraged to construct themselves as responsible citizens by caring for their children. What may be viewed by individuals themselves as personal decisions made in the intimate context of family life are part of the apparatuses of biopolitics. In neoliberal

discourses of self-responsibility and care of the self, state objectives are taken up by individuals voluntarily as part of their everyday lives. For Beck's risk society thesis, risk consciousness in late modernity has become pervasive. Control over and management of risks is viewed as part of consciously planned 'project' of the self. The concept of risk is a central part of intensive parenting culture, as parents are constantly exhorted by expert advice to protect their children from apparent dangers. From preconception well into late adolescence, children are positioned as threatened by numerous risks that require management on the part of their parents. As both governmentality and risk society theorists suggest, a particular type of reflexivity and subjectivity is required and expected of parents in relation to their children, one which positions the child as central to a family's life, as needing continual care and assessment of their needs and conscious decision-making (Beck and Beck-Gernsheim, 1995; Lupton, 1999, 2008, 2012; Jackson and Scott, 1999; Christensen, 2000; Murphy, 2000, 2003; Lee, Macvarish and Bristow, 2010).

Mothers, in particular, are singled out as primarily responsible for engaging in caring for their children and protecting them from harm. Indeed, an important expectation of mothers is that they constantly undertake surveillance of their children to protect them and promote their health (Henderson, Harmon and Houser, 2010). The emphasis on mothers taking responsibility for their children's health begins in pregnancy, when women are exhorted to engage in a plethora of activities, such as taking vitamins and attending regular prenatal checks, or on the other hand to avoid certain practices such as eating the wrong foods, gaining too much weight or consuming alcohol, cigarettes and other drugs so as to achieve the optimal health and development of their unborn children (Lupton, 1999, 2011, 2012; Kukla, 2005, 2010; Weir, 2006; Bell, McNaughton and Salmon, 2009; Lowe and Lee, 2010). This expectation has resulted in a growing market for technological devices such as baby monitors that assist mothers to maintain continual surveillance of their children and which position the ever-watchful mother as the ideal type (Marx and Steeves, 2010).

Numerous studies on motherhood have demonstrated that ideals of the 'good mother' includes notions that mothers are constantly engaged in caring for their children when young, that they meet their needs without fail, even if to the detriment of their own, and that they are willing to take up expert advice in caring for their children. They are also expected not only to promote the physical health of their children, but to ensure that their children receive appropriate stimulation so as to optimise their cognitive development (Nadesan, 2002; Wall, 2010). These notions are intertwined with moral meanings that include judgements of women's mothering practices (Hays, 1996; Walzer, 1996; Lupton, 2000, 2008, 2012; Murphy, 2003; Holdsworth and Robinson, 2008; Bell, McNaughton and Salmon, 2009; Henderson, Harmon and Houser, 2010; Maher, Fraser and Wright, 2010). Mothers are expected to not only be engaging in embodied caring activities for their children, but to be constantly thinking about and anticipating their child's needs, worrying about them and weighing up the value of expert advice: actions Walzer (1996: 219) has referred to as 'invisible, mental labour'.

In this sociocultural and political context in which mothers are expected to continually monitor and regulate the health status of their children's bodies, how are women responding to these morally-charged imperatives? Some research exists which has specifically investigated women's concepts concerning protecting their infants' health (Murcott, 1993; Lauretzin, 1997; Murphy, 2007; Brownlie and Leith, 2011) and their ideas about healthy eating in relation to their families (for example, McVittie, Hepworth and Schilling, 2008; Cook, 2009a, 2009b; Ristovski-Slijepcevic, Chapman and Beagan, 2010). Other studies have examined more generally the ways in which mothers conceptualise and recognise good health and signs of illness in their children (Cunningham-Burley, 1990; Irvine and Cunningham-Burley, 1991; Backett-Milburn, 2000; Cunningham-Burley, Backett-Milburn and Kemmer, 2006). While this research has provided some interesting findings, all of it originated from the global north – the UK, North America and Sweden. The study here described built upon this previous research by identifying how Australian mothers from various socioeconomic backgrounds conceptualised their young children's health, illness and embodiment, what actions they considered important in promoting and maintaining the optimal health and development of their children, how they went about putting this into practice, what risks they saw as potentially affecting their children's health and how they responded to illness in their children.

The study

A total of 60 women living in Sydney with at least one child aged 5 or younger were recruited for the study. The participants were recruited using a research assistant who was experienced in recruiting and qualitative interviewing for market research and other researchers. She used a variety of methods to recruit participants, including drawing on contacts made in previous studies, snowballing from these contacts, advertising in places such as libraries and child health clinics and randomly approaching women with young children in shopping areas and day care centres.

The research assistant deliberately sought participants in different areas of Sydney to include participants with differing education levels and income. As a result, the 60 women were a heterogeneous group, with half from socioeconomically advantaged and the other half from disadvantaged suburbs (based on the *Social Atlas of Sydney* classification of suburbs by the Australian Bureau of Statistics). They ranged in age from 19 to 48 and had between one and 11 children. Eleven of the interviewees were from a non-English-speaking background (including Chinese, Middle Eastern and Latin American) but were fluent in English and required no interpreters to take part.

An interview schedule with open-ended questions was used that allowed the interviewees to explain their beliefs and opinions and recount experiences at length. Ethics approval for the research was granted by the institution [Charles Sturt University] at which I was employed at the time of data collection. The research assistant conducted the interviews, which were audiotaped and transcribed, and the author undertook the analysis of the transcripts. The names of the interviewees and their children were not kept in any records and any names of family members they

mentioned in the interviews were substituted with pseudonyms to ensure confidentiality.

The analysis of the interview transcripts took a discourse analysis approach, with a central focus upon identifying the broader sets of meanings (discourses) that underpinned the women's explanations of their beliefs and experiences. Each interview transcript was carefully read and re-read and compared with the others as emergent themes, topics and discourses were identified. For the purposes of this research, 'discourse' is understood as a pattern of words, figures of speech, concepts, values and symbols that cohere to form a particular way of describing or categorising concepts, practices and experiences. Discourses are embedded in social, cultural and political settings, and used for certain purposes. In the case of the data here analysed, the discourses that are identified in the interview transcripts give certain actions and ideas context and meaning. The interviewees drew on particular discourses emerging from their personal experiences and interactions with others and from popular media and expert sites to give meaning to and justify their experiences, practices and ideas.

Findings

Elsewhere I have discussed in detail the self-care that the women engaged in when they were pregnant and the practices in which they engaged to ensure that their babies were healthy and developing normally once they were born. I noted that the mothers demonstrated a strong sense of responsibility for caring for their children's health and protecting them from harm. The mothers commented upon how other people, particularly other mothers, noticed their parenting practices and the stage of development their children had reached and in some cases commented negatively or with obviously judgemental attitudes. The interviewees evinced strong feelings of guilt or shame if they felt that had not conformed to the imperatives of the 'good mother' in promoting the health of their children. I also identified concepts of their infants' bodies held by the women, which portrayed them as highly vulnerable to illness and open to infection, particularly when they were very young (Lupton, 2008, 2011).

The present discussion takes a different focus in exploring aspects of the interviews that concerned the health of children once they had passed the first few months of life, focusing in detail on three major topics: how the interviewees conceptualised good health and illness in their children; the importance they placed upon good diet and physical activity in relation to their children's health; and their concerns about spaces, physical safety and bad influences.

Conceptualising good health and illness in children

The women were asked how they knew if their children were healthy or ill. In their responses, the idea was expressed that children's health required constant monitoring and vigilance on the part of their mothers, as one mother said: 'I feel like I'm always on the lookout for what could be going wrong.' In terms of the corporeal signs believed to characterise a 'healthy' or 'well' child', the women's replies centred on the appearance, habits and demeanour of the child. Such aspects as the child's eating, bowel and

sleeping habits, their energy levels and their progress in growth and development were observed and considered. Healthy children were described as those who slept well, displayed a good appetite and had regular bowel movements. Their behaviour and mood were happy and energetic rather than continually cranky, tired or whiny. They had plenty of energy, wanting to run about and play and engage in activities. As one mother commented, she knew that her son was in good health if he had:

> good energy levels, happy, good appetite, his overall appearance, his hair and his eyes and his skin. Sleep is another thing. He's got a good energy level, and when he's off then you can tell, because he's just not as interested in things, he's not as inquisitive, he's just sort of, pulls back a bit.

Poor behaviour, with more than usual complaining and grumpiness, paleness and lack of energy, loss of appetite were all seen to be the result of ill health, as were more specific signs of an infection, such as a sore throat. Physical appearance was an important sign for the interviewees. 'Healthy' children were thought to look bright and alert, with no dark shadows under their eyes, shiny hair and a pink colour in their face rather than being pale. Another mother noted that when her children were feeling well:

> they're bright and you can see the colour in their face. At the moment they look very pale, pasty, eyes are sunken in, a bit whingey cause they're tired, they haven't had enough sleep.

Growth patterns were also viewed as important. Healthy children were described as those who were putting on weight and growing according to the guidelines of a normal growth schedule, but not as overweight or too thin. According to one interviewee, for example, children should be:

> growing at a steady rate. You don't necessarily have to be on the top percentage of your age and height and all the rest of it, but when you're monitoring it week to week, you want to see consistent, steady gains.

The importance of a 'strong immune system' was often mentioned in the interviewees' accounts as part of their concept of good health in children. Infants are viewed as having undeveloped immune systems which require 'building up' as they mature, and for this reason the interviewees were very positive about immunisations (Lupton, 2011). Older children too, according to the interviewees, need to be able to counter infections to maintain a state of good health, and thus a strong immune system was a vital factor in their health status. One mother, for example, commented that her idea of good health was

> a strong immune system. I think good health is a lack of sickness, regular illness, I think. That's where food and stuff comes in. You want to give the child the best possible ability to fight any potential viruses or whatever might be floating around.

The repercussions of not having a strong immune system could be dire, according to the interviewees. Their children, vulnerable as they were seen to be to infection, could succumb to a virulent virus or bacterium and become very ill:

> I suppose there's always anything that could threaten their health. All these viruses that are always around, they're always a worry. You always worry in winter time with all these deadly 'flus and stuff like that. Just things like that I tend to worry about a little bit, not excessively, but if you hear on the news that there is a new deadly virus going around you sort of panic a little bit.

In terms of their development, healthy children were described as being able to do what others of their age did. In contrast, the sign of an ill child was 'if they're not up to speed with the other kids, if they're not functioning the same way, going through the same milestones', as one mother commented. Mothers of infants in particular were very aware of the need to ensure that their children were developing normally and receiving adequate stimulation to do so. They were observant about whether their babies were developing in line with 'milestones' as outlined in the expert literature on child development, and tended to compare their children to others of the same age in doing so. As one mother of an infant commented:

> One thing I was particularly interested in is babies' development in terms of milestones. And I think that's one thing that you tend to be really aware of when you're a new parent -- you worry are they doing what they're supposed to be doing at a certain age, when do they start crawling, sitting up, making more noises, vocalising more, and that kind of thing.

It was not only physical signs which alerted the women that something may be wrong, however. Many mothers referred to the kind of close emotional relationship they had with their children, in which they could tell if their children were ill by picking up on their mood or slight changes in demeanour. The interviewees emphasised that they knew their children very well, and could tell if something was wrong by virtue of this knowledge of their bodies and dispositions. The women also often talked about instinct or intuition alerting them that something was wrong with their child's health, as in this woman's account:

> I've always gone by my gut with everything that I do, so I suppose I do the same with my child as well. You just have this feeling. Obviously if she was showing signs to me, if she was looking lethargic or showing signs, I would kind of have a feeling something's not right or this is what I should do.

The importance of a good diet and physical exercise
Ensuring that their children consumed 'healthy foods' and engaged in regular exercise were by far the most commonly mentioned ways that mothers said they sought to ensure their children's good health and development. Indeed *all* of the mothers, without

exception, identified a healthy diet as a strategy they employed to promote good health in their children. These Australian mothers, indeed, were more vehement and less ambivalent about providing such a diet to their children than is evident in some of the British and American research (for example, that by McVitie, Hepworth and Schilling, 2008; Rawlins, 2008; Cook, 2009a).

The notion of the 'healthy diet' described by the participants typically encompassed such foodstuffs as fruit, vegetables, meat and chicken and excluded 'junk food' as being bad for children's health. For some women, indeed, food was represented in overtly medicinal terms, such as the mother who referred to her children receiving 'doses' of healthy foods:

> I think it is important for everyone to get their dose of vegetables in the evening and a dose of protein, whether it be red meat or chicken or fish.

 'Junk food' was described as consisting of fried, fatty, salty or sugary food such as is commonly available from fast food vendors or available in supermarkets as packaged and processed snack foods. Mothers with very young children (infants or toddlers) were often extremely concerned about protecting them from 'junk food'. They generally found that they were able to achieve this while they still had full control over their children's diets. Mothers of older children, however – those spending more time with other children, at child care, preschool or school – noted that such ideals were more difficult to achieve. As a result, they often aimed for a 'good balance' in their older children's diet which allowed for some 'treats' but mostly concentrated on the intake of fruit and vegetables and protein foods.

This focus on a healthy diet was often supported by reference not only to the importance of such a diet to good health in general, but more specifically to the threat of obesity in children. Over the past decade or so, there has been an increasing moral panic in the popular media about the 'obesity epidemic' in western countries, including Australia, and how it has affected children (Gard and Wright, 2005; Rawlins, 2008; Keenan and Stapleton, 2010; Holland et al., 2011). The interviewees were highly aware of the prevailing 'obesity epidemic' discourse. As a result, they sought to protect their children from problems of overweight, which they saw as bringing with them both health problems and social stigma. As one mother contended:

> I absolutely refuse to allow my children to end up with any sort of obesity, heart problems, that sort of thing, because I just see so many unhealthy children, overweight, unhealthy children that are just setting themselves up for short lives. Aside from the physical side of it, there's also society's perception to it, and how they treat people who have weight problems. It affects every facet of your life, I think, your employment, the whole lot, whether say they discriminate or not, people do discriminate.

Some mothers talked about being a good example to their children, but ensuring that they themselves ate a healthy diet:

It's a hard one because I'm quite a fussy eater myself, so I obviously try to eat the things that I enjoy, the healthy things that I enjoy I eat a lot of. Luckily my husband eats a bit more than I do and to a certain extent, what we eat they eat. We obviously make sure that we eat healthily so they eat healthily. I think that's probably the biggest thing, from the time of about one year old, when they eat solids, we sit down at the table and we have the same meal together.

I'm his main person that he sees all the time, so if he sees me not doing anything, not eating crap and all of that, then he is going to follow in my footsteps, he thinks 'Why do I have to do this when Mum, you do the other things?'

In their efforts to ensure a healthy diet and avoid obesity, the women were keen to try and avoid a fussy or picky eater, but many described their children in these terms. Such children caused them much concern, because their mothers felt that they were not eating the right kinds of foods despite their best efforts. A mother with a very fussy eater, for example, said that he ate very little and that she was concerned about his health and growth as a result:

I worry constantly that he's not getting enough vitamins, iron, he's not getting enough to sustain him, he's quite skinny and all my other children are quite plump and it's not a problem. With Luke it's a drama to make him eat, it's a fight, I have to chase him round, pin him down. I pin him down to make him eat which makes it worse. Basically he lives on Perivite, a children's multi vitamin … oh, and milk.

Another woman with a fussy eater described the reserves of energy she required to deal with him and the anxiety she felt in attempting to ensure that he ate properly:

You feel exhausted and drained and always question if you're doing the right thing or the wrong thing. And then you worry that when they actually like something are you giving it to them too much?

Here the issue of ensuring that children were growing 'normally', without being too fat or too thin, was reiterated. In accordance with the interviewee quoted above, some mothers commented that children's bodies could be a little plump when they were very young, and that this indeed was a sign of good health. There is a fine line, however, between 'normal' or 'healthy' plumpness and sliding into overweight, one which mothers believed they had to continually monitor.

As noted above, ensuring that their children engaged in regular physical exercise, particularly of the outdoor variety, was emphasised by the interviewees as the second most important factor in promoting their children's health by the interview participants. Reference to 'lots of fresh air and exercise' recurred often in the women's accounts of how important they deemed outdoor active play, as was evident in Backett-Milburn's (2000) research. Exercise was seen as a means for children to be physically active, thus keeping their bodies fit, and also to avoid overweight by burning off calories and acting as an alternative to passive indoor pursuits such as television watching or computer game playing. Too much engagement in the latter activities was seen as a

major problem to be avoided, with the mothers having responsibility to regulate the time their children spent in these activities. As noted by one mother:

> I don't like my children sitting inside a lot, they need to be outside, especially boys, they need to be outside running, playing, swimming, rather than sitting inside.

Ensuring that one's children engaged in enough exercise and were not too sedentary also involved quite a degree of vigilance and surveillance from mothers.

> I also monitor and time how much time they're allowed to be on computer games or watching the telly, things like that, well, because I think it can make them lazy. They become very sedentary and while I think it's important that they do get exposed to the computer and various things so they're going to be able to develop and progress in their education, I still am more of a believer in getting outside and running around and instilling a love of activity.

Here again several women commented that they felt it was their responsibility to act as role models for their children, by modelling eating healthy food and engaging in physical activity:

> I try to lead by example, like walking and taking them to the beach and running around with them and keeping them active. They know that video games and things like that are banned in our house, because I won't have them, I'd rather them outside playing, playing on the swings, on the trampoline, or the bike, rather than playing in the house ... Just my general eating and wellbeing, I hope that if they see me eating healthy and exercising and trying to balance my life it will rub off on them.

Space, physical safety and bad influences
As noted above, the interviewees tended to portray their children's bodies as vulnerable to infection because of what they considered to be their immature immune system. As a result of their concern about the permeability of their children's bodies, the mothers' accounts sometimes represented other young children as the sites of infection, posing a threat to their own children's health. They talked about attempting to ensure that their infants, in particular, were kept away from young children with an infectious illness such as a cough or cold and making sure that their own homes were clean so that their infants or toddlers did not touch 'dirty things'. Some parents noted that they felt they were able to protect their children from exposure to germs at home, but once at childcare or school this control was lost. For example one woman said that she found this issue difficult when deciding whether or not her child should continue to attend day care:

> The contact with other children, and I don't mean that in a paranoid kind of way, but he's around a lot of, there is a lot more germs in the environment that what you would have in your house. They're out there playing in the sandpit with other kids who may have a slightly running nose and things like that, and kids don't have any concept of personal hygiene. Things like that I find a dilemma.

The women's accounts, therefore, represented certain places and spaces as potentially 'unclean' or 'contaminating': specifically those frequented by other, potentially infectious, children. Interestingly, the women's own homes were also conceptualised as possible sources of contamination if they were not kept 'clean enough'.

Little difference was noted between middle-class women and working-class women (assessed as such based on their suburb of residence and occupation) in most of the interviewees' responses. One difference, however, that did emerge was that the middle-class women were more vigilant than some of the working-class women in disciplining their bodies when pregnant – avoiding smoking and alcohol, for example (see Lupton, 2011). Some of the more disadvantaged mothers also felt less empowered when dealing with medical and other health professionals in relation to their concerns about their children's health (Lupton, 2008).

Another major difference evident between the working-class mothers and the middle-class mothers was the discussion on the part of some of the working-class women concerning the physical safety of the wider environment (that outside the home) and their worries that this was not conducive to their children's health and wellbeing. One woman, for example, talked about how she would like to move from her current housing estate, which she did not feel was safe enough for her children because of undesirable behaviour from some of the other residents:

> I'd love to move. I know that every area you go to has bad areas, but with the price of housing I would like to move into a nicer estate where you can. It's really quiet where I am, the neighbours are excellent, but just the language that you hear, there's a lot of people walking past, and of a night walking past drunk, and it's not the type of environment you want them in.

Another working-class woman was concerned about the safety of public spaces, especially parks:

> I'm very scared, I'm very worried when I go to the park if there are syringes or condoms or things like this. I'm very worried about this. I would love to take children over there, but before taking them I park my car and go down and look everywhere.

According to a third working-class woman, she was anxious to protect her children from witnessing undesirable behaviours among adult family members and friends of the family that they might then seek to copy:

> I don't like people to smoke around my children. I don't like people to drink around them really, to see the way that some people carry on when they're drunk -- just bad influences on them. And it's not too good for them to be breathing in the smoke anyway.

This woman also worried about the possibility of child abuse:

You never know what someone can do to your kids when you're not there. I don't think that anybody should trust anybody because you hear so many stories of, even family members that have abused kids, or whatnot. That's why the only place that my kids go is my mothers, or maybe my partner's sister's house, they're the only places we leave them alone.

Discussion

This study found that the mothers who were interviewed were highly aware of their role in surveilling and monitoring their children's health, and did so constantly. Aspects of embodiment for both the mothers and their children were central to the women's concepts and experiences of health and illness in their children. Women were expected to 'read the signs' of their children's bodies, to 'know' their bodies intimately in order to do so, and to interpret the signals of their own bodies – their 'gut instincts' – as part of the process of maintaining careful surveillance of their children's health state. The interviewees constantly employed such expressions as 'looking out' and 'monitoring' their children's bodies, development and behaviours to achieve this. They also discussed regulating their own bodies in certain ways to provide a 'good example' to their children, by demonstrating and modelling healthy eating and exercise behaviours. They were engaged in practices of bodily discipline, therefore, in relation to both their own bodies and to their children's bodies as part of their enterprise in maintaining their children's good health.

It was also clear from the findings of the research that notions of space and judgements about the bodies within these spaces were important to some of the women's concepts of protecting their children's health and wellbeing. Concepts of contaminating spaces and threatening spaces were constructed based on the women's ideas of what kinds of people were to be found in these spaces and how 'clean' or otherwise these people's bodies were judged to be. Public spaces were a source of concern for some mothers, but they also focused on the space of their own home in terms of its hygiene and the people who visit there. Other children infected with contagious illnesses, drunk, disorderly or drugged adults and adults who smoked or swore and were seen to be bad influences were the contaminating disorderly bodies with whom the women did not want their children to have contact (*cf* Murcott, 1993; Kelley, Mayall and Hood, 1997; Kelley, Hood and Mayall, 1998; Holdsworth and Robinson, 2008). Working-class women who lacked the opportunity to live in areas which they considered safe and appropriate for children were forced to deal with situations they considered less than ideal. This made it more difficult for them to conform to the ideals of 'good' motherhood compared with middle-class women. For example, some women were not able to feel confident about letting their children play outside, and they thus found it difficult to ensure that their children could have access to the kind of outdoor physical activity which the vast majority of the interviewees valued as contributing to children's good health.

The women had internalised the prevailing dominant discourses which position healthy eating, regular exercise and the avoidance of overweight as central to good

health. They invested much time and energy in attempting to ensure that their children conformed to these expectations. The prevalence of immune system discourse was also evident in the interviews. Children's bodies were conceptualised as more open to infection than those of adults, unprotected by their own immune systems and therefore requiring the proxy protection of their mothers to defend them against 'germs' and 'dirt'. This preoccupation with immunity and germs is demonstrative of the increasing dominance of concepts of the immune system in contemporary lay understandings of health and embodiment (Martin, 2000; Cohen, 2009; Brownlie and Leith, 2011).

As discussed in the Introduction, contemporary maternal subjectivity is constructed via the discourses of 'intensive parenting', which expect mothers to devote resources of time and emotional labour in caring for their children in unprecedented ways. The invisible mental labour required of women expects them to assume the role of selfless carer, putting others' needs before their own, continually anticipating children's needs and observing their bodies for signs of illness. As the Foucauldian concept of biopolitics argues, individuals' behaviours and subjectivities in relation to health and embodiment are constructed through imperatives emerging from a diverse array of sites: the mass media, government agencies, medical, scientific and public health professionals, experts and institutions, educational institutions, the family and other personal relationships. People come to accept and act on certain beliefs about health and embodiment as part of their participation in everyday life and their interaction with the institutions which structure society (Lupton, 1995; Petersen and Lupton, 1997; Weir, 2006).

Women, as mothers, are thus encouraged to position themselves as predominantly responsible for the health of their children and to see themselves as failing if their children become seriously ill, overweight and unfit or demonstrate developmental problems. They are, therefore, both the subject of surveillance – from other mothers, medical professionals, friends and family members – who regularly assess their efforts to promote the health and wellbeing of their children, and the instigators of surveillance over their children. While women's panoptic gaze is firmly fixed upon their children, others are observing these women and making judgements. Mothers and children are disciplined together, with women in large part voluntarily adopting biopolitical imperatives in the interests of their children, and in turn enforcing these imperatives upon their children. Thus disciplinary techniques are reproduced in the family context, with the result that as they grow and mature into adults, children themselves will take on the practices enjoined upon them by their mothers and discipline and exert the panoptic gaze upon themselves. Yet children's bodies are unruly and excessive, open to infection, not always compliant with their mothers' attempts to control and regulate them. They may become seriously or chronically ill despite their mothers' best attempts to keep them well.

A continuum exists, at which foetal bodies are at one end, conceptualised as solely and purely the responsibility of the women in whose bodies they are growing, and older children at the other, subject still to a high level of surveillance and regulation from their mothers but able to challenge and resist their mothers' attempts to exert

control over their health. As this suggests, children themselves are active agents in shaping and deporting their bodies and will seek in some situations to transform and resist their mothers' injunctions and warnings rather than accept them passively (Mayall, 1993; Kelley, Hood and Mayall, 1998; Prout, 2000; Cook, 2009a, 2009b). Mothers find that when their children are very small, they must engage in a greater intensity of bodily caring, but they are also able to exert more control over the conditions in which their children eat and play. As children grow older and become more independent and less pliant and begin to leave the controlled world of the home, mothers must relinquish some of this control.

The study found that mothers' loss of control over their children's health and wellbeing was often experienced by them as confronting, frustrating and distressing. The emotional dimensions of practising 'good motherhood' and monitoring and maintaining children's health were therefore an important aspect of the interviewees' accounts. In the risk society and in the context of neoliberalism, where concepts of luck, chance and fate are less accepted as reasons for ill-health and risks are individualised as personal responsibilities, mothers find themselves in a position where their children's ill-health reflects poorly on them as mothers. I would argue that the emotional dimensions of biopolitics and risk society have been largely ignored in the sociological literature. How one's positioning as a self-responsible citizen and, in the case of mothers as a citizen responsible for others' health and wellbeing, is invested with emotion is a topic requiring further research and analysis.

Acknowledgement

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