Accounts of Mothers’ Experiences of ‘Advice’ During Pregnancy and Early Motherhood

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ABSTRACT

The aim of the study was to understand and interpret women’s experiences of advice, from the standpoint of differing personal contexts, during pregnancy and throughout the transition into motherhood. The welfare state encourages mothers to utilise the institutions of expert knowledge to gain education regarding ‘appropriate’ maternal behaviour. However, the obligation for women to practice health professionals’ advice can be viewed as a form of social control (Ussher, 2006). An extensive literature review illustrated that women value informal advice, as it provides a mutual understanding of maternal experience.

Using a semi-structured interview, the accounts of six women’s experiences regarding maternal advice were explored. Five themes were encoded through thematic analysis; expert advice, informal advice, feeding options, changes and neoliberal values, providing reliability for the findings of previous studies. The research illustrated the conflicting ideologies between autonomous motherhood and the objectification of women’s bodies through medical interventions. However, the different levels of care within the medical system impacted maternal experiences of advice, as the participants valued the female-dominated position of the midwife. This recognises a need to expand women-centered models of midwifery to build bridges between medical environments and the personal, instinctual and psychological aspects of motherhood, symbolising women’s agency.
The concept of ‘advice’ is defined as information which is provided as guidance, usually by knowledgeable or authoritative individuals, whom express concern or care for the choice of the responsive action. Therefore, as the welfare state is built around ‘trusted’ institutions of expert knowledge, women are encouraged to utilise ‘formal’ professional advice in order to educate themselves about appropriate behaviours during pregnancy and motherhood (Lowe et al., 2009). This has been referred to as the ‘institution of motherhood’ (Rich, 1995). However, this evokes ideas about the relevance of social cognition models because the theoretical framework of the Theory of Planned Behaviour (Ajzen, 1991) suggests that maternal behavioural intention relies on numerous influences, such as, personal attitudes, self-efficacy, social norms and the opinions of close individuals (McMillan et al., 2009). Consequently, mothers seek advice from various sources, including from women’s informal stories of pregnancy and motherhood within their social network.

Historically maternal and child healthcare services were concerned with improving the safety of childbirth, fortunately since the 18th century increasing ‘scientific’ advancements within biology have significantly revolutionised maternal mortality, especially the development of obstetric technologies (Jacobson et al., 1991). However, the ‘male’ orientated ‘scientific’ knowledge devalued the essentially ‘female’ domestic arena of childbirth understanding; constructed of experience and intuitiveness handed down through generations of women (Stacey, 1988). This introduces a further significant notion of the ‘medicalisation of motherhood’. Obstetric intervention encourages a pathological perception of reproduction and motherhood, as opposed to a natural phenomenon (Cahill, 2001). The exaggeration of the physical aspect of reproduction, such as, foetal monitoring and caesarean section, grants the foetus’ needs with absolute priority and undermines the needs of the mother, for example, maternal choice and emotional support (Lawler, 1999). Therefore, this conception has been the recipient of feminist critique, positioning Feminism as an additional important concept with regards to maternal advice.

A study which highlights the key concepts relevant to the current research was conducted by Reid et al., (2010). This involved a meta-synthesis of nine selected studies exploring women’s perceptions and decision-making processes in response to advice encouraging antenatal screening for Down syndrome. The study revealed five core concepts which represent a framework of women’s decision-making processes with regards to accepting or discarding antenatal screening advice; ambiguous future expectations, sense of choice, risk, treading on dreams and women’s right to know. In particular, the research discovered that women’s sense of choice within the decision-making process was restricted, for example, Chiang et al., (2006) illustrated that some women accepted screening advice as they viewed it as a ‘formality’. In addition, women view expert authority as legitimate; therefore, their recommendation for screening influenced women’s decisions (Heyman et al., 2006). Furthermore, focusing on the ‘treading on dreams’ concept, some women reported that antenatal screening casted a shadow over their emotional involvement with a ‘perfect’ foetus just in case Down Syndrome was discovered (Heyman et al., 2006).
An advantage of the meta-synthesis study is that the acknowledgement of a collaboration of research provides reliability across the factors which influence women in deciding whether or not to adhere to antenatal screening advice. From a feminist perspective, the developed framework could potentially empower and prepare women to make well-considered decisions regarding reproductive choices. However, the power of authoritative advice encouraging screening demonstrates how women are subjected to surveillance both medically and scientifically (Ussher, 2006) and that can lead to women facing negative ethical (the decision to terminate a pregnancy) and emotional dilemmas. This highlights a form of social control over women to ensure that producing a ‘perfect baby’ is their prime consideration in order to avoid being socially defined as a ‘bad mother’ (Remennick, 2006). A critique of this previous research is that it considers the framework involved in women’s decision-making processes concerning only antenatal screening advice and fails to explore the bigger picture of ‘advice’ in not only pregnancy but also motherhood.

Advancements in communication systems over recent decades have seen expert biomedical advice for mothers become more easily ‘visible’ within the public sphere, producing common ‘scientific’ knowledge. This distances the psychology of motherhood (Nicholson et al., 2010) further from the ‘female’ private sphere of maternal understanding, experienced by women from older generations. Therefore, a relevant background study which explores the historical development of maternal advice progressing from the domestic to the public domain was carried out by Heffernan et al., (2011). The objective of the researchers was to investigate the impact of the growing accessibility of ‘expert’ advice on the experiences of motherhood across different generations.

The study had two phases as it utilised a mix-method. Phase one consisted of a questionnaire given to mothers from different generations to identify how they experienced motherhood in terms of received and accepted advice during pregnancy and the early months of the postnatal period. Phase two involved conducting interviews on mothers from different generations, which focused on the source of women’s maternal information, probing specific issues, such as, diet, lifestyle and infant feeding. The different generations were classified as the ‘myself generation’ including current mothers and the ‘my mother generation’ composing of the mothers of the women in the latter group.

The results of phase one demonstrates how differing advice across generations affected women’s experience of motherhood. For example, more women in the ‘myself’ generation had given birth through Caesarean section than the ‘my mother’ group. This highlights increasing expert biomedical advice over recent decades. Thematic analysis conducted in phase two illustrates that the ‘my mother’ generation reported bodily instincts, old wives’ tales and experience as a considerable influence for decisions made during motherhood, as professional advice could only be accessed during doctors’ office hours. They also received less pressure from cultural expectations of appropriate maternal behaviour. The ‘myself’ generation reported being informed through professional intervention but also through actively educating themselves, using the internet and
magazines. This generation also reported more cultural pressure and policing, for example, one woman reported being denied the right to buy hair dye by a shop assistant because she was pregnant. This highlights how expert knowledge has become embodied within society and how mothers are susceptible to both medical and social surveillance (Ussher, 2006). A limitation of the study is that the narrow sample only included white, heterosexual, middle-class women, the majority of which were either married or cohabitating with their children’s father, therefore, re-establishing the ‘traditional family’ values of romanticised motherhood (Gaffney, 1992).

It is important to note that the ‘myself’ generation did not always accept ‘expert’ advice. A qualitative study which supports this finding, documented a participant who justified disregarding professional advice, to not consume caffeine during pregnancy, because a friend told her to (Nicholson, 2010). This emphasises how ‘informal’ sources of advice are also valued by mothers (Pollock, 1999) and suggests that women may not ‘internalise’ (Markens et al., 1997) social and medical policing if it does not identify with their personal needs, alternately seeking advice which does. Therefore, this questions the extent to which the power of occupations can continue to define the reality of motherhood, as individualism begins to overshadow the conformist nature of the welfare state.

Nevertheless, there is further evidence which demonstrates an internalisation of ‘expert’ discourses surrounding ‘good’ and ‘bad’ mothering, which is expressed through self-surveillance. For example, Davis (2012) conducted 160 oral history interviews with Oxfordshire mothers to explore the themes of ‘change’ and ‘continuity’, throughout their experiences of motherhood, between the years of 1945 and 2000. The research examined women’s thoughts and feelings towards key maternity issues such as, education for motherhood and mother’s relationship with childcare experts. The interviews revealed the continuous contradictory and oppressive nature of childcare ‘bibles’, across the years, setting unattainably high levels of maternal behaviour. Consequently the responsive discourses portrayed feelings of anxiety and guilt. However, the study does not account for mothers from the millennium onwards, therefore, this raises questions as to whether 21st century women unquestioningly oblige the romanticised ideology of ‘carework’; defined as the practice of women following expert advice (Morgan, 1996), as there is a shift away from the welfare state towards neoliberalism. An additional critique is that the reflective nature of the methodology may have affected the validity of maternal recall.

The study primarily aimed to follow on from previous research by qualitatively exploring the advice women received and adhered during pregnancy and early motherhood, using a semi-structured interview to allow the participants to arrive at their own perceptions and emotions towards their experience of guidance. The literature review highlights the justification behind the study, as the research explored advice mothers personally considered significant throughout the whole transition into motherhood. The broad inclusion criteria, recruited 21st century women who had given birth to their first child within the last five years; this ensured valid maternal recall and challenged the ‘traditional family’.
Methodology

Design

The study utilised a qualitative methodology in order to explore, understand and interpret women’s experience of advice during ‘motherhood’, considering both antenatal and postnatal periods. The narrational nature of the study encouraged a semi-structured interview approach to be employed. This allowed an informal, conversational interaction to establish rapport, whilst maintaining a structured focus on specific themes, across all participants, to ensure validity. The coexistence of flexibility (Gall, Gall, & Borg, 2003) and adaptability within the design promoted a more personal and intimate feel to the interviews by encouraging the women to continuously incorporate their perspectives, emotions and experiences within their stories concerning maternal advice (Chase, 1995).

Participant Recruitment

The sampling criterion required the recruitment of 6 women, over the age of 18 years, who had given birth, for the first time, within the last 5 years. The rationale behind the number of participants selected was that it is a suitable amount in regards to gathering exhaustive information from a diverse sample. The justification of the five year time-frame was to eliminate biases in maternal recall. It was important for the inclusion criterion to be as broad as possible for this particular study as it aimed to account for a range of mother’s perspectives concerning advice (Cheyne et al., 2012) in order to challenge and break free from the romanticised constructions of ‘appropriate motherhood’ suggested by dominant ideologies (Johnston & Swanson, 2003). Therefore, the study extended its recruitment to women with differing marital statuses; single, in a relationship, cohabitating and married. The criterion continued to include diverse personal contexts, for example, education and occupation, as women mother in differing situations (Phoenix et al., 1991); therefore, differences among women could be assessed regarding their interaction with maternal advice.

The exclusion criterion held back women from taking part if they did not speak English, as funds could not stretch to provide resources to interpret their responses. The study also refrained from recruiting females under the age of 18 years; the reason behind this was that young mother’s may have to cope with additional issues during pregnancy and motherhood, such as, educational and vocational opportunities, the emotional demands of adolescence and economic dependence, which could impact the maternal advice they receive, affecting the validity of the study (Konje et al., 1992). Furthermore, surrogate mothers were
also excluded from the study as they would not be able to account for experiences of advice progressing into motherhood.

The participants were attained through various sampling methods. For example, opportunity sampling was employed due to the considerable availability of women who fulfilled the criteria, therefore, ‘referrals’ of potential mothers through snowball sampling were utilised. The justification for the use of ‘referrals’ is that a trustworthy relationship can easily be built as the majority of the participants were not complete strangers (Frizelle, 1999). Consequently, this created a relaxed environment, encouraging more in-depth reflexive disclosure (Burman, 1994b). A couple of willing participants were also identified through project engagement talks. The subjects were contacted through telephone and email.

**Data Collection Methods**

The study setting of the face to face, independent interviews was situated within the homes of the interviewees. This was to ensure that an effort was made in order to fit around the schedule of the mother. The only requirement of the setting was that it was quiet to avoid distraction. The interviews were approximately 45 minutes long, which was suitable as it did not consume too much time out of the mother’s routine. It was also recorded using audio-tape. To begin, the interview used broad, open-ended questions to develop a conversational feel, for example, ‘What advice were you given during and after pregnancy?’ This not only assisted in creating a relaxed, friendly environment but also promoted individuality by encouraging the participant to arrive at their own interpretation of advice experience, satisfying primary research objectives. However, to ensure that all participants followed a similar structure an interview schedule was followed. This contained prompts of themes and unanswered questions to explore, which was generated through an extensive review of literature. For example, ‘What emotions did childcare manuals evoke?’ ‘Compare the advice received and adhered to with your first child and their siblings’ reflected secondary research questions.

The interviewer was the author, who does not personally have an insider’s status within ‘motherhood’; therefore, it was important not to express ignorance or naivety due to a lack of shared identity and language (Asselin, 2003). However, justification for the outsider status is that the author was not embedded within the everyday realities of motherhood; therefore, the participants’ perspectives are not clouded by the researcher’s own experiences (Dwyer and Buckle, 2009).

After each interview the audio recording was listened to and transcribed. In order for the researcher to gain familiarisation with the dialogue the transcripts were repeatedly read (Staneva & Wittkowski, 2012). The analytical technique which was used was thematic analysis. This process involved recognising a pattern within each transcript, which responded to the primary and secondary research questions, and therefore needed to be classified and encoded as central themes and subthemes (Braun and Clarke, 2006). The rationale behind
the codes being inductively generated is that the study aimed to discover the actual facts about mothers’ own interpretations of ‘advice’, from differing personal contexts, before the researcher created their own understanding of the patterns. Further justification for this technique is that the analysis presented a sense of involvement with the participants in order to represent the mother’s voices.

The methodology of qualitative, semi-structured interviewing is justified as the open-ended questions developed a conversational feel to elicit a narration of the participants’ actual lived experiences of maternal advice (Sevon, 2005) in order to understand their thoughts and feelings (Hugh-Jones, 2010). This access to depth and complexity could not be achieved through other approaches. Furthermore, after reviewing literature it is notable that the intimidating and ‘authoritative’ nature of cultural narratives surrounding advice during motherhood have the power to cause stressful effects, such as guilt, as they place a sense of unrealistic responsibility onto mothers for choosing the ‘right’ methods for childrearing (Davis, 2008). Consequently, from a feminist perspective the proposed methodology is necessary as it attempted to qualitatively represent women’s voices and experiences in order to discover whether mothers feel ‘inadequate’ due to being faced with the ‘ideals’ embedded within the everyday reality of ‘motherhood’ (Byrne, 2004). Especially women with differing circumstances to the traditional family, which dominates cultural narratives, for example, lone mothers as they may not have the social support necessary to cope with unattainable ‘ideals’. This provides further justification for the recruitment of women using a broad inclusion criterion.

However, taking into account that women are not usually given the opportunity to reflect on maternal guidance in this depth, it may have been a difficult process for some mothers. For example, it may have produced feelings of guilt for not adhering to a specific piece of advice or possibly distress after recollecting confrontations which occurred due to not agreeing with advice from a close family member. Therefore, the protection of participants was an important ethical consideration, especially because the transition into motherhood can be a vulnerable period. Furthermore, considering the study setting was at the homes of the participants, it was vital to follow the university safeguarding procedures in order to also protect the researcher; this included attending the interviews with a peer.

Prior to the interview informed consent was obtained from the subjects for their participation in an interview addressing ‘advice’ during motherhood and for their permission to be audio-recorded. Additionally, the confidentiality guideline was abided as pseudonyms replaced all names throughout the research report; this included not only the participants’ names but also professionals and service settings. When the interviews came to an end, relatively light questions were used to ensure that the subjects were not left feeling personally exposed (Hugh-Jones, 2010) and were given the opportunity to withdraw their data if wished.

To disseminate the findings and conclusions of the study it is intended to be submitted to the Journal of Gender Studies. The justification behind this choice
is that relevant background literature has also selected this journal to publish research, for example Heffernan et al., (2011). The planned study highlights key concepts which are applicable to the journal; issues surrounding motherhood from a feminist perspective and the relationship between mothers and the essentially ‘male’ expert advice. Despite the fact the impact factor is 0.667; the journal is indexed in the Institution of Scientific Information and is ranked generously across three categories; Women’s Studies, Social Issues and Social Sciences Interdisciplinary.

Results

Five themes were encoded through thematic analysis; expert advice, informal advice, feeding options, changes and neoliberal values. These are presented within hierarchal networks to clearly demonstrate the central themes and subthemes (Figures 1-5). It is important to note the dynamic interrelationship between the themes. Table 1 contains key extracts, taken from each participant, to demonstrate the prevalence of each theme in a positive, negative and neutral context. The presentation allows for an easy comparison of the similarities and differences between each participant regarding their experiences of maternal advice.

Theme 1 - Expert Advice

![Figure 1: Hierarchal network for the theme, ‘expert advice’.

Theme 2 - Informal Advice

![Figure 2: Hierarchal network for the theme, ‘informal advice

**Theme 3 – Feeding Options**

Feeding Options

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Breast is
  Pressure
  Maternal morality

Bottle-feeding
  Maternal
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**Figure 3**: Hierarchal network for the theme, ‘feeding options’.

**Theme 4 – Changes over time**

Changes

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Over time – across

Suggested changes for future
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**Figure 4**: Hierarchal network for the theme, ‘changes’.

**Theme 5 – Neoliberal Values**

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Postponed motherhood

Choices

Self-regulated, autonomous mothers
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Neoliberal Values

Motherhood as a site of
Identity work

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**Figure 5**: Hierarchal network for the theme, ‘neoliberal values’.
Table 1: Data extracts taken from each participant to demonstrate the prevalence of the 5 central themes in a positive, negative and neutral context.

<table>
<thead>
<tr>
<th></th>
<th>Expert Advice</th>
<th>Informal Advice</th>
<th>Feeding Options</th>
<th>Changes Over Time</th>
<th>Neoliberal Values</th>
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</thead>
<tbody>
<tr>
<td><strong>P1: Positive</strong></td>
<td>“If you have more of a kind of difficult pregnancy, erm, they may give you, you know, different kind of advice... they were really good from that point of view” (57)</td>
<td>“you go on the forums, you know other pregnant people are going through the same” (40)</td>
<td>“they'll support if you do want to breastfeed” (76)</td>
<td>“like I found her [Gina Ford] because.... I like to be organised I guess” (116)</td>
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<td><strong>P1: Negative</strong></td>
<td>“they don’t really give you a lot of advice I wouldn’t of said” (56)</td>
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<td><strong>P1: Neutral</strong></td>
<td>“they tell you to take folic acid, that’s like from the health benefits point of view” (44)</td>
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<td>“over the years things have changed. I mean you only use to get like 3 months of maternity” (157)</td>
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<td><strong>P2: Positive</strong></td>
<td>“It did feel more that it was an instruction [doctors’ advice] rather than. Whereas with the midwives, you felt like you can say well can I ask why or whatever. Erm, which I suppose is why you have the different levels of care” (31)</td>
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<td>“I was glad that I was doing it [breastfeeding] [laughs] and not having to sort of go against what they [experts] were all saying” (43)</td>
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<td>P2: Negative</td>
<td>“experts say that but you feel that they are only saying that because it’s what’s got written down” (20)</td>
<td>“I think it might be harder for them [bottle-feeding], because there is so much, erm, what’s the phrase, they [expert] are really keen” (41)</td>
<td>“I think and she [her mother] just feels that it’s all very erm I suppose to an extent health and safety gone mad, type thing” (129)</td>
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<td>P2: Neutral</td>
<td>“informal advice was more about the day to day things, getting on with things, about resting when the baby rests, them sort of things” (19)</td>
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<td>P3: Positive</td>
<td>“the night I had had him, staying in hospital overnight that was fantastic” (38)</td>
<td>“and it’s not pushed in any way, but ...it’s definitely breast is best” (53)</td>
<td>“there’s so many avenues and options and areas that you can go down” (81)</td>
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<td>P3: Negative</td>
<td>“at the beginning of pregnancy there isn’t much advice from health professional...until your scan at 12 weeks” (6)</td>
<td>“with informal advice I think that people can be quite patronising and they like to put their two pence piece in if you like” (11)</td>
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<td>P3: Neutral</td>
<td>“we’d go and discuss it as a partnership and say that well maybe that method doesn’t suit us or this method does” (27)</td>
<td>“I feed him as and when he needs it, which I know is different to a lot of mums and a lot of friends” (175)</td>
<td>“I think its worlds apart. I think, you know, the whole, the whole system is different back then” (75)</td>
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<td>P4: Positive</td>
<td>“you know like people who have been through it before and tell you what they would do and their experiences” (13)</td>
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<td>“I went back to uni when she was about 7 months old” (72)</td>
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<td>P4: Negative</td>
<td>“I didn’t really get that much really from like doctors and midwives and stuff like when I first found out... they first basically did anything was when I was like 12 weeks pregnant and I got my scan” (5)</td>
<td>“this woman said to me at a [local service] that I went to, babies who are breastfed are less likely to be obese... that’s ridiculous... she’s not turned out to be obese” (117)</td>
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<td>P4: Neutral</td>
<td>“I remember they told me to take err these vitamins, pregacare vitamins to make sure I was getting all the vitamins, to get iron and things” (19)</td>
<td>“I use to get up in the middle of the night, erm with my kettle next to my bed [laughs] and my pot and I would be making these bottles up, for like the first month I would do it like that and then I went to see my friend who had had a baby just before me and she was like I make them up before bed” (43)</td>
<td>“every time she’d [mother] had a different child, the recommendations and advice of what they would give you had changed every single time” (48)</td>
<td>“not supposed to have any solid food like before six months because that’s what the health visitors said but I think [her baby] was about four months when I started... so then they sleep like through the night better” (186)</td>
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<td>P5: Positive</td>
<td>“family and friends, their advice was a lot better” (20)</td>
<td>“Throughout my pregnancy I didn’t feel that they pushed you at all but I don’t know if that’s because I said I’d like to try breastfeeding” (96)</td>
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<td>P5: Negative</td>
<td>“I get the impression that health professionals think that all babies can be made to be like a textbook baby” (76)</td>
<td>“someone who doesn’t have much family and friends for help and support, I think they’d struggle” (21)</td>
<td>“it took them two days to actually give me a bottle and I, I actually had to break down crying before they did anything” (100)</td>
<td>“the government are making far too many cut backs in the wrong areas because the midwives, especially for new mums, they need that advice” (188)</td>
<td>“think it’s one of the hardest experiences …especially a single mum as well.” (139)</td>
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<td>P5: Neutal</td>
<td>“the main things like not to drink, not to smoke, take folic acid. Erm, obviously be careful with your health” (14)</td>
<td>“going to the hair dressers, going to beauticians or shopping or going out with your mates get it all done before it comes because once it comes that’s it” (207)</td>
<td>“my mum told me to do it when he was 11 weeks I did and she was and it was the best thing I ever did…. when you tell the health visitor, your feeding him, they don’t, they won’t entertain you” (65)</td>
<td>“I think when she had her two it was different then so erm her eldest is 7 and her youngest is 4, so it’s changed a lot already in that short space of time” (173)</td>
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<td>P6: Positive</td>
<td>midwives said that sometimes doctors will tell you to stop feeding if you are on antibiotics if you have mastitis but you can still feed through it and things like that and I actually got that after I had my little boy so I got that, so it was quite helpful” (40)</td>
<td>main source of information was through a friend who had had a baby just a couple of months before me so she was just that one step ahead of me, so she supported me a lot” (62)</td>
<td>“erm I think we probably got more information than what my mum received” (120)</td>
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<td>P6: Negative</td>
<td>“I got told off from one of the midwives for giving [her baby] a bottle so I found that quite intimidating” (16)</td>
<td>“at first when you have a baby its very confusing and maybe if all the professionals were saying the same thing it might help you” (139)</td>
<td>“made you a bit more vigilant and cautious, over cautious sometimes” (90)</td>
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<td>P6: Neutral</td>
<td>“they showed us all the different instruments that might be used on us [laughs]” (37)</td>
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Discussion

The literature reviewed in the introduction suggested that the ‘medicalisation of motherhood’ is a reoccurring theme within previous studies. This can also be applied to the present study, as one of the main findings discovered through thematic analysis is the pathological nature of expert advice. For example, participant 6 disclosed that part of the process of receiving expert advice during pregnancy is the familiarisation of obstetric technology. The humorous tone which accompanied this utterance could be interpreted as a defence mechanism to mask suppressed emotions concerning the alienation of women from the experience of pregnancy and childbirth (Young, 1984). This highlights the dual psychological fragmentation of women (Martin, 1989) as even though their sense of self is preserved, they become objectified within a medical process of invasive interventions to assist the body, not the mother, as a machine throughout the childbirth process (Brodsky, 2008).

The medicalisation of pregnancy depicted by Reid et al (2010) through advancements within screening technology is also supported within the study. For instance, some mothers revealed that they did not receive any guidance from health professionals until the intervention of ultrasound technology at 12 weeks. This demonstrates how increasing access to the private world of the foetus has led to an exclusive professional focus on the baby’s development, as the identity of the infant is able to be perceived separate from the mother (Lupton, 1999), reducing women to a ‘maternal container’ (Young, 2005). Consequently, this could be argued as a prioritisation of the rights of the foetus (Avishai, 2007), establishing reliability across the different studies.

This distancing of the experience of motherhood from the private world towards a modern society concerned with the surveillance of risks (Beck, 1992) reflects the study carried out by Heffernan et al (2011) and can also be depicted within the present study as the participants suggested that expert advice was specifically attentive towards the medicalisation of deviance (Conrad & Schneider, 1992). For example, participant 5 used the term ‘obviously’ when explaining that professionals scrutinise the consumption of harmful substances. This indicates not only the internalisation of common ‘scientific’ knowledge (Markens et al, 1997) but also how it is assumed that medical advice is intelligible to laypersons within the public sphere, such as, from the outsider perspective of the researcher.

This is associated with an additional theme extracted from the analysis, as it suggests that despite advancing neoliberalism and the expected self-regulation of mothers’ responsibilities, the process of individualisation has boundaries set by biomedical knowledge (Lee, 2008), portraying freedom within the contemporary public sphere as an illusion (Heffernan et al, 2001). This highlights a strength within the current research as it recognises a need for professional maternal advice to be given not as a form of social regulation (Ussher, 2006) but as recommendations to strengthen women’s resources to manage maternal decisions for themselves (Stockill, 2007), encouraging women’s agency.
However, for ethical reasons it is important to note that the purpose of this research is not to undermine the safety which is provided through obstetric technology but to make women more aware of the dehumanising aspect of unnecessary routine interventions (Wagner, 2001) as they cast a shadow over the personal, private and instinctual aspects of the psychology of motherhood (Johanson et al, 2002). This is further supported within the theme of ‘changes’ as it indicates that older generations of mothers ridicule ‘intensive mothering’ (Hays, 1996), perceiving it as ‘health and safety gone mad’.

The subtheme of ‘hierarchy’ encoded within the theme of ‘expert advice’ demonstrates how the different levels of care within the medical system impacted on the participants’ experience of maternal advice. For example, some participants revealed that they valued the advice from midwives more as they were more willing to compromise their power by allowing the mother to question their advice (Nolan, 2011), whereas, doctors ‘textbook’ advice was ‘instructive’, establishing a power relationship (Lupton, 2002).

This can be related to the reference of Cahill (2001) within the introduction, highlighting that the exclusion of women’s social value from the maternal pathological process can be extended to the marginalisation of the female-dominated position of the midwife as obstetric technology is considered ‘toys for the boys’ (Murphy-Black, 1995, p. 287). Consequently this illustrates how patriarchy is reflected within the hierarchy of medical knowledge as it places restrictive boundaries on midwifery’s attempt to re-establish a ‘female’ private sphere within maternal practices (Witz, 1994). Nevertheless, this finding portrays the usefulness of the research as it recognises a need to build bridges between medical environments and mothers (Kitzinger, 2005), creating a holistic midwifery model of woman-centeredness, incorporating not only physical needs but also respects the psychological, emotional and social aspects of pregnancy, childbirth and motherhood.

Previous research has reported an increasing utilisation of midwifery in Canada, quantitatively characterised by lower caesarean section rates (CIHI, 2004). Therefore, a future qualitative study could cross-culturally evaluate women’s maternal experiences, who have given birth in both the UK and Canada, aiming to illustrate the value of physio-social midwifery models. This has the potential to establish reliability for the current research, as the theme, ‘changes’, suggests that the expansion of midwifery could improve the failings of maternal support in the UK, as the centralisation of woman-focused care could reduce issues of medico-technical dominance (Berg et al, 2012).

The theme of ‘informal advice’ highlights a woman-centered source mothers turn towards to compensate for professionals emphasis on infant monitoring. This is associated with the study carried out by Nicholson et al (2010). For example, the interviews demonstrated that participants 4 and 5 followed their mother’s advice to begin weaning their babies before the expert recommendation of 6 months in order to fulfil personal needs. This self-regulation highlights a fight against medical surveillance as women actively seek knowledge which makes them feel empowered as mothers (McNay,
embracing neoliberalism and portraying the influential nature of informal communities of mothers encouraging a prioritisation of instincts and experience. This further supports the need for the centralisation of a women-centered midwifery model.

However, it is important to note that participant 5 is a single mother, challenging the traditional family model. Furthermore, participant 4 is a young mother, giving birth to her daughter at the age of 18 which is incompatible with neoliberal values of ‘postponed motherhood’ (McRobbie, 2007, p. 731) as contemporary idealised femininity is associated with controlled fertility to enable a participation within the economy and consumer culture (McRobbie, 2008). Nevertheless, their self-governance over maternal advice contradicts previous literature which states that women in vulnerable positions may not feel that they have the power to challenge professional advice and exercise freedom over their maternal choices (Lupton, 2002). In contrast, the findings of the present research discovered that women positioned within a secure family model unquestionably adhered expert advice; participant 3 revealed that she breastfeeds by demand, highlighting ultimate acceptance of professionals’ emphasis on the needs of the infant over the mother’s. This suggests that more research is required regarding how the personal contexts of mothers influence their interaction with maternal advice and demonstrates the benefits of the broad inclusion criteria utilised within the recruitment process.

However, despite the self-sacrificing motherhood practiced by participant 3, this does not undermine the value of domesticity (Butler-Wall, 2012), which is expected considering advancing neoliberalism. For example, participant 3 suggested that she would advise friends to make time for their selves during motherhood, whereas, participant 5, proposed that she would recommend friends to go to the hairdressers and beauticians before the baby is born ‘because once it comes that’s it’. Therefore, this highlights that the support from husbands for women within a traditional family unit allowed them to achieve the ‘yummy mummy’ status which is a contemporary marker of ‘responsible’ motherhood, as it embodies the neoliberal values of economic success, consumerism and aestheticism (McRobbie, 2008).

However, this illustrates the dynamic nature of the themes as postponed motherhood is assisted through the medicalisation of conception (Fountain & Krulewitch, 2002), highlighting the conflicting ideologies between the objectification of women’s bodies through technological intervention and autonomous mothers. A further study could explore how in vitro fertilisation and surrogate motherhood influence experiences of maternal advice.

The central theme of ‘feeding options’ identified that health professionals’ ‘breast is best’ campaign further separates the participants situated within a vulnerable position and those within a family unit. The data indicated that the latter division of participants reported more positive experiences regarding infant feeding advice as they adhered to experts recommendations of breastfeeding, for example, “it’s not pushed in any way”. In contrast, participants 4 and 5 accounted the distressing and overbearing nature of professionals’
behaviour (Murphy, 1999); participant 5 had to ‘break down crying’ before they allowed her to bottle feed. This shift of focus away from the maternal ‘deviance’ and towards the unacceptable behaviour of experts highlights ‘identity work’ (Murphy, 2004) as the participant responds to the maternal morality associated with breastfeeding.

Nevertheless, this disclosure raises ethical concerns regarding health professionals’ prioritisation of the vulnerable child over the vulnerable mother (Furedi, 2001). However, the encouragement for women to monopolise their babies through breastfeeding (Murphy, 1999) suggests that a future study could include accounts of males’ experiences of paternal advice, recognising the importance of the social aspects within women-centered care, and therefore extending attention to their families.

Participant 4 was the only mother who entirely resisted the push to breastfeed, therefore, a strong sense of defensiveness was illustrated within her identity; the mother undermined health professionals’ fear-inducing approach, portraying breastfeeding as a preventative measure against obesity, as she had successfully raised a healthy child despite using formula. This highlights a critique of the current research as the interview did not explore the reasons behind the participant’s decision to formula feed.

However, the participant returned to university within seven months, therefore, formula feeding may have provided an opportunity to fulfil the demands of motherhood and youth simultaneously, without being restricted to the maternal commitments of monopolisation through breastfeeding. This recognition of the need to transform into an economically active subject via education (Bullen et al, 2000) represents neoliberal principles. This suggests that a more women-centered approach may be more valuable within the breastfeeding campaign; the promotion of the weight benefits of breastfeeding to the mother (Ineichen et al., 1997) appreciates the ‘yummy mummy’ status as a contemporary marker of ‘good’ motherhood.

**Reflexivity**

A final consideration is the importance of reflexivity, as the recognition of personal experience, intimacy and the role of intuition within the qualitative process (Lambert et al., 2010) reflects the values of a ‘private’ maternal sphere promoted throughout the research. However, this made me question whether the participants would accept my ‘outsider’ role as a researcher as I could not provide a reciprocal role of embodied maternal experience. This concerned me as Oakley (1981) suggested that good feminist practice involves self-disclosure.

Nevertheless, participants tended to advise me about maternal issues; demonstrating their acceptance of my role within the research, as a woman, encouraging me to further invest myself creatively within the process, acknowledging my future self as a mother (Savin-Baden, 2004). The interactive relationships established reflected women’s agency, which is an important aspect of the study.
During the process I found myself unintentionally disagreeing with some of the mothers’ attitudes towards maternal advice. However, on reflection, I began to see the realities behind the women’s stories; this individuality of participants would be lost within quantitative methodologies. Therefore, as a qualitative researcher it was my responsibility to represent these voices whilst maintaining a degree of self-awareness. I self-critiqued my cultural position within a privileged institution of western medicine as it had become embedded within my understanding of ‘appropriate motherhood’. Even though the research process opened my eyes to a feminist political resistance to ‘medicalisation’, as it symbolised oppression, upholding cultural awareness was vital from a moral-political standpoint as feminist voices within developing countries appeal for more medical intervention due to alarming rates of maternal mortality.

I determined the positive, negative and neutral contexts of the narrative extracts in Table 1; however, this demonstrates how my engagement with the data has influenced the findings. A critique of this is that associating negativity with an aspect of maternal advice limits ‘choice’, which is a goal within feminist politics. This encouraged me to reflect on my engagement with the data in relation to my possible future self as a mother, as embracing the availability of reproductive technology could provide greater agency.

As a researcher I felt privileged to access the intimate world of maternal experience, therefore, I continue to conclude that the personal, emotional and psychological aspects of motherhood need to be recognised within maternity services.

References


