

# **Velcro babies: A Qualitative Study Exploring Maternal Motivations in the Night-time Care of Infants**

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*'In every work the beginning is the most important part, especially in dealing with anything young and tender'*

Plato, The Republic

## ABSTRACT

New Zealand has one of the highest rates of sudden unexpected death in infancy (SUDI) in the OECD, with most deaths occurring during sleep and at night. Whilst recommendations for safe infant sleep are promoted to parents, there is little understanding of how parents make decisions as they interpret these population level recommendations at the individual level. The objective of this qualitative study was to explore how mothers made decisions in the night-time care of infants, in one suburb of Christchurch, New Zealand. An inductive qualitative design was used to explore the topic. Thirteen semi-structured interviews were held with mothers of infants aged less than 6 months old, living in a more socio-economically deprived suburb. Thematic analysis was used to search for emerging themes and these were analysed in the context of existing literature and concepts from appropriate critical social theories.

The study found that night-time infant care decision-making was complex. Mothers were dealing with competing tensions between keeping their babies safe from death, and meeting their immediate needs for food, comfort and sleep. Added to this were pressures from the dominant 'intensive mothering' ideology which holds mothers accountable for their infants' psychological and emotional wellbeing. In attempting to live up to the myth of intensive mothering, women individualized and privatized risk behaviours in ways that aligned with neoliberal rationalities. Part of being a 'good mother' was being seen to follow 'expert' advice around safe infant sleep practices. When the baby was settled and healthy, mothers were more likely to trust 'expert' advice and follow recommendations. However, on occasion and in unplanned ways, the needs of the baby and/or the mother, led mothers to act in ways that differed from 'expert' advice. Mothers mitigated risks in their own ways, and used intuition to protect their infants from perceived danger. Nonetheless, anxiety levels were high for some mothers, due, in part, to the knowledge that a baby could die despite their efforts. Anxiety levels are not helped by recommendations that leave no room for negotiating the complexity of night-time infant care, nor by prosecuting mothers whose infants die in unsafe sleep environments. Greater recognition needs to be given to the complex realities within which decisions are made. The use of empathy in individualizing population level public health recommendations may relieve maternal guilt and anxiety, and empower mothers.

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## Chapter 1. Introduction

Unlike many in the animal kingdom, human infants are completely reliant on their parents for survival and wellbeing in the early months. Parents are constantly required to make decisions about how best to nurture their infant, including how, when and where the infant will sleep. Although a seemingly routine event, infant sleep has recently garnered a large amount of attention from researchers, governmental agencies and the media in New Zealand. In 2013, a coroner appealed for bed sharing (the practice of bringing a baby into an adult bed to sleep) to be legislated against, suggesting it was akin to 'child abuse' (Fuatai, 2013 para.1). In 2014, researchers reviewing infant deaths classified as asphyxiation, recommended that more consistent messages about avoiding bed sharing should be given to families (Hayman, McDonald, Baker, Mitchell, & Dalziel, 2014). Most recently, in November 2015, the Children's Commissioner advised that parents can be prosecuted if they choose not to follow recommended advice around bed sharing and their baby dies (Sharpe, 2015). These comments are driven by a concern to reduce infant deaths that are seen as preventable. As Elder (2015) states: 'For those of us who have to provide information and support to parents who have had a baby die in a bed sharing situation, it seems to be straightforward. These are preventable deaths'. (p. 13).

At the same time however, there is a large body of literature suggesting close mother-infant contact at night is beneficial when the infant has not been exposed to smoking in pregnancy, was not born prematurely or with a low birth weight and when the mother is not impaired by alcohol or drugs (Ball & Volpe, 2013; McKenna, Ball, & Gettler, 2007; McKenna & Gettler, 2015). In particular, bed sharing is viewed as important for 'reinforcing attachment, supporting infant development and facilitating breastfeeding' (Ball & Volpe, 2013, p. 86). McKenna and McDade (2005) note that 'mother-infant co-sleeping represents the most... appropriate sleeping arrangement for humans and is both ancient and ubiquitous' (p.135). Indeed, in many countries such as Japan, Sweden, Malaysia and Taiwan, it is common for a mother to sleep with her baby (Mindell, Sadeh, Kohyama, & How, 2010; Nelson et al., 2001; Tahhan, 2008).

There are contradictions in the above advice exhorting mothers to avoid sleeping with their baby on one hand, and promoting the benefits of doing so on the other. This contradiction is just one example of the confusion that mothers must navigate in their decision-making around infant care practices at night. The expert discourse around bed sharing is, however, dominated by advice that infants are safest in their own bed. For example, official New Zealand Ministry of Health (MOH) advice aligns with the view that putting babies in the adult bed when adults are sleeping is unsafe. As a consequence, the alleged benefits of bed sharing are largely ignored in recommended advice to parents. As Ball and Volpe (2013) note, 'the question of sleep location is caught between two public health agendas: Safeguarding (the prevention of infant death/injury and safety awareness); and the promotion of breastfeeding, bonding and infant mental development' (p. 86). Accordingly, there is a tendency to classify sleep locations as either 'good' or 'bad', and for public health campaigns to assume that knowledge of risks will lead parents to modify their behaviour to reduce any potential risk.

The issue of how and where an infant sleeps is important in New Zealand, as we have high rates of infant mortality compared to other countries. In 2011, New Zealand ranked 30<sup>th</sup> out of 40 OECD countries for infant mortality with a rate of 5.5 deaths per 1000 live births. This is higher than the OECD average of 4.1 deaths per 1000 (OECD, 2013). Sudden unexpected deaths in infancy (SUDI) make up the largest proportion of deaths in the post neonatal period (28 days to one year) in New Zealand (NZ Mortality Data Group, 2013). The term SUDI includes both the deaths that can be explained (such as asphyxia and suffocation) and deaths that cannot be explained (termed sudden infant death syndrome (SIDS)) (Ministry of Health, 2010). SIDS is a classification of exclusion, described as:

The sudden unexpected death of an infant <1 year of age with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history (Krous et al., 2004).



New Zealand has historically had one of the highest rates of SUDI in the western world. Out of eight high income countries included in a recent study comparing SUDI death rates between 2002- 2010, New Zealand's SUDI rate was the highest at 1.00 per 1000 live births. In comparison, the Netherlands with a rate of .19 per 1000 live births had the lowest rate (Taylor et al., 2015). This inter-country disparity is one of the key reasons why the issue of infant sleep has received so much attention in New Zealand.

I first became interested in this area of research when I was employed as a project manager by a social innovation company. As the holders of a national contract to reduce rates of sudden infant death in New Zealand, my role was to educate health professionals about safe sleep. I became the interface between research evidence and the health professional. Through this public health professional lens it seemed obvious to me at that time, that knowing the risks of SUDI, mothers would logically follow safe sleep recommendations. However, it wasn't until I became a mother myself that I gained first-hand experience of just how difficult it is to keep infant safety at the forefront of decision making, while also juggling the realities of an unsettled baby and an exhausted mother.

Some of the decisions I made on occasions did not adhere to recommended advice and I began to wonder how other parents negotiated the advice of 'experts' with the reality of caring for their baby at night. I was also interested in exploring what other factors impacted on decisions mothers made and if like me, they felt guilty if they did not do things 'by the book'. When I first started to review the literature, it became clear that there had been a focus on assessing knowledge of safe sleep recommendations, and reviewing actual infant care practices. This research which explored what parents 'know' and 'do' with regards to infant safe sleep, was often then used to recommend health promotion strategies for higher uptake of key safety messages.

The assumption, which will be explored more fully in my thesis is that knowledge leads to behaviour change. Studies exploring maternal motivations at night-time have predominantly focused on reasons for bed sharing. While epidemiologists have highlighted reasons for not bed sharing,

anthropologists have studied the benefits of, and maternal motivations for bed sharing as an important element of infant development. There is a large amount of academic interest in exploring maternal-infant feeding decisions within the context of both 'risk' discourse and threats to 'maternal identity'. However, at the time of my study, I could find no literature examining maternal-infant sleep decisions in these ways. I therefore became interested in exploring the broader issues that impact on night-time care decisions such as how society's pressure to be expert-led, and expectations for what it means to be a good mother, impact on decision-making.

### Thesis Aims and Structure

The objective of this qualitative study was to explore how maternal values, safe sleep knowledge and practical realities influence decision making in the night-time care of infants in one suburb in Christchurch, New Zealand. In particular, I set out to answer two questions:

What influences maternal decision-making in the night-time care of an infant? (By 'night-time care' I mean how mothers make decisions on how, when and where their infant will sleep during the night).

How do mothers reconcile infant sleep recommendations with actual behaviour when caring for an infant aged less than 6 months old during the night?

As qualitative studies allow for more in-depth exploration and analysis of how people make sense of the world around them (Cresswell, 2009), I felt that an inductive qualitative study interviewing mothers who were in the midst of this often challenging time, would be most appropriate for my research aims.

In the following chapter, I provide background literature and statistics on SUDI and trace public health efforts to reduce rates of sudden infant death in New Zealand. The chapter then examines the epidemiological research upon which the MOH infant safe sleep recommendations are based. The chapter concludes with a review of current research and gaps in studies exploring maternal decision-making in the night-time care of infants.

In chapter three, I provide an account of the methodology and methods upon which my qualitative study is based and provide a reflexive account of my journey as the researcher. Chapters four to six explore the major findings which emerged from the process of thematic analysis. To gain a deeper insight into my data, I found I needed to invoke a broad mix of theoretical concepts from a range of different academic disciplines. In the first of these chapters, societal expectations of living up to the ideology of being a 'good mother' are discussed using concepts from different feminist theories and Goffman's (1959) concepts of 'identity work' and 'impression management'. In chapter five, the theoretical concepts of Beck (1992) and Giddens (1991) 'risk society', which suggests we are living in a society focused on reducing risk of harm, are explored in the context of how mothers navigate expectations of being expert-led against this backdrop. The dominant worldview that assumes mothers respond to risk in a calculative and scientific way will also be investigated in this chapter. In the final of these thematic chapters, I explore how socio-cultural perspectives of risk and everyday realities impact on maternal decision-making.

Chapter seven draws all these findings and discussions together to consider their impact from a broader socio-political perspective. The chapter discusses the implications of my findings within the context of neoliberal philosophy. In particular, how the reshaping of healthcare whereby mothers are held accountable for protecting their infants from any and all risk, impacts on both their decision-making and anxiety levels. The chapter also discusses the implications of developing electronic applications (apps) to identify an infant's risk status, and the threat of prosecution for mothers who do not follow recommended practice. Finally, the chapter outlines recommendations for future research, and identifies the need for a more empathetic public health approach towards infant sleep safety.

## Chapter 2. Background and Literature

Several key findings have emerged from over 25 years of research about infant sleep safety. These findings have played an important role in reducing the number of infants dying suddenly and unexpectedly in their sleep. Mitchell and Blair (2012) note that over 3000 lives have been saved in New Zealand as a result of the dissemination of these findings to New Zealand families. In particular, the advice to avoid sleeping infants in the prone or side position. Most research has focused on identifying risk factors associated with SIDS and on testing hypotheses as to the cause of these sudden and unexpected deaths. Within this chapter, I outline the established epidemiological risk factors for SUDI, and provide a New Zealand-specific overview of the most recent SUDI data. I trace public health efforts to reduce rates of SUDI in New Zealand and explore the literature identifying reasons behind the inequitable rates of death for Māori infants. Although each of my thematic chapters includes appropriate literature, I have also provided a review here of the literature used to support the key MOH safe sleep recommendations. Finally, I review recent studies assessing knowledge and behaviours related to safe infant sleep, and identify a lack of studies exploring infant sleep within the contexts of maternal identity and a risk averse society.

### Sudden Unexpected Death in Infancy

Research has identified that the majority of sudden infant deaths occur during night-time sleep (Blair, Platt, Smith, & Fleming, 2006) and in the first six months of life, with deaths peaking between 1 and 2 months (Child Youth Mortality Review Committee, 2009). Crane (2014) notes that 'the most common epidemiological characteristics of infants at greater risk of SIDS are premature, low birth weight, age 2-4 months, prone sleep, exposure to cigarette smoke, maternal alcohol consumption and maternal drug use' (p. 12). While the definitive cause of SIDS remains unknown, it is suspected that there is not one, but a cluster of causal mechanisms involved in a SIDS death including environmental and biological risk factors (Blair, 2015; Garcia, Koschnitzky, & Ramirez, 2013). One model that has been cited often in the

literature is the triple risk hypothesis developed by Filiano and Kinney (1994) that suggests SIDS is an event that occurs when three factors intersect. It is hypothesized that a vulnerable infant, for example an infant exposed to smoke in utero, in a critical stage of development (less than six months old), may die if exposed to an external stressor, such as an unsafe sleep environment. Despite this hypothesis, many babies do not die when these factors intersect, and SIDS remains a relatively uncommon event.

Owing to the long investigative and coronial process of classifying infant deaths, the most recent official SUDI figures in New Zealand are from 2012. In that year, of 61,172 live births in New Zealand (Statistics New Zealand, 2015) 36 babies died suddenly and unexpectedly, a rate of 0.6 per 1000 live births. Of these, 18 deaths were classified SIDS (Ministry of Health, 2015b) whereby the coroner found the cause of death to be undetermined. The way that infant deaths have been classified has also changed over time. The number of deaths due to strangulation and bed sharing have increased since the early 1990s. However, as Craig, Dell, et al. (2013) note: "It is unclear...whether this represented a diagnostic shift in the coding of SUDI, or whether the sleeping environment made an increasingly greater contribution to SUDI' (p. 159).

The number of deaths registered in 2012 is much lower than when SIDS rates were at their highest during the 1980s. At that time, ministerial reports revealed two thirds of infant deaths in New Zealand were attributable to SIDS. At a rate of 6.2 deaths per 1000 live births in 1985, the New Zealand SIDS rate was almost twice as high as countries such as Sweden, Denmark and Australia (Fraser & De Boer, 1987). Cowan (2010) reflects on this as a time of 'high community and professional concern, high parental anxiety and no confirmed way to protect babies from SIDS' (p. 88). As awareness of the dangers of babies sleeping prone become evident, the first public health campaign was initiated in Christchurch in 1987, by parents and professionals under the auspices of the 'Cot Death Society' (Cowan, 2010).

Between 1987 and 1990, a three year case-control study was undertaken in New Zealand (Mitchell, Aley, & Eastwood, 1992; Mitchell et al., 1991). The study was one of the first in the world to confirm the increased risk of SIDS

for babies who were placed to sleep in the prone position (Mitchell, Ford, et al., 1992). The study also found an increased risk of SIDS for babies who were smoke-exposed, sharing a bed, and not breastfed (Mitchell, Taylor, et al., 1992). Further analysis revealed an interaction between smoke-exposure and sharing a bed, with increased SIDS risk when both factors operated (Mitchell & Scragg, 1993). Other large case-control studies since this time have found similar associations (see for example: Carpenter et al., 2004; Fleming et al., 1996; Zhang & Wang, 2013).

As a result of these findings and the community work already underway, a national cot death prevention programme was initiated in 1991. Mitchell (2009a) notes that early on in the campaign the focus was on stopping parents from placing their babies in the prone position for sleep. The early message of 'back or side' was then amended to 'back only' as evidence became stronger for the risks associated with side sleeping and SIDS. Several authors have explicitly linked the reduction in prone sleeping with the reduction in rates of SIDS in New Zealand and around the world (Dwyer, Ponsonby, Blizzard, Newman, & Cochrane, 1995; Fleming, Blair, & Pease, 2015; Mitchell, 2014).

However, not all babies who are placed to sleep in the prone position die, and as such the infant sleep position is only, as Blair (2015) highlights, 'part of the causal pathway for some deaths but not in itself a cause of death' (p.281). It is dangerous therefore to consider prone sleeping a panacea to SIDS, without considering that each case-control study was undertaken in countries with different cultural practices around sleep. It is likely that these countries were also implementing other public health initiatives that may have contributed to the reduction in SIDS rates. For example, the New Zealand government also initiated its first tobacco control programme during this time (Laugesen & Swinburn, 2000), and New Zealand adopted the World Health Organization's Code of Marketing of Breast-milk Substitutes (Burgess & Quigley, 2011).

Nonetheless, by 1990 incidence of prone sleeping in New Zealand had been reduced by almost half, and the SIDS mortality dropped from a mean of approximately 6.4 per 1000 live births between 1982-1989, to 3.6 per 1000

in 1992 (Mitchell, 2014). Rates plateaued at this time, but in the past few years have been reducing again. The MOH reports that between 1996 and 2012 total infant death rates fell 35%, from 7.3 to 4.7 per 1000 live births (Ministry of Health, 2015b). With regard to SUDI, in the five years to 2011, the SUDI rate fell 40% from 1.0 to 0.6 per 1000 live births (Ministry of Health, 2015b). As Cowan (2015a) observes:

Total infant deaths are not SUDI deaths. They include SUDI, but they also include infant deaths from all other causes, preventable and non-preventable. As such, we can logically assume that if total infant death rates are changing, then SUDI rates are too, SUDI being a largely preventable category of total infant deaths (p. 4).

The latest official New Zealand SUDI information indicates that 'between 2008-2012, SUDI death rates were higher for babies born: premature (between 32-36 weeks), with a very low birthweight (1000g-1499g), to young mothers under 20 years of age, and living in the high deprivation areas of Northland, Lakes, Whanganui and Hutt Valley District Health Boards (Ministry of Health, 2015b).

There are significant differences in SUDI rates for those in higher and lower deprivation areas in New Zealand. The New Zealand Deprivation Index (NZDep), has been classified using data from the 5 yearly population census. It is widely used in New Zealand as a means of identifying socio-economic conditions at a geographical level, utilising nine socio-economic deprivation variables (Salmond & Crampton, 2012). The deprivation index utilises a rating of 1 (low deprivation) to 10 (high deprivation). For those living in high deprivation areas (9-10), the rate of SUDI death is seven times greater than for those in the least deprived areas (Craig, Adams, et al., 2013).

There is a clear disparity between rates of SUDI for Māori and Pacific compared to other ethnicities in New Zealand. Between 2007-2011, Māori rates of SUDI were almost five times higher and Pacific Island rates double that of European babies (Simpson et al., 2014). According to Jones (2000), differential access to the determinants of health is one of the pathways that contribute to ethnic inequalities in health. Reid and Robson (2007) assert

that access to determinants of health such as income, education and employment differs for Māori, leading to exposure to other risks.

Research by Mitchell et al. (1993) indicated Māori were over represented in both 'modifiable' and so called 'non-modifiable' risk factor groups for SUDI. Smoking in pregnancy is linked with low birth weight and preterm birth, both identified risks factors for SIDS (Cnattingius, 2004; Erickson & Arbour, 2012). In addition, the combined modifiable risk factors of smoking and bed sharing increase the risk of SUDI (Zhang & Wang, 2013) and research has revealed these practices are more common among Māori mothers (Tipene-Leach et al., 2010). In 2009, it was estimated that around 45% of Māori women smoked in the antenatal period, compared to 16% of Europeans (Dixon, Aimer, Guilliland, Hendry, & Fletcher, 2009). Two different studies in one geographical area of New Zealand (Hutchison, Stewart, & Mitchell, 2006; Tipene-Leach et al., 2010) found that '65% of Māori mothers had bed shared for some period the night before the survey was undertaken, compared with 27% of European mothers' (Abel, Stockdale-Frost, Rolls, & Tipene-Leach, 2015, p. 3). Māori mothers were also more likely to visit an antenatal clinic later in their pregnancy and to have poorer birth outcomes. Also, Māori mothers were over-represented in some of the non-modifiable risk factors such as lower socio-economic status and being a younger mother (Mitchell et al., 1993). Similar findings were reported by Ratima and Crengle (2013) in their review of Māori women's experience of maternity services in New Zealand. The authors found that many of the poor birth outcomes for Māori infants were exacerbated by inequitable access to maternity care. They noted several key barriers including; 'access to information to make informed choices, insufficient numbers of independent Māori midwives, inadequate access to culturally responsive care including *whānau* [extended family]-centred services and cost barriers' (Ratima & Crengle, 2013, p. 353).

While rates of SUDI are higher for Māori, it is the combination of exposure to risk factors, rather than ethnicity, which has led to the inequity. However, the most recent total infant mortality statistics suggest that this inequality between SUDI rates for Māori and 'other' may be reducing. During the period 2009-2014, while the overall infant death rate for babies aged 1 week to 52 weeks, fell from 2.6 to 2.1 per 1000 live births, the rate of decline was most



notable for Māori, falling from 4.4 to 3.0 per 1000 live births during the same period (Cowan, 2015a).

### Ministry of Health Safe Infant Sleep Recommendations

The Ministry of Health (MOH) is the New Zealand government's principal health advisor. It provides guidelines on health and disability related topics including safe infant sleep. At the time of interviewing my participants, the MOH recommendations for infant sleep safety were based on the epidemiologically identified risk factors for SUDI described earlier in this chapter. These were published on the MOH website (Appendix A), -although these have since changed- and in a Ministry of Health funded booklet available to parents and health professionals called 'Keep your Baby Safe during Sleep'. Similar resources were also available from organisations involved in safe sleep education such as the Royal New Zealand Plunket Service (Plunket)<sup>1</sup>, Whakawhetu<sup>2</sup>, TAHA<sup>3</sup> and Change for our Children<sup>4</sup>. The MOH fund a Well Child/Tamariki Ora service for parents of which Plunket is the largest provider. The service provides home visits and health workers are required to discuss safe infant sleep with families (Ministry of Health, 2015d). At the initiation of this study, the remaining three organisations had contracts with the MOH to reduce rates of SUDI in New Zealand. Change for our Children, a private social innovation company, had a contract to provide national support to health professionals and families around safe infant sleep education. Whakawhetu and Taha focused on reducing SUDI for Māori and Pacific populations respectively.

The key recommendations from the Ministry of Health included putting babies to sleep on their backs, with a clear face, free from smoke and in their own sleep space near an adult bed for the first 6 months of life (Ministry of Health, 2014). Recommendations to place babies to sleep on their back, and to ensure a smoke-free environment are well supported in the literature (see for example: Fleming et al., 1996; Gilbert et al., 2005; Mitchell, Freemantle,

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<sup>1</sup> <https://www.plunket.org.nz>

<sup>2</sup> <http://www.whakawhetu.co.nz/>

<sup>3</sup> <http://www.taha.org.nz/>

<sup>4</sup> <http://www.changeforourchildren.co.nz/>

Young, & Byard, 2012). A recent meta-analysis confirmed a dose-dependent increased risk of SIDS for infants who were exposed to prenatal or postnatal maternal smoking. The study also concluded that the risk was further increased when the infant was sleeping with the mother in a bed sharing environment (Zhang & Wang, 2013). The recommendation to ensure that a baby has a clear face is based on case-control data showing the prevalence of SIDS deaths where an infant's head was found covered by bedding (Carpenter et al., 2004; Fleming, 2000; Hauck et al., 2003; Mitchell et al., 2008). A systematic review found an eightfold increase in risk of SIDS where an infant's head was covered and concluded:

The epidemiology of SIDS does not fully support one particular causal chain but neither does it suggest that head covering is just part of some agonal event. If the relationship is causal, approximately one quarter of SIDS deaths might be prevented if head covering was avoided (Blair, Mitchell, Heckstall, & Fleming, 2008, p. 778).

However, evidence and messaging around location of sleep, that is, where babies should sleep, is more contentious. The sheer number of infant sleep locations makes the issue complex. Parents may choose for their baby to sleep in a separate room, on a couch, in a bassinet, cot or portable sleep space, in the same room as a parent, beside the adult bed, or in the adult bed to name but a few of the possible choices. The MOH however, recommends that babies sleep near an adult for the first six months of life (Ministry of Health, 2014). This recommendation is based on epidemiological evidence showing an increased risk of SUDI for infants who sleep in a separate room compared to sleeping in a cot in a parent's room (Blair et al., 1999; Carpenter et al., 2004; Scragg, Mitchell, Stewart, Ford, et al., 1996).

The issue of an infant sharing an adult bed is a controversial topic. There is currently no consensus in the literature to even define the terminology, with different academics interpreting and defining the practice of sharing a sleep surface with an infant in different ways (see Ball et al., 2012; Fetherston & Leach, 2012). For the purpose of this thesis, where the term 'bed sharing' is used, it will denote a baby sharing the same sleep surface (an adult bed) as

one or more persons, whether planned or incidental and for either all or part of night-time sleep.

There is general agreement in the literature and between epidemiologists and anthropologists around the risks associated with bed sharing and SUDI for babies whose mothers smoked in pregnancy (McGarvey, McDonnell, Hamilton, O'Regan, & Matthews, 2006; Mitchell, Taylor, et al., 1992), consumed alcohol, drugs or were over-tired (Blair et al., 1999; Carpenter et al., 2004), and for babies who were premature or of low birth weight (Blair et al., 2009; Fleming, Pease, & Blair, 2015). There is also general agreement of the risks associated with sleeping on couches and soft surfaces such as beanbags due to the danger of suffocation (Blair et al., 1999; Fleming, Pease, et al., 2015; Tappin, Ecob, & Brooke, 2005).

A key area that is still being debated in the literature is whether there is a risk for a healthy full-term baby who is breast-fed, smokefree and sharing an adult bed when they are still under 3 months of age. In 2012, a meta-analysis reported an increased risk for these younger babies. However, the study also highlighted that although there was emerging evidence of the interaction between bed sharing and parental drug and alcohol use, and SIDS linked with sofa sharing, the meta-analysis could not explore these topics because these data were not collected in all the studies they reviewed. Based on the missing evidence, the authors concluded: 'For public health advice, it is not clear whether a strategy to advise against bed sharing in general or just particular hazardous circumstances in which bed sharing occurs would be more prudent' (Vennemann et al., 2012 p. 47).

In 2013, a study combining five sets of case-control data controversially reported that even when the mother was not smoking, there was an increased risk of SIDS for infants under three months of age (Carpenter et al., 2013). There has been criticism of the study, in particular over the use of imputed data for variables such as alcohol consumption and drug use, the lack of data on prenatal smoking and the broad definition of bed sharing (Bartick & Smith, 2014; Dodds, 2013; Fleming, Pease, et al., 2015). McKenna and Gettler (2015) observed that 'no less than nine significant critiques followed its publication mostly focusing on the validity of the

statistics' (p.3). It has been suggested that prospective studies to test, rather than generate hypotheses, are needed to clarify the issue of risks associated with bed sharing for the younger infant (Horsley, Clifford, Barrowman, & et al., 2007). However, given the rare occurrences of SUDI, and the ethical implications involved in randomly allocating mothers to test potentially unsafe sleep practices, such a study is unlikely to occur.

While many epidemiologists are focused on researching how bed sharing is associated with infant deaths, anthropologists on the other hand, suggest that bed sharing is important to meet the needs of both infant and mother (Ball & Volpe, 2013; McKenna et al., 2007). It is argued that inconsistencies in the findings of case-control studies around the safety or otherwise of sleeping in close proximity to a caregiver are the result of a lack of consensus around the definition and usage of the terms 'bed sharing' and 'co-sleeping'(Ball & Volpe, 2013). Academics who perceive bed sharing from an evolutionary theory perspective, argue that an infant needs to be in close proximity to its mother for optimal physical and physiological development (Ball, 2006). McKenna and McDade (2005) assert that epidemiologically based public health messages on unsafe infant sleep locations should be challenged using anthropological evidence. In a recent publication, McKenna and Gettler (2015) argue that mothers' bodies are 'incredibly responsive to and regulatory of the vulnerable human infant'... [and are not the] lifeless wooden rolling pin or metal cleaver [that they are portrayed as in safe sleep campaigns]' (p. 2). It is this conflict between navigating risk of death and infant developmental needs that this thesis aims to explore.

Evidence around best practice for infant sleep and development may be confusing, but infant physiology requires infants to sleep somewhere. The literature explores in depth the *behaviours and knowledge* of parents when caring for infants at night, especially with regards to the adherence—or not—to safe sleep recommendations (see for example: Hauck, Signore, Fein, & Raju, 2008; Hutchison et al., 2006; Hutchison, Thompson, & Mitchell, 2015). Recent research from New Zealand suggests that while only 5% of mothers could list all the MOH recommended sleep advice, 43% placed their babies to sleep in ways that aligned with the advice (Hutchison et al., 2015). However, there was a marked increase in knowledge of advice around

'avoiding bed sharing, keeping a clear face and sleeping in the same room as a parent' (p. 20). It has been suggested that this knowledge may have influenced the decrease in SUDI rates in New Zealand in recent years (Elder, 2015; Hutchison et al., 2015; Pitama, Lacey, & Huria, 2015). Yet this study was from only one geographical region of New Zealand and the sample was predominantly New Zealand Europeans, so it is difficult to generalize these findings to the whole of the country.

Another recent study by Galland et al. (2014), found that adherence to recommended practice was high, although again the group sampled were predominantly European, of low SUDI risk and in one geographical region of New Zealand (Galland et al., 2014). The study reported that almost 90% of infants were sleeping in the recommended supine position and only one mother in the sample smoked and slept in the same space as her infant. Thirteen percent of smokefree mothers reported bed sharing at three weeks, with this reducing by half to 5.6% at 19 weeks. It was hypothesized that the higher number of mothers bed sharing when the infant was three weeks old compared to when the infant was slightly older may have been due to 'parental choice, maternal sleep needs, or infant feeding practices' (Galland et al., 2014, p. 7). However the study did not define 'bed sharing' so it is unclear if mothers were reporting on regular or occasional bed sharing, and in addition if this referred to bed sharing all night or for some part of the night. It has been noted by other academics that mothers may not 'report their actual sleeping strategies- particularly if the parents suspected their practices were not the norm' (see Ball, 2006, p. 8). As such, it is difficult to determine if bed sharing practice has been under reported in this study or not.

Studies exploring maternal motivations for infant care decisions focus predominantly on infant feeding and bed sharing. There is a large body of work exploring reasons why mothers choose to bed share. A recent meta-analysis listed ten common themes found across 34 studies. These were: 'breastfeeding, comforting, better/more sleep, monitoring, bonding/attachment, environmental, crying, tradition, disagree with danger, and maternal instinct' (Ward & Salm, 2015, p. 675). These studies highlight factors other than risk of death that mothers consider when they make their

infant care decisions. These motivations will be examined further in my study.

In exploring maternal motivations around infant feeding, some academics have explored decision-making within the context of 'intensive mothering' and 'risk society' (Knaak, 2010; Lee, 2007; Murphy, 1999, 2005), suggesting that breastfeeding is a moral imperative of being a 'good mother' and a way to reduce risk to the infant (Knaak, 2010). In reviewing the literature, I found a limited number of studies exploring infant sleep within these same contexts (see Dodd & Jackiewicz, 2015; Lupton, 2011). Dodd and Jackiewicz's (2015) study explored Aboriginal and non-Aboriginal mothers' decision-making, specifically on the topic of bed sharing. They found that the dominant discourse of 'intensive mothering' and 'involved fathers' caused challenges for non-Aboriginal women. The authors concluded that a non-aboriginal mother's authority to be an expert in her own infant's care was undermined by the need to negotiate her decision-making with her (male) partner. This was not the case for Aboriginal women, who described more defined mother/father roles.

A qualitative study by Lupton (2011) explored mothers' perceptions of their roles in promoting infant health more generally. In her study, Lupton linked high levels of maternal anxiety to the dominance of 'good mothering' ideology in a risk society context, which requires mothers to be responsible for their infant's health. Of these studies, neither examined the dominant mothering ideology nor 'risk' within the broader framework of where and how mothers choose to put their infants to sleep at night. In addition, both studies were based in Australia. As mothering has discrete socio-cultural contexts which include different forms of support services, government guidelines and cultural practices, it is important to have country-specific literature. For example, Ball and Volpe (2013) describe how attempts to implement the American Academy of Pediatrics (AAP) safe sleep guidelines in countries outside America have failed due to differences in cultural practices. The authors note that 'it is inappropriate to transfer health-related recommendations from one cultural setting to another without evaluating variation between the target and source populations' (Ball & Volpe, 2013, p. 89). This thesis attempts to address some of the gaps in the literature

exploring maternal decision-making within a broader socio-cultural perspective, and to provide a specific New Zealand exploration of maternal motivations around infant care decision making.

To research the complexities within which mothers make their decisions at night, a qualitative design was deemed the most appropriate. This decision-making is happening within the context of a society focused on reducing risks and encouraging mothers to be 'expert'-led. At the same time, the decision-making is also occurring within the context of a neoliberal ideology in which particular forms of citizenship are produced. Neoliberalism requires both the risk and the burden of responsibility to be on the shoulders of the individual (Ayo, 2011). As the literature continues to inform public health guidelines on safe infant sleep, it is important to consider the implications of neoliberal ideologies on maternal infant care decision-making. The final chapter of this thesis, considers in more detail, the individualization of risk as a key tenet of neoliberal ideology. The current chapter has highlighted some of the relevant literature and New Zealand specific history on the topic of SUDI, and further literature will be woven into the three thematic chapters. The next chapter will outline the methodology and methods used in my study.

## Chapter 3. Methodology and Methods

When it comes to the nurturing of babies, mothers are often inundated with advice about how best to feed, sleep, wash, soothe and even dress their newborn. In undertaking this study, I wanted to explore in more depth how mothers reconcile advice, especially that of health professionals, with the reality of their own night-time experiences. Accordingly, a qualitative study allowed me to investigate in much greater detail than has been the case previously, and in areas that had not been examined in sufficient depth. Within this chapter I outline the methodological approach as well as the methods that I have used throughout my study. In addition, I describe the limitations of my study and reflect upon how my world views and prior experiences have influenced the direction of my data collection and analysis.

### Methodological Approach

Epistemologies range from the objectivist to the constructionist in nature (Crotty, 1998). My study has been undertaken from the social constructionist end of the spectrum. This worldview rejects the notion of objectivity, for a view that 'human phenomena are socially constructed rather than objectively real' (Padgett, 2012, p. 4). It is based on a belief that there is not one truth to be discovered, but that multiple meanings are constructed based on how participants interact with and make sense of the world around them (Crotty, 1998). Meanings are based within a context of differing historical, social and political processes (Green & Thorogood, 2013) that together allow a person to construct their own meanings.

This constructionist worldview fits with my ontological position that there is not one, but multiple realities to be understood about caring for an infant at night. Two mothers with a crying baby in the middle of the night, will likely be motivated to act in different ways based on the socially constructed nature of their different worlds. Indeed, an individual mother's definition of truth may change as context changes. My intention was not to find the one 'truth' behind why mothers acted in the way they did, but rather to explore the often contradictory and messy world of night-time infant care and make



sense of patterns that emerged. I am aware that had I asked the same questions on a different day, the answers I received could well be different. It is possible that responses would differ, based for example, on how much sleep the mother had the night before, how happy her baby was at the moment or in the days leading up to our interview, or by the current status of her relationship with the infant's other parent. Although I may have received different individual responses had I interviewed on more than one occasion, this was not a concern as I was looking for patterns that repeated across interviews.

### Reflexivity

Engaging in self-reflexivity throughout the study, has allowed me to examine the ways in which my prior beliefs and current assumptions and understandings might influence the research process and outcomes. The process of self-reflexivity, is an important tenet of the constructionist paradigm (Clarke & Braun, 2013; Green & Thorogood, 2013; Tracy, 2010). It requires the metaphorical microscope to be turned inwards; for the same level of rigorous analysis to be given to the researcher's own processes and practice as to that which is given to the study of the phenomena itself (Green & Thorogood, 2013).

As a mother myself, I have experienced caring for an infant at night, and have also worked as a public health professional translating academic literature into safe sleep principles for families. As such, I recognize that I bring preconceived notions about this phenomenon to the research and I cannot bracket my prior knowledge and beliefs out of the study. For example, prior to interviewing, I believed that all mothers gave as much thought to the risks of SUDI as I had. It came as quite a shock to learn from one mother, that it was not a topic she had given any thought to, or perceived any risk from. It is difficult to know if my face revealed my shock, but on reviewing the audio, I did not sound surprised. I was aware that I had planted a seed for this couple that may have led them to feel guilty about not knowing more about the possibility of infant death. I had also assumed that all mothers would understand the mechanisms of a sudden infant death. Therefore, I was again taken aback to learn that one family had taken 'cot death' literally and assumed that if there was no cot in the house, then cot death could not

happen. After these interviews, I avoided using the words 'SUDI' or 'cot death' unless it was something the participant themselves referred to. I did not want the women to feel I was judging them on their infant safety knowledge.

In the concluding chapter of this thesis, I place my findings and discussions within a socio-political framework. I pondered why it was that I could find no other literature exploring the topic of infant sleep from this perspective. I have since reflected that my interest in exploring how individuals are impacted by government policies and initiatives, was likely influenced by my study of political science as an undergraduate student. In viewing infant sleep within a different lens, I feel I have added to the literature.

## Methods

### The purposive sample

A purposive sampling method was used to select mothers in an area of Christchurch (Linwood/Avonside) that had NZ Deprivation index scores of 8 and 9 respectively. This is markedly higher than the average Christchurch deprivation score of 4.6. Social deprivation by geographical area was chosen based on evidence of a higher risk of SUDI for infants living in lower socio-economic areas (Mitchell, Taylor, et al., 1992). I was aware that even though an area is given a deprivation score, it does not mean that everyone within the area will be living at that level of deprivation. However it was a useful tool to identify an area of Christchurch whose residents were more likely to be socio-economically disadvantaged than Christchurch as a whole. While Aranui had the highest deprivation score in Christchurch (10), it was purposely not chosen for this study due to the population flux arising from the loss of housing stock in this area after the February 2011 earthquake. The city of Christchurch was chosen for convenience as this is the city in which I live.

A total of 13 participants were recruited from the Linwood/Avonside Plunket clinic in Christchurch. Over 90% of babies in New Zealand are enrolled with some part of the free Plunket Well Child/Tamariki Ora programme (Plunket, 2015b). With its high enrolment rate, the organisation provided a useful way

to recruit mothers of different ages, cultures, and with different parenting beliefs and practices.

A 'gate-keeper' as noted by Liamputtong (2009), is a useful way to gain access to a group of participants. For this reason, I engaged a Plunket nurse from the clinic to identify and recruit mothers from her case load. A Plunket Kaiāwhina (Māori Health worker) also helped to find Māori and Pacific mothers for inclusion in the study. In addition, an advertisement (Appendix B) was displayed in the Plunket rooms with pull-off strips for mothers to contact me directly, although no women self-selected in this way. Mothers on the Plunket nurse's case load were invited to participate in the study when the nurse made her second home visit (at about 8-12 weeks after birth) as part of the Plunket Well Child/Tamariki Ora programme. This resulted in a cohort of mothers with babies around the same age (between 3-5 months). The Plunket nurse talked through the information sheet (Appendix C) with prospective participants. If they were happy to proceed, the Plunket nurse then asked their permission for me to contact them via telephone to arrange an interview.

#### [Eligibility criteria](#)

The sample of mothers was restricted to those with an infant aged less than six months old. This was to aid with mothers' recall of night-time care, and also to encompass the period of highest risk for SUDI. Mothers needed to be aged over 16 years, as the potential time and complexity of gaining parental consent for mothers under this age was not deemed feasible in the timeframe of a Masters Thesis. Mothers were required to speak English, as paying an interpreter was beyond the allocated budget. As English is my only language this also reduced the potential for misinterpretations. The Plunket nurse only invited women who had not previously experienced the death of an infant. This was to avoid stigmatizing mothers whose infants may have died because of unsafe sleep practice.

#### [Ethical approval](#)

Ethics approval was obtained from both the University of Otago and Plunket ethics committees prior to conducting interviews. As recruitment of participants was through a health agency, it was important that participants felt confident that if they declined to take part in the study it would not

jeopardise their support from the agency in any way. It was also important they knew that anything spoken about in the course of our interview would not be reported back to Plunket or to any other agency. Confidentiality and anonymity were made clear in the conversations held by the Plunket nurse when she provided a full disclosure of the purpose of the study (Liamputtong, 2009). I reiterated this in my initial phone call with the participant and again at the start of the actual interview. It was also explicitly outlined in the consent form signed before the start of the interview. Transcripts were anonymized through the use of pseudonyms, and other identifying features, such as age, and names of the baby or father, were also left out as a measure to ensure anonymity of participants. Interviews were deleted from the handheld recorder after being transcribed, and data were stored electronically on a password protected computer. Printed transcripts were stored securely and then destroyed.

At the start of the study, I was concerned that our discussions around infant care practices may have raised personal issues such as indications of postnatal depression or frustrations relating to the woman's status as a mother. I also considered what I would do if it became clear that a family was at a heightened risk of their baby dying from SUDI. As a researcher I knew it was not my place to advise a family on how to care for their infant, but I would have felt morally responsible if I had known an infant was in danger and had not acted. To remedy this, the information sheet left with the participant included a page of free support services and websites that could be accessed by participants if needed. These included mental health, breastfeeding, safe sleep services and a directory of websites providing support for mothers.

#### [Generating data](#)

Thirteen face to face interviews took place during April and May 2015. This recruitment and subsequent interview process was much quicker than I had anticipated, with 13 of the 14 women approached immediately agreeing to participate. Only one woman, of Pacific Island ethnicity, declined the invitation to be part of the study.

Creswell (2007) suggests a natural setting such as the participant's home is the most suitable location for an in-depth interview. Liamputtong (2009)

notes that 'participants tend to be more comfortable being interviewed in their own home. They do not have to travel and they may have young children to take care of' (p. 54). Although I gave participants the option to have the interview in their own home or elsewhere, all were happy for me to come to their home. I was comfortable interviewing mothers in their own homes, as I had previous experience of working with pregnant women in their home environment. After the first couple of interviews, I noticed that if I accepted a cup of tea from the participant the interview seemed to flow more easily. The making of a cup of tea provided time for an informal chat before the interview. This seemed to relax the participant and allowed them to regard me as a visitor rather than my more formal role of interviewer.

I reflected that by making myself the guest, it may have given the locus of control back to the participant and addressed some of the power imbalances that are often cited between researcher and participant in qualitative interviewing (see Braun & Clarke, 2013, p. 88; Mason, 1996, p. 56). Other ways I attempted to address the potential power imbalance were: dressing casually, creating common ground by talking about the challenges I faced as a mother, using colloquial language and listening empathetically to participants' experiences of caring for their infants at night. I felt the building of rapport through empathy and understanding, as discussed by Corbin and Morse (2003), was a strength in my interviewing style.

Interviews lasted between 25 and 75 minutes and were audio recorded with a digital recorder after consent had been granted. In many houses, the infant and/or a toddler were also in the room, televisions were on in the background and in some instances, partners and/or other family or friends were also present. In several interviews, conversation continued either on-topic or on more general topics after I turned the recorder off at the close of the interview.

Each interview began with an introduction of my reasons for the study and my motivations to talk with them. After clarifying that they had seen and read the information sheet (Appendix C), which in most instances had been given about a week prior, participants were asked to sign a consent form (Appendix D). At the end of the interview, I collected demographic

information and asked participants to provide ethnicity data according to the 2013 New Zealand census ethnicity question (Appendix E). I chose not to ask women about their socio-economic status as I thought it might disrupt the relationship between myself and the participant.

A semi-structured interview guide (Appendix F) was developed, but as suggested by DiCicco-Bloom and Crabtree (2006), the guide was modified throughout the collection phase as I became more familiar with the topic and as new issues emerged. The guide ensured I covered the topics I was interested in whilst also allowing me to follow the participant's lead and pursue themes that emerged in more detail (Britten, 1995; Low, 2012). This flexibility to explore as topics emerged fits well with the social constructionist perspective I had taken. As I grew in confidence, I relied less on the interview guide and more on listening to the participant and delving further into areas as they naturally arose. I found that asking a general question about how the first months as a mum had been, followed by asking them to talk through a night in the life of their infant, was a useful way to open the interview. These general questions naturally led into topic areas I was interested in exploring. At the end of the interview, I followed the advice of Douglas (as cited in Liamputtong & Ezzy, 1999) and Braun and Clarke (2013), to ask if there was anything additional they would like to add about caring for their baby at night. In several interviews, this led to a lengthy discussion and brought new information to light, that may otherwise not have been shared.

I found that all the mothers appeared happy to talk to me, and I did not feel like I was an imposition at any time. For many, this was the first time they had spoken in such depth about their experiences and feelings associated with their role as a mother. It felt to me that this opportunity was welcomed by the mothers. Their willingness and openness to talk, led me to reflect on how little support is given to the psychological well-being of the woman during her transition to motherhood.

At the end of the interview, participants received a \$30 voucher to thank them for their time. Where possible, the recording of the interview was transcribed verbatim immediately. As I was transcribing for a thematic analysis rather than a discourse analysis, I omitted my verbal affirmations

('yeah', 'ok', 'hmm') when they did not add anything to the meaning. The verbal pauses of participants were transcribed as '...' and this is reflected in the quoted excerpts that have been included in this thesis.

Immediately transcribing my interviews was useful as it allowed me to reflect on the interview and critique my role as interviewer. As Liamputtong and Ezzy (1999) note, it was also useful to review ways I could have asked the questions differently and highlighted cues that I had missed. This made me more aware of listening for such cues in subsequent interviews. It was evident after my first interview that my length of silences needed to increase and my use of the affirmation 'yeah' needed to decrease. I became more careful about not interjecting when I thought the participant had finished speaking. On transcribing the audio, I found that often mothers seemed to be just pausing for thought or reflection and may have had something further to add if I had given them the space. Although I improved with each interview, I was always aware of cues that I had missed and points at which I cut off the participant too quickly.

To ensure a robust outcome when using qualitative methods, academics suggest interviewing until no new themes emerge (Guest, Bunce, & Johnson, 2006). This stage is called data saturation. Several studies have found data saturation was achieved at between six and 12 interviews depending upon sample homogeneity (Guest et al., 2006; Morse, 1994). Although I interviewed 13 mothers, I noticed that after about ten interviews, many of the same themes were emerging.

#### [Participant demographics](#)

Although living in the same geographical area, the women in my study were not a homogenous group. Ranging in age from 19 to 40, the median age was 25 years old. Three mothers were aged under 20 when their first child was born, and for nine women in my study, this was their first child. The ethnicity of mothers, using New Zealand census classifications was predominantly New Zealand European, although two mothers identified as Māori, one as Cook Island Māori, and one as Other (German).

All the mothers lived with a male partner, who was also the father of the child, and only two women had returned to paid employment at the time of

our interview. Five women had left school with no academic qualifications and the remainder had completed at least one National Certificate of Education Achievement (NCEA) level one credit or above. Two women had continued to tertiary education. At the time of our interview, ten women were smokefree and had been smokefree in pregnancy, and nine women were partially or fully breastfeeding their infant.

#### Data analysis

The data were analysed using a process of inductive thematic analysis as described in the literature (Braun & Clarke, 2006; Vaismoradi, Turunen, & Bondas, 2013). This was not a one-off endeavour, but rather an iterative process whereby 'coding [was used to] identify anything and everything of interest and relevance' (Braun & Clarke, 2013, p. 206). Codes were identified, analysed and collated across the entire data set and the process was repeated until three key themes were established. In practice, data analysis started very early, as some of these codes and patterns were identified almost automatically during the process of interviewing participants.

After reading three interview transcripts, I noticed that the majority of the codes I would subsequently use had been established. At the end of the process I had about 110 codes and soon realized this was too many. After reading the transcripts again, this number was reduced to 55 codes and then into three key themes. These were then explored more deeply using a range of theoretical concepts, as deemed appropriate for a study undertaken within a social constructionist paradigm (Attride-Stirling, 2001; Braun & Clarke, 2006). The themes of 'intensive mothering', 'risk' and 'mothers as experts' led me to return to the literature as my original search had focused on infant care practices and SUDI. I reflected as to why, when there was a large body of research studying moral motherhood and decisions around breastfeeding or vaccination, I had found very few studies reviewing moral motherhood within the context of infant sleep decisions. In addition, the theoretical concepts around risk also needed to be explored in more depth.

Over the next three chapters I will combine my data analysis, its discussion in relation to the literature and the concepts and theories I have used to deepen the analysis, within each chapter, rather than separating them. In



doing so, I will highlight the complex nature of mothers' decision-making in the night-time care of their infants.

### Study Limitations

My study is a small qualitative study and is not designed to be representative of the wider New Zealand population. The study is in a specific area of one city, with a small number of participants and as such the findings are limited in their generalizability. Nonetheless, the strong themes that have emerged throughout this research process are possibly applicable to mothers living in other areas of New Zealand, as they discuss issues likely to be affecting women in general. Another limitation of the study was that I did not collect individual information about the women's socio-economic status, so I cannot say that the findings in my study are representative of socio-economically deprived mothers. However, the women were all living in a higher deprivation area of Christchurch and issues of deprivation arose within our interviews.

A third potential limitation of this study is that it did not focus on mothers at the highest risk of experiencing a SUDI, such as teenage mothers or those who had smoked in pregnancy. In addition, by recruiting mothers who used the Plunket Well child/Tamariki Ora service, I did not access women who were disengaged from this programme. These mothers may have a different perspective on decision-making that would be useful to study. However, I was interested in exploring the way that population level advice is assimilated by the wider population of mothers and not just those with infants most at risk of SUDI. Therefore the findings may well be relevant for those professionals working with families in other higher deprivation areas who may not necessarily be at the greatest risk of SUDI.

## Chapter 4. 'They are dependent on you like a velcro baby': Living up to the Good Mothering Ideal

Tied in to the complexity of how mothers make decisions at night are the tensions experienced in living up to the 'good mother' ideal that is dominant in western culture. A 'good mother' is described as one who amongst other things is self-sacrificing, expert-led and child-centred (Hays, 1996). If a mother does not live up to these ideals, there is the potential for both social condemnation as well as a personal sense of failure. This sense of failure can be cumulative and comes at a formative time in mothers' lives.

The idea of a good mother is not static, but more nuanced and is redefined as the socio-cultural expectations of good mothering change over time (Porter, 2010; Thurer, 1994). When I write of a 'good mother' I am referring to the feminist derived body of work studying the ideology of motherhood rather than a specific set of skills (Goodwin & Huppertz, 2010). In this chapter I will explore through concepts from post-structuralist feminist theory how mothers navigate the 'myth of motherhood'. This is an expression used by Thurer (1994), to describe the impossible nature of living up to the 'good mother' ideal.

In this context of the good mother, I use Goffman's ideas of 'identity work' and 'impression management' to explore the dynamic of mothers' narratives around 'intensive mothering' ideology. Erving Goffman (1959) likened the way we present ourselves to a theatrical performance. Individuals are actors who have both a front and back stage persona, the front being public, and the back stage, private. The backstage is an area where 'the performer can relax, he can drop his front, forego his speaking lines, and step out of character' (Goffman, 1959, p. 115). Whilst caring for an infant at night is backstage work, the discourse around decision making and behaviour is front work, as it often involves discussions with family, friends and health professionals. In practice, mothers are required to negotiate perceptions of themselves as 'good' or 'bad' mothers. How they do this is explored in this chapter within the context of intensive mothering ideology.

## Theoretical Background: Intensive Mothering

As early as the eighteenth century, there was evidence of discourse around feminist issues. Mary Wollstonecraft's (1792) pivotal work *The Vindication of the Rights of Women*, argued that women would be better mothers if they had equal opportunity to education (Tong, 2013). Ironically, while Wollstonecraft argued for equality, there was no expectation that women would be anything other than mothers. Since this time and especially during the first wave of feminism, the notion of equality for women and mothers was a key focus of feminist discourse. Some academics perceived this focus as anti-mothering. As Ann Oakley wrote in 1979:

the concerns of organised feminism since the 1960s have been with freeing women from their child-bearing and child-rearing roles...The ability to grow and breastfeed babies and give birth to them in pain but with satisfaction is only now beginning to be seen by feminists as a valid and valuable aspect of being a woman, a resource to be drawn on rather than a burden to be disposed of (as cited in Porter, 2010, p. 11).

Adrienne Rich (1976) was also a key, if somewhat more radical scholar on the topic of mothering at this time, distinguishing between 'mothering' as a biological imperative and the patriarchal oppressive 'institution of motherhood'. She argued that mothering could be empowering; the paradox for mothers was that of maintaining the empowering and enjoyable elements of being a mother, without the restraints and oppression of the patriarchal 'institution' of motherhood (Blum, 1993).

The assumed homogeneity of mothers in early feminist discourse, as being white, middle class, married and heterosexual, was questioned by African-American scholars during the second wave of feminism. As a result, feminist writing has since expanded to include other class, race and social groups (Arendell, 2000; Porter, 2010) within topics such as: mother's identity (Laney, Hall, Anderson, & Willingham, 2015; McMahon, 1995; Rittenour & Colaner, 2012) moral motherhood (Lee, 2011; Liamputtong, 2006; Wall, 2001) and mother's lived experiences (Avishai, 2007; Lupton, 2000).

Since the 1990s the dominant ideology has been 'Intensive Mothering' (Hays, 1996), also referred to as The 'New Momism' (Douglas & Michaels, 2005) and 'Total Motherhood' (Wolf, 2010). The Intensive Mothering ideology as I will refer to it herein, is described by Hays (1996), as 'a gendered model that requires mothering to be child-centred, self-sacrificing, expert-led and emotionally, physically and financially intensive' (p. 8). In recent times, some feminist mothering literature has focused on debunking the myths surrounding this intensive mothering ideology, citing the expectations of mothers as unrealistic and unattainable (Douglas & Michaels, 2005; Hays, 1996; Thurer, 1994). It should be noted here that although the latter attribute of mothering as being 'financially intensive' has been explored in the literature, it was not a theme that arose in my study.

Hays (1996), traces the roots of intensive mothering ideology to the 'moral' mother of the late 18<sup>th</sup> and early 19<sup>th</sup> centuries. During this time there was a dramatic shift in the way children were regarded. They were no longer viewed as sinners, as they had been in Puritan times, but as innocents in need of protection. Mothers in turn focused on maintaining the innocence of the child and became the 'shepherdess, leading their flocks on the path of righteousness' (Hays, 1996, p. 30). Middle class children were no longer seen as economic assets to be sent out to work. Rather, the focus was on developing morals and manners. In order to develop these, the mother-child relationship became important.

Child rearing was seen no longer as the domain of servants, wet nurses and others, but rather the mother. It was at this time, that maternal instincts were deemed insufficient and mothers had to be 'scientifically trained' (Hays, 1996, p. 39). This saw the rise of scheduled feeding and leaving the baby to cry. At about the same time in New Zealand (1907), the Royal New Zealand Plunket Society was formed by Dr. Truby King, to provide guidance for mothers and infants (O'Reilly, 2010). Mothers were warned not to spoil their baby by feeding on demand, bringing the baby into bed or handling them too often. 'Spoiling' King warned, 'may be as harmful to an infant as callous neglect or intentional cruelty' (Kedgley, 1996, p. 51). King's book *Feeding and Care* (1908), became very popular in New Zealand and his later infant

care books were given to all marriage license applicants (Plunket, 2015b). King determined that:

By teaching, training and helping mothers in motherhood and mothercraft we can ensure as far as possible, that every new arrival and potential parent of the future shall grow up strong, healthy and capable, and fit in due time for full citizenship and ideal parenthood... (from 'Natural Feeding of Infants' as cited in King, 1947, p. 130).

Conforming to Plunket's instructions, and recording an infant's progress against Plunket feeding, sleeping and growth targets became the norm in New Zealand (Kedgley, 1996).

Several feminist scholars have traced the origins of intensive mothering as we now know it, to the latter years of the Second World War. As the war drew to a close, jobs which had been taken up by women, were required again for returning servicemen. As such there was political and social pressure for women to return to their domestic home-maker roles, and to maintain social order by raising 'moral' children (Hays, 1996; Johnson, 2014; Kedgley, 1996).

The rise of maternal attachment theorists such as John Bowlby, who argued that infants needed to be close to their mother to form a bond, become popular (see Bowlby, 1977). Dr. William Sears, a prominent parenting 'expert' in the USA, developed attachment theory into a parenting practice that required closeness through breastfeeding, baby wearing (the practice of keeping baby close by wearing or carrying a baby in a sling or other carrier), and co-sleeping. These parenting practices are still prevalent today. Attachment parenting is commonly cited in the literature as a euphemism for intensive mothering (Afflerback, Carter, Anthony, & Grauerholz, 2013; Douglas & Michaels, 2005; Hays, 1996). Porter (2010) notes that with the rise of attachment parenting 'the 'good mother' now was the mother who wanted children, loved them unconditionally and was constantly available to them' (p. 10).

In recent times, the ideology of intensive mothering has been criticized, most notably by the French scholar Elisabeth Badinter (2012), as creating a

generation of privileged children and over-tired mothers, which has 'stalled women's progress towards equality' (p. 3). Badinter's solution is that women should simply stop being so intensive in their mothering. This argument however, ignores the embedded social and cultural norms that dictate intensive mothering as the dominant ideology. Academic literature is clear that the cultural contradictions of motherhood first highlighted by Hays twenty years ago, continue to exist today. For example, several academics highlight how the ideology continues to be reinforced through the use of mass media, the internet and celebrity mothers who are portrayed as perfect specimens, living up to the myths of motherhood (Brown, 2014; Chae, 2015; Collett, 2005; Douglas & Michaels, 2005). Brown (2014) explores how advertising uses the norms of intensive mothering to create an image of the perfect mother who 'can do it all' (section 2, para 1); looking pretty, fit and always available with the right advice for her child. Douglas and Michael (2005) also examine how the myth of the perfect mother is perpetuated in television programmes and magazines. In this chapter I am interested in analysing how the decisions of mothers in this research were influenced by this dominant ideology.

### Mothering as Self-Sacrifice

Women in my study seemed drawn, whether consciously or otherwise to the ideology of intensive mothering. One of the key tenets of intensive mothering is that to be a good mother, a woman should devote her 'entire physical, psychological, emotional and intellectual wellbeing, 24/7, to her children' (Douglas & Michaels, 2005, p. 4). Mia was typical of the women I interviewed, who spoke of dedicating themselves exclusively to their infants:

*I just think that if you're going to have a baby that you should dedicate your time, at least the first 3 months like just all to them...I dunno...like rather than leaving him to cry or whatever, you should just go straight to them and tend to their needs...*

For Mia, mothering was a verb, in that it was something she 'did', rather than a noun to describe her status as a mother. Mia's comments are reflected in the literature on good mothering which suggests that a good mother

sacrifices her own needs for the sake of her children (Liamputtong, 2006; Lupton & Fenwick, 2001; Murphy, 1999). Advice on the importance and practice of mothers' sacrifice is everywhere for new mothers including in books and more commonly online<sup>5</sup>. It is interesting to note that whilst these sources of advice often make reference to both father and mother, both Hays' (1996) British study of 20 years ago and a more recent American study by Huisman and Joy (2014), found that it is still mothers who take on the responsibility for this intensive infant care. This suggests that while parenting books are changing their discourse around infant care, socio- cultural norms have not yet evolved to this extent.

Parenting books and websites commonly refer to the new-born period as the 'fourth trimester' whereby infants are completely dependent on mothers for their care. One popular parenting website [www.bellybaby.com.au](http://www.bellybaby.com.au) listed eight ways for parents to recreate a womb-like experience for their infant, including baby wearing, breastfeeding, and co-sleeping. These all require mothers to sacrifice their bodies and personal space in ways that the alternatives do not. Consequently, a mother's sacrifice has been likened to the selfless ecclesiastical icon of the Madonna (Breen, 1975 in Weaver & Ussher, 1997). This sacrifice can take the form of giving bodily of themselves, in the form of providing breastmilk, sacrificing their own needs for sleep or giving all their time and energy to the infant. As Penelope Leach (2010) notes in her best-selling childcare book:

Stop. Listen to him [sic]. Consider the state that his crying has got you into. There is no joy here. Where is he happy? Slung on your front? Then put him there. Carrying him may not suit you very well right this minute but it will suit you far better than that incessant hurting noise... (p. 12).

Caitlyn, a young mother, illustrated this Madonna-like sacrifice. In discussing what she thought made a good mother, she replied:

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<sup>5</sup> See books such as: *Your Baby & Child* (Leach, 2010) , *Baby's First Skills* (Stoppard, 2009) websites: [www.kidspot.co.nz](http://www.kidspot.co.nz) , [www.slingbabies.co.nz](http://www.slingbabies.co.nz) and magazines: *The Natural Parent Magazine* (see:[www.thenaturalparent.co.nz](http://www.thenaturalparent.co.nz))

*I just reckon they should put their child first at all times, that's what I do...like I get told, like if she's upset or something and I'll be told, no, just go and have your food, go and have your dinner, and then, no I don't do that...I just always put her first before everything else, make sure her needs are met and everything... clean, fed, (laughs)...as long as she's happy that's it pretty much*

Caitlyn epitomized the role of the self-sacrificing 'good mother'. Despite, having spent many weeks sitting on a couch feeding and holding her unsettled 'colicky' baby late into the night, she merely laughed at the inconvenience and described it as 'enjoyable' as her baby was 'entertaining'. Caitlyn's identity as a good mother was further reinforced when it came to her avoidance of risk taking:

*I wouldn't put her on her stomach 'cause anything could happen...I'd just try to make her settle another way...like a few times she would get really upset so I'd chuck her in her pram and walk around the house like that...so I'd just try heaps of different things to settle her...even if it was the only thing that would settle her, I'd put up with the crying (laughs)*

Caitlyn's description of sacrificing her own sleep and putting up with the crying to avoid risk [of tummy sleeping], needs to be understood in the context of a societal norm which suggests that a good mother will reduce even miniscule risk to their infant, despite the cost to the mother (Wolf, 2007).

Lauren was another mother who sacrificed her own needs for those of her infant. Lauren had little family support in the city, a partner who worked outside the home, and a very unsettled baby. She took pride in her ability to just keep going. Her partner only became involved in the night-time care when Lauren was literally at breaking point:

*I got to the point where I was like, I'm so tired and I'd almost start crying when he started to wake up again 'cause I'd be like oh no...and then I'd do it again, and then the last night I remember he actually had a cry in his cot for a good 30 minutes, 'cause I couldn't pick him up, I was so tired that I had no strength and that's when*



*my partner had to help because I was like, I need to change him but I physically cannot lift him, I'm scared I'll drop him, and so that's the night when his dad had to get up and help.. and it got to the point where I was just dropping everything, um, dropped the jug, I was walking into stuff, I went to go make a bottle with the boiling water from the jug and I dropped it and it spilt all over me, the boiling water...and that's when my partner finally realized, and his Auntie came round, took him for a day, just so I could have a break....I got some sleep and I've been fine since...*

Lauren's comments suggest the dominant discourse of intensive mothering led her to normalise self-sacrifice, especially as she went on to say '*I got some sleep and I've been fine since*'. It is as though being so tired, that you pour boiling water on yourself is just a normal part of the role of mothering. However, for Lauren, her role as main caregiver also provided her with a purpose in life:

*Um, it's been difficult at times, but I mean you know, I only turned 21 when I was pregnant with him so before that it was just casual, free, no responsibility, go out and drink, go out and hang out with friends, and now I couldn't even imagine doing that, and it's kind of like, I never even seen myself having kids and now I can't imagine not having my son, that one break I did have, you know after half an hour of having a break by myself, I wanted him back and I just... it's right, you know, I don't have family here so I've got to focus now, I 've got someone who's completely dependent on me and it just kind of gives you purpose each day*

Lauren and Caitlyn appear to engage in what Goffmann (1959) described as 'identity work'. This attention to identity work is described as a 'narrative process of self-making that mothers engage in as they raise their children' (Faircloth, 2014). For Lauren and Caitlyn becoming a mother gave them purpose, and their sacrificing helped them develop their mothering identity.

Other women in my study were more open about the physical and emotional toll of their self-sacrifice:

*I was just exhausted and I was stressed...and um I didn't know it was gonna be this hard and she was very very demanding...but no matter what goes on, no matter if baby's stressing you out or...if you're exhausted and can't deal with anybody...you have to persevere...to me that is your only option, because as a mother, the baby relies on you, like he/she knows you...you've been carrying her for 9 months, and then they come out and they know you, they know your heartbeat, everything and so it's like, they are dependent on you, like a velcro baby (Rae)*

*I knew babies were hard but I had no idea how hard they could truly get...it was horrendous, um we ended up... we...basically didn't sleep, 5 hours a week sleep if we were lucky... Yeah, I was a mess...yep it was very hard...sleep deprivation...all the pain of childbirth, healing, and then the breastfeeding, oh it was ohhh uggh, I don't like thinking about it (laughs) (Fiona)*

Although Fiona talked about the physical toll of mothering, she made light of the sacrifice as good mothers who are intensive parenting are meant to do:

*Even at our wits end and stuff, the priority was always taking care of the baby and making sure she was okay... I wanted to do the right thing, want to do it properly, so like I use reusable rather than disposables, even though I found breastfeeding was extremely painful and it was really hard in the beginning I still persevered with breastfeeding 'cause I wanted what was best for my baby, I wanted her to have all that immunity, I want to give her the best chance possible for the future, so...my little hardship was nothing in comparison to the benefits for her... (Fiona)*

Mothers were so willing to share with me examples of their self-sacrifice, it made me reflect on their motivations for sharing so openly on this particular topic. Goffman's (1959) ideas on the presentation of self would suggest that mothers were engaging in 'impression management'; whereby mothers present a 'front stage' persona that fits with social norms. In this instance the front stage work is around meeting societal expectations of being a good mother. In discussing their self-sacrifice so openly, participants were

confirming their identity as a good, self-sacrificing mother. Equally their willingness to engage in this discourse could be seen as a desire to compete with other mothers. Narratives around competitive mothering have been noted as prevalent and influential in other studies (Crane, 2014; Lupton, 2011; McHenry & Schultz, 2014), with Crane (2014) noting these competitive narratives are more a western cultural phenomenon.

McHenry and Schultz (2014) investigated how competitive behaviour between mothers is fuelled by intensive mothering ideology. They found numerous articles from websites, magazines and blogs acknowledging how competition between mothers undermines feminist goals of empowerment and equality for women. The authors concluded that a new principle of intensive mothering has evolved; that of mothers demonstrating to *others* their intensive mothering. Although their study was undertaken in America, aspects of their findings were also apparent in my study. While I did not specifically ask mothers about comparisons and competition between and with other mothers, several women made comments hinting at an agenda of competition. Lauren mentioned that *'we do kind of judge others' parenting, which can be good or bad.'* The idea of judging others could be seen as a way for mothers to consolidate their own sense of righteousness and morality or as a way to boost their own self-worth. Rae commented on the competitive element of being jealous of what some mothers manage to look like after a baby:

*This is what I don't get...like I envy this sometimes, like how mothers can have babies and like they look like models already and I'm like 'how do you do that?, like teach me, how!...It looks like they didn't even have a baby...got all this makeup on... like my hair was tragic, like I've only just started straightening it*

Rae's comments about other mothers looking like models also highlights the absence of discourse around being a 'yummy mummy'. The term is common in Britain to describe a certain type of mother, who is often older, with an established career and disposable income, for whom living up to celebrity standards of beauty and body shape are important (Allen & Osgood, 2009; Littler, 2013; McHenry & Schultz, 2014). The mothers in my study were living

in a lower deprivation area, and may have had less disposable income. This may explain the lack of discourse around 'yummy mummy' ideals in my study. In addition, the pursuit of perfection for the 'yummy mummy', contradicts the self-sacrificing nature of intensive mothering; as it requires the mother to spend time focusing on herself and her body.

Rachel spoke of another group of mums who met for coffee at the same cafe as her group: *'then there's always another group, and they've always got the perfect hair and nails...I couldn't do that'*. She did not elaborate on why she 'couldn't do that', but it does suggest an awareness of 'other' mothers and a judgement of priorities that differ from her own. While mothers do not share expectations of being a 'yummy mummy' in relation to themselves, their awareness of mothers fitting this description, does provide an insight into another layer of social expectation placed on new mothers.

In contrast to the competitive element of mothering, Rachel spoke of her antenatal group of mothers as a source of encouragement and support:

*Um, we're really supportive, we talk on Facebook all the time, we've got our own website...so we just put up ideas, and someone will say, Oh I've done this, or try it this way, or have you tried this or have you tried this product...we'll put up milestones or photos, like 'yay, baby slept for 12 hours last night' or....it's a really supportive group, it's nice knowing that they are there*

Rachel had a baby that slept through the night from four weeks old. I cannot know if other mothers in her antenatal group interpreted comments like 'yay, baby slept through the night' as supportive or disempowering. An infant sleeping through the night was seen to be a sign of success; whether that be of the mother, or the baby, I could not ascertain. Keira highlighted this societal expectation:

*Everyone keeps saying, 'oh is your baby sleeping through the night yet?' and I'm like, 'well is he supposed to be?'...you know like, 'cause he's not and you know you hear of people saying that their babies are, and then you're like, well what are we doing wrong...is it 'cause we're breastfeeding or bottle feeding or...you know just all*

*this stuff....it is some kind of pressure on you...like am I doing something wrong...?*

Having a baby that did not yet sleep through the night, led Keira to question what she was doing 'wrong,' and her comments reflect a level of anxiety about her infant care practices. This is an example of the contradictions of the intensive mothering ideology, whereby a good mother is defined by her 24/7 dedication to her infant, yet we define a 'good baby' as one who sleeps through the night, and as such is independent of its mother. As Thurer (1994) argues:

Current standards for good mothering are so formidable, self-denying, elusive, changeable and contradictory that they are unattainable. Our contemporary myth heaps upon the mother so many duties and expectations that to take it seriously would be hazardous to her mental health (p xv1).

#### Mother as Primary Caretaker

Douglas and Michaels (2005) argue that the rise in intensive mothering, or as they term it 'the New Momism' is based on a belief that 'women remain the best primary caretakers of children' (Douglas & Michaels, 2005, p. 4). Given the historical context of feminist struggles for gender equality, I was expecting to find a more equitable sharing of night-time care duties between mothers and fathers. Instead, I found that all the women spoke of night-time care as their responsibility:

*I knew, I felt 110% she was my responsibility, I never would have expected anybody else to take her out of my hands, even in the early stages...while I was very thankful for someone to take her off my hands for 5 minutes but...I still, I guess, put that pressure on myself to be her 100% caretaker, do you know what I mean? Carer, looker-afterer, everything (Fiona)*

During the late 1980s and early 1990s there was a cultural shift to a more egalitarian attitude to parenting, whereby many mothers expected, and fathers wanted, to be more involved in childcare activities (Daly, 1993; Doucet, 1995; Lupton, 2000). The research at the time was predominantly

focused on gender roles, especially around housework. It is perhaps understandable that the focus was on housework because it is relatively easy to measure. However, this narrow research focus ignored the many other tasks that women leave behind when they re-enter the workforce as a mother. The consensus from the research at the time was that while there were expectations of egalitarianism, the reality was mothers were still taking on the greater responsibility of childcare and housework (Doucet, 1995).

Since this time, numerous studies have noted an increase in the amount of time fathers spend with their children (see for example: Paltineau, 2014; Pedersen, 2012). In particular, fathers were more likely to attend childbirth classes, be present at the birth and involved in childcare activities (Paltineau, 2014). However, studies focusing more specifically on the early months of infant care found that fathers were often less involved during this time compared to mothers (Barclay & Lupton, 1999; Schmidt, 2008). In my study, mothers talked about fathers' involvement predominantly in the early weeks, when fathers were on paternity leave and the mother was often still recovering from childbirth. Sally describes this scenario, and also confirms what Schmidt found in her 2008 New Zealand study, that often fathers want to be involved, but the mothers' breastfeeding can exclude them, especially at night:

*I was the only one who got up um...he got her for me when she was just new from hospital, 'cause I had a C-section so I took a long time to get out of bed (laughs). Um so he would get her in the first couple of weeks and bring her to me, um but he felt quite useless...because with his other daughter, my step daughter, she was formula fed from very very early on, so he did night feeds with her, so he felt like 'Oh I can't do anything 'cause I can't feed her', so he's taken a big step back even though he could have, after I fed her, gone and changed her nappy and got her to get to sleep, but you know what's the point in both of us being awake...*

This biological difference, which determined that Sally took on the night-time care because of her ability to breastfeed, has been described in feminist literature as 'essentialism', whereby gender inequalities are attributed to an

'essential biological difference between men and women' (McDowell & Sharpe, 1999, p. 76). This essential difference is obvious in Keira's comments below, in which she suggests her breastfeeding makes it more logical for her to get up in the night:

*I always do the night, that was always my thing...I'm just better with no sleep than he is (laughs), he doesn't handle no sleep very well, so...and I guess because if Z cries and by the time R (partner) gets up and heats the bottle I'm already awake...and it's 10 times faster just to breastfeed than to actually heat a bottle up, wait for it to cool, then get it to him...I could have done the whole thing by that time, and I'd be awake anyhow if I hear him cry, so...yeah, it's just always been that I do it*

Protecting fathers' sleep, was a common reason cited by the women in my study as to why the father was not more involved at night. Carlee commented that her partner '*gets quite tired easily and obviously he has to work all day and has to concentrate a bit at work, but um...so it's hard for him to have the baby*'. Her comments suggest that caring for an infant requires less concentration than her partners' paid employment. Talia also highlighted the need to protect her partners' sleep when she spoke of his limited role at night:

*Yeah, he actually tries to do quite a lot, because he can sometimes work 12 hour days, I was... 'cause, oh.... 'cause I smoke...that was kind of like, if you hold him while I go for a smoke then I'm happy...and um that worked.. I know he wished he was allowed to do a lot more but it's bad enough having one parent who's tired than two...so yeah just made it work*

The comments above suggest that these mothers do not perceive their own sleep to be as important or as in need of protecting as their partners. This may be due to the financial rewards of the partner's work and the importance of this to the household.<sup>6</sup> However, protecting partners' sleep was also a

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<sup>6</sup> New Zealand Paid parental leave provides mothers and adoptive parents in permanent employment, up to \$516.85 per week for a period of up to 16 weeks, and unpaid leave up to 52 weeks (Inland Revenue, 2015). Whilst some mothers were on paid maternity leave, some were on Work and Income

theme where the partner was not in paid employment, and for those mothers who had already returned to work part-time. When juxtaposed against the earlier comments from Keira, about being so tired she poured boiling water on herself, the self-sacrificing comments of the mothers above highlight another cultural contradiction of living up to intensive mothering ideology. The expectation was on the mother, rather than the father to sacrifice sleep. The role of the mother at home with the baby (and presumably doing all or most of the work to be done in the household) is not seen as 'work' in the same way that paid work is. It suggests that the partner's paid employment takes precedence over the mothers' child raising duties. Earlier forms of feminist thinking by academics such as Rich (1976), would argue that this construction reinforces the devaluation of women's unpaid work of caring for their infants and reinforces the patriarchal institution of motherhood.

There was also an underlying sense of mothers as superior to fathers in the role of infant care. It has been suggested that these beliefs of superiority lead to maternal gatekeeping, whereby without necessarily being aware of it, mothers relegate their partners to that of helper (Gaunt, 2008). This was noticeable in several interviews:

*He's been very involved from word go, but because he's ...not around her 24/7 and...he doesn't always quite understand what she's screaming for and what she wants...and if he's tired he'll leave her to scream a bit longer than I would personally like...before he tends to her needs (laughs) which annoys me (Fiona)*

*...they [partners] don't have the same bond as like us, like we carry them for 9 months and get them out, and we're pretty much like their first person and so yeah...so he didn't know, he didn't even know how to comfort (Rae)*

While some mothers' beliefs around appropriate care led them to exclude their partners from night-time care, for others, beliefs around traditional gender roles led to partners excluding themselves. It is important to note here that I did not interview fathers, so my observations are based on

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benefits, some had already returned to work part-time. One mother was being pressured to return to work before the end of her leave entitlement period.



mothers' accounts. When asked about her partner's role at night-time, Lauren laughed and replied:

*There is no role (laughs). I wish! Because he works all week, yeah, he works all week so I don't expect him during the week days to help, and then in the weekends he just sleeps through everything...it's a bit of an argument causer at times (laughs), 'cause it's kind of like, 'well it's your day off you could be helping'*

Lauren's laughter when she spoke of the lack of support from her partner suggests she has accepted the situation, although she may not agree with it. The division of labour between herself and her partner echoes 'traditional functionalist theory' developed in the 1950s by Parsons (as cited in Barnett & Hyde, 2001). The theory was based on a belief that families functioned optimally when the man (husband) went out to work and the wife stayed at home to care for their children. Stacey and Thorne (1985), noted that although feminists were quick to argue against this theory, the notion of gender roles has become one of the most embedded forms of inequality for women. Although those comments were from the 1980s, the discourse on gender roles below suggests that similar beliefs do still exist today:

*He [partner] was so good in the first 2 weeks and then it just sort of went south after that...he just got that motto that he goes out and works and I look after the baby (laughs)...yeah which I struggle with quite a lot....like it gets to the weekend and I'm like he could possibly do a night feed, she is bottle-fed but he doesn't want to...yeah, and one time he was like, 'oh I just can't get myself up' and I was like, 'I have to do it every night of the week'... if I whinge for ages about it, he'll finally do a feed... and one time my mum came and stayed and she was like, 'Oh I'll do the night feed for you' and I was like, 'oh thank you' and he was like 'why's she doing that, isn't it your job?' (Laughs)...so he sees it as this is my job and his job is to go out and work (Sara)*

There are elements in this quotation that support Parson's notion of the family working best when gender roles are constrained. Nevertheless, Sara

challenges this idea, telling me she would prefer to share the night-time feeding. In addition, Sara was intending to return to work in the near future:

*He's [partner] gonna get a bit of a shock when I go back to work 'cause I'll go back to work once she's 14, 15 weeks old, probably only do part time, maybe like 20 hours a week but um, yeah he's gonna have to suck it up and start helping a little bit I think... 'cause he's got it pretty good*

Sara's expectation of her partner's input to night-time care when she returns to work suggests a desire to challenge functionalist understandings of gender roles. It highlights her disillusionment with social norms that dictate that she, as the mother, is the best person to care for her infant at night.

Although mothers talk of themselves as the primary caregiver at night, it is important to note here, that mothers are not necessarily talking about being isolated. Discourse on general mothering support from friends, family and/or mother support groups was common. In non-western cultures it is still common to find extended family helping to raise children (Abel, Park, Tipene-Leach, Finau, & Lennan, 2001; Crane, 2014; Gantley, Davies, & Murcott, 1993). For example, a New Zealand study of Māori and Pacific Island mothers, found it was common in New Zealand based Pacific Island families for a new-born to be the responsibility of not just the mother, but the extended family (Abel et al., 2001). This appeared to also be the case for the two Māori mothers in my study. One mother was living with extended family, including her parents and grand-parents and the other spoke at length about the everyday support she received from her mother. The remainder however, most of whom were New Zealand European, lived independently of extended family. While some spoke of grandparents caring for their infants at times, they were not intimately involved in the day-to-day care or decision-making surrounding the infant. Mothers did not talk about this in a negative way, as though they were nostalgic for more traditional extended family support. Rather, the notion of independence to make their own decisions was strong:

*I kind of like that I do all the decision-making, that I don't have annoying parents here telling me what to do and stealing my child constantly, and that I'm the one doing it all, although sometimes I*

*think it would be great to have them here to take him off my hands and to make the big decisions, ...handle him with his injections, but I don't think I'd change it, all its gonna do is make me a stronger mother in the long run, so if I ever decide to do it again you know, I'll be able to do it easily (Lauren)*

Whilst mothers in my study celebrated their autonomy in decision-making, both the expectation to make the 'right' decisions with regards to their infant, and the impossibility of living up to the ideals of intensive mothering, conspired to produce levels of guilt in mothers. The idea of mother guilt is not new. In 1978, it was noted that 'the desire for perfection, the nature of consumerism, and the proliferation of 'expert' advice was contributing to frustrations within motherhood' (O'Reilly, 2010). Mother guilt was identified by Hays (1996), as an outcome of the cultural contradiction of intensive mothering, and this theme continues to be linked to feelings of being a 'bad' mother today (see Ennis, 2014).

### The 'Other' Bad Mother

One of the ways we construct our definitions of normal is by constructing something else as abnormal; in this case the 'good' mother versus the 'bad' mother. Some social theorists have suggested that the 'existence of a dominant privileged social category depends on the existence of a pathologized *other* for their identity' (Rosiek, Heffernan, St.Pierre, & Jackson, 2014, p. 730). Some versions of feminist theory around mothering have discussed this dichotomy in relation to breastfeeding, with formula feeding regarded as the unspoken 'other' to being a good mother who breastfeeds (Barclay & Lupton, 1999; Knaak, 2010). In regards to intensive mothering ideology, Vissing (2014) notes that 'with the perfect mother fantasy comes its harsh negative counter-pole: the idea of the bad or terrible mother who can be blamed for her child's sufferings or failures' (section 3, para. 3).

Both of the women who smoked in my study referred to themselves as bad mothers: *'I couldn't help smoking so much.... it was real bad, I was so bad, and I feel bad about it '(Ngairé)*. Keira talks in a similar way: *'I had it so*

*drilled into my head that like he's gonna stop breathing and it's gonna be my fault, 'cause I'm a smoker (laughs)'.*

In providing a public 'front stage' persona of being a good mother, women shared that they didn't always tell 'experts' (mostly Plunket) when they were not following their advice. For example, Sally talked about how 'they [professionals] ask if they're sleeping every sleep in their own bed and you say yes, even if they're not, 'cause you just don't want the yes, but...'. This is the same mother who was wracked with guilt when she didn't follow expert advice:

*S: a couple of times, naps, I couldn't get her to go to sleep...I'm gonna sit down on the couch with her to get her to sleep, 'cause that's what works and I would doze off and then feel guilty about it for the next week*

*J: So even though nothing happened, it was still that guilt, that you'd done something wrong or that you'd done something that might have hurt her?*

*S: So I guess it was, you're just told that you shouldn't do it, so you felt like you've done something wrong...so you're against the rule...bad mother 'cause I've let her sleep on me again...bad mother 'cause I've got her into bed with me again...guilt...[New mums should] try and get rid of the guilt.*

Ironically Sally's intensive mothering whereby she sacrificed her own needs for her infant, led to her falling asleep in the potentially risky setting of a couch. In turn, this also led to her feeling like a bad mother for not following the perceived rules around caring for her baby.

Mothers described good mothering in terms of sacrifice and always putting the baby's needs first. In contrast, a 'bad' mother was one who did not prioritise their baby:

*Like a not so good mum to me is one that just goes out and gets on the piss and leaves their kid all over the place or takes their kid, like I've seen it and I'm like, how can you do that, like all the time, like these, like some people I know that do that...and I'm like, I don't*

*know how the hell you can do that.. and your kid's probably hungry and...or their kid is hungry and they're like 'go away'...you know, like before I had a baby I knew these mums, they weren't my friends, they just, to me they were just not good mums, like they would all just get on the piss, take their kids you know and they were out till like 10 at night with their baby and their baby's in the same crap they were wearing all day...I just did not like that....made me want to like ...want to hurt them (Ngaire)*

Ngaire's discourse links back to Goffman's identity work, in that she is constructing a coherent sense of self that she can live with. In relation to the 'other' mothers described above, Ngaire can orient herself in the 'good mother' camp. She has distanced herself from the 'bad' mothers, explicitly telling me that they weren't her friends and describing feelings of anger towards them and their bad parenting. Ngaire had not left this partying side of her life behind. However, she could identify herself as a good mother because she gave her baby to her own mother when she went out drinking: *'cause I'm on the piss I don't want to be a mum at the same time...that would not be cool...I wouldn't like that, I wouldn't do that, 'cause I wouldn't like that'*. Ngaire differentiates her 'mothering' self from her 'social' self. Ngaire had support from her mother to care for her baby, which may not be available for the other 'bad' mothers that Ngaire talks about. Ngaire's comments also highlight class differences in mothering as noted by Hays (1996). Whilst middle class mothers identified bad mothers as those who were more concerned with their own image, working class mothers described bad mothers as 'those who are too lazy or too preoccupied with drugs, alcohol and boyfriends to properly supervise their kids' (Hays, 1996, p. 87).

Being a 'bad' mother was not an identity that any of the mothers in my research wanted to cultivate, with socio-cultural norms appearing to place a high value on mothers achieving 'good mother' status. In turn, mothers presented a front stage persona that fit with these norms. However, the impossible nature of always living up to the good mother ideal, again highlights the paradox involved with this social expectation.

## Summary

The comments of mothers in this chapter highlight both the dominance of intensive mothering ideology and the cultural contradictions that exist in attempting to live up to the ideology. Socio-cultural expectations of mothering as self-sacrificing and essentialist, whereby women are viewed as innately the best carers, appear to remain embedded in our society. This is despite the feelings of guilt, anxiety and exhaustion that many mothers experienced in subscribing to the 'myths of motherhood'.

Despite all the women in my study having partners, essentialist notions of the mother as primary carer appeared to be firmly embedded, at least for these early months of life. Büskens (2001) argues: 'the problem is not the fact of this requirement [for intensive nurturing of infants] but rather that meeting this need has come to rest exclusively, and in isolation, on the shoulders of biological mothers' (p. 81).

Hays (1996) originally identified intensive mothering as a white, middle class phenomenon. Ennis (2014), argued that this ideology has now evolved to include different social classes, albeit unequally. My study supports this assertion. Although I chose not to ask about socio-economic status, I can extrapolate to some extent, from the fact that the women lived in a more socio-economically deprived area of Christchurch. The 'financial' element of intensive mothering was not present in my study and this may be due to a lack of disposable income, although I cannot know this. Nonetheless, mothers still engaged in the other elements of intensive mothering. A further tenet is that of being 'expert-led'. Whilst infant care decisions are privatized and made away from the public gaze, they are also influenced by warnings and advice from others. Accordingly, the next chapter will examine the influence of experts in maternal decision-making about night-time infant care, and how mothers make sense and act upon advice they are given by so called 'experts'.

## Chapter 5. 'I didn't just go through the whole pregnancy and birth to have them die in their cot': Managing Risk in the Context of Expert Advice

A perception of infants as fragile and in need of protection from an ever increasing number of risks has emerged alongside the rise of intensive mothering ideology (Lee, Macvarish, & Bristow, 2010; Lupton, 2011; Nelson, 2008). One of the well-publicised risks that mothers manage is that of an infant dying in their sleep.

The term 'risk', when applied to infant sleep, is used to denote a threat to infant safety. Initial SUDI research focused on socio-economic factors and infant care practices to identify which infants were at 'risk' of SIDS (Mitchell, 2009a). As Douglas (1992) noted, 'the word 'risk' means danger, 'high risk' means lots of danger' (as cited in Lupton, 2013b, p. 9). Depending on risk factors and risk taking by parents, infants can be classified by experts as 'at risk' or at 'high risk' of death. As seen in the previous chapter, society often constructs this type of risk taking as being associated with 'bad' mothering.

Lupton (2013b) describes three ways that risk is commonly addressed by social scientists. These are: the technico-scientific perspective, defined by its basis in technical and scientific understandings of risk; cognitive psychology, using psychology to explore how individuals respond to risk; and social constructionism, a perspective that views risk as constructed within social and cultural contexts. Beck (1992) and Giddens (1991) argue that we are a society preoccupied with reducing risk. Their ideas will be used to discuss how the technico-scientific perspective of risk has come to be the dominant worldview with regard to infant sleep safety. In the previous chapter, the guilt that mothers experienced when they did not follow expert advice was one aspect of intensive mothering that was examined.

In this chapter, the concepts of 'experts' and 'risk' will be explored in more depth with regards to mothers being encouraged to follow 'expert' infant sleep advice. This chapter will also explore how mothers make sense of the expert-led technico-scientific assumption that if mothers know the potential hazards associated with infant sleep, they will always act in ways that

mitigate these hazards. Examining the role of so called 'experts' and expertise on the topic of infant sleep is important because of the dominance of scientific discourse in this area. This includes the MOH recommendations, based on epidemiological risk factors and the dominance of science-based risk in the debate around bed sharing. With regard to risk, the objective of this study was to explore how mothers weave considerations of risk into their night-time infant care decisions, rather than assessing mothers' knowledge of risk per se.

### [Theoretical Background: Technico-Scientific Perspective of Risk](#)

As discussed in the previous chapter, the ideology of intensive mothering places responsibility for ensuring the wellbeing of infants, firmly in the hands of mothers. Decisions about 'risk taking' are therefore highly relevant in the context of this prevailing ideology. In addition, it has been argued that we live in what is becoming a 'risk society' (Beck 1992). Sociologist Ulrich Beck argues that not only have people in western societies become more aware of possible risks, but that risks have become the 'cornerstone of a new modernity' (Wolf, 2010, p. 50). The term 'risk society', has been used to describe 'a systematic way of dealing with hazards and insecurities induced and introduced by modernisation itself' (Beck, 1992, p. 21). In using the term 'modernisation', Beck and Giddens appear to mean the period of time in the late 20<sup>th</sup> century when the process of cultural, social and economic change intensified. As the process sped up it created our new modern society preoccupied with risks (Ransome, 2010).

Although the risk of dying during childbirth or early infancy has reduced dramatically from a century ago, the new 'modern' world provides different risks to be avoided. An example of this process is the increased risk of death for infants whose mothers smoked in pregnancy. Tinkler (2006) argues that smoking has changed from being the domain of males in the 1800s to being an equal practice in contemporary times. Accordingly, the modern phenomena of mothers smoking in pregnancy could therefore be seen as a 'hazard' that has been introduced by modernisation. Beck (1992) asserts that we are preoccupied with minimizing the risks that are a by-product of modernisation. It should be noted however, that Beck's definition of risk as



'bad' ignores the many supposedly 'risky' leisure pursuits that adults willingly engage in, such as base jumping and parachuting (Zinn, 2015). That is not to say however, that citizens are not aware of nor attempt to mitigate risks, whether these risks are willingly taken or not. Beck asserts that risk is so pervasive that he describes individuals as approaching life with a 'double gaze' (1992, p. 72); a sense that danger is everywhere and choices will have unexpected consequences which will only become known after the consequence has become reality. In a society where mothers are trying to live up to the ideals of intensive mothering, it is therefore understandable that a 'good mother' is seen as one who 'takes measures to minimize potential risks posed to her children' (Afflerback et al., 2013, p. 388).

Anthony Giddens, another influential sociologist, discusses risk society in terms of avoiding what people perceive to be future negative events. He proposes that because people view the future as unknowable, they approach it anxiously and with a 'calculative attitude' (Giddens, 1991, p. 28). Lupton and Tulloch (2002) note that a risk society is one where people live in fear, 'constantly dogged by feeling of anxiety, vulnerability and uncertainty in relation to the risks of which they are constantly made aware' (p. 113). Giddens perceives that as there are so many risks and so much information, people trust scientific experts to assess risks on topics they lack knowledge in. As a result, science becomes the prevalent method by which people assess risks and plan their lives (Beck-Gernsheim, 1996). However, this notion ignores the practice of 'reflexivity' that lay people engage in as they weigh up the merits of expert advice (Lupton, 2013b). The term 'reflexivity' is used by Beck to denote a 'response to conditions that arouse fear or anxiety that is active rather than passive' (Lupton, 2013b, p. 23).

As a result, both scientists and lay people must navigate the complexity of defining, assessing and managing risk in their own way. An example of this process for scientists is the change in MOH recommendations around infant sleep that occurred during the course of my thesis. The MOH draws on scientific literature, predominantly epidemiological data from SUDI studies, to define its recommendations for parents on how to protect infants during sleep. The MOH recommendation regarding infants sharing an adult space for sleep, published on their website, has been extended to advise that it is

now '*never* safe to put an infant in an adult bed...' (Ministry of Health, 2015c, my emphasis). The previous advice was that the practice was only risky for 'more vulnerable' babies (Ministry of Health, 2014). While this topic is still being debated in the literature, the MOH have utilized a version of epidemiological science to define bed-sharing as now 'risky' for all infants in the first year of life.

If mothers follow MOH advice, they will forego the known benefits of sleeping in bed with their baby, such as bonding, ease of feeding and settled sleep (McKenna & McDade, 2005; Ward & Salm, 2015), and ignore cultural traditions attached to the practice (Abel et al., 2001; Ball, 2006). While this strategy may potentially reduce the dangers associated with infant sleep, it may also undermine public health initiatives to increase breastfeeding as these often encourage bed sharing (Gordon, Rowe, & Garcia, 2015). A multivariate study by Chen and Rogan (as cited in Blair, 2010), found that post-neonatal mortality rates were 26% higher for bottle-fed compared to breast-fed babies in the United States. It has been hypothesized that the difference in death rates may be due to breast-fed infants sleeping for shorter periods of time than formula-fed infants (Elias, Nicolson, Bora, & Johnston, 1986). The length of sleep is important because the ability to arouse often is thought to be a protective factor against life threatening cardiac episodes associated with SIDS (Horne, Witcombe, Yiallourou, & Richardson, 2010; Mosko, Richard, & McKenna, 1997).

Blair (2010) argues that while the difference in mortality rates cited by Chen and Rogan above is not conclusive evidence, it does suggest that any changes that lead to reduced breastfeeding rates in the population may potentially increase infant deaths. Blair also argues that due to the complex interactions that occur between a mother and infant when they breastfeed and share the same sleep surface, 'advising parents to avoid co-sleeping may conceivably reduce the SIDS rate even further, but not necessarily infant mortality in general' (Blair, 2010, p. 69). It is not the case in New Zealand that breastfeeding rates are reducing, however it is important to bear in mind the possible implications of a 'no bed sharing' message on the practice of breastfeeding.

Mothers may engage in reflexivity as they weigh up the merits of this new 'expert' advice. Volpe, Ball, and McKenna (2013) note the complexity involved:

For social scientists, the question of where and with whom babies sleep does not have a right or wrong answer, but involves biology, history, cultural values, context and motivation to determine outcomes. Public health specialists, however, designate infant sleep locations as appropriate (e.g. infant-specific furniture such as cribs) or inappropriate (all other surfaces including non-infant specific furniture and adult bodies) (p. 84).

Volpe et al. (2013) highlight a contradiction between those who perceive infant sleep from a risk viewpoint, and others who may perceive infant sleep from an infant development perspective. Mothers must weigh up the advice from both sides in making their decisions.

This requirement to navigate risks is an ongoing concern for parents. Mothers in particular are already well versed in risk navigation by the time their baby arrives. The notion of mothers' sacrifice, as discussed in the previous chapter is also becoming embedded at this early stage. For example, during pregnancy, mothers are advised to be hyper-vigilant about what they eat and drink, to take multivitamins, avoid x-rays, have scans to check for foetal abnormalities and stay emotionally calm (Lupton, 2012). Even before they become pregnant, women are advised to become smoke-free, eat healthily, take folic acid, avoid stress and be mindful of the risks and complications associated with reproduction. As Wolf (2010) notes, women are 'propelled into a reflexive contemplation and routine assessment of how their actions might affect their ability to conceive' (p 76). Deborah Lupton (2011), suggests that any resulting abnormal foetal developments or outcomes are often attributed to the mother not acting in accordance with appropriate health promoting advice. Several scholars have noted that with the rise of a risk society, the responsibility of mothers to follow 'expert' advice to minimize risks has also risen (Knaak, 2010; Murphy, 1999), although not all women do follow this advice. From a gender perspective, the dominant discourse

here is focused on the woman and her reproductive and infant care responsibilities, and not the man and risks around his responsibilities.

Within the context of a risk society, it is logical to expect that official expert advice on infant sleep will be about reducing risk. The MOH website outlines ways for caregivers to reduce risk of accidental suffocation and SIDS<sup>7</sup>. Advice includes always putting the baby to sleep on its back, ensuring the baby has a clear face during sleep and is not exposed to smoke (Ministry of Health, 2015c). This advice focuses on ways parents can increase resilience and decrease an infants' SUDI risk. For example, sleeping on the back increases resilience by protecting an infant from hypoxic challenges and strengthens the arousal response (Garcia et al., 2013). Rather than highlighting the risks, the advice focuses on ways that enable parents to protect their infant (Cowan, 2010). In this way the message is focused on actions parents can take to safeguard their infant. For example, the advice is to place the baby on its back to go to sleep, rather than highlighting the 'risks' associated with putting the baby to sleep on its tummy. This population level advice sits within, what Deborah Lupton (2013b), refers to as a 'technico-scientific' perspective of risk. The assumption of the technico- scientific perspective is that risks are pre-existing and can be calculated and controlled using scientific knowledge (Lupton, 2013b).

Consistent with technico-scientific understandings of risk is the view that education and knowledge of objective quantifiable risks are key to behaviour change. This perspective is dominant in the thinking of many SUDI researchers. For example, recommendations from a recent article on infant suffocation deaths in New Zealand, suggest that the prevention of further deaths lies in supporting 'changes in family behavior with safety messages that are consistent, persistent and disseminated widely' (Hayman et al., 2014, p. 1). A similar recommendation was made by Chu, Hackett, and Kaur (2014) after reviewing notes associated with infant death cases in America. The authors recommended that not only should the focus be on telling parents what to do, but also on advising parents of the 'severity of the risk' (p. 8); in effect, that parents should be scared into action. The idea of

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<sup>7</sup> <http://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/helpful-advice-during-first-year/safe-sleep>

assessing risk is gaining momentum in the field of SIDS research. A recent study in New Zealand trialled the development of a 'risk assessment instrument [to identify] groups within the community as priorities for education about safe sleep practices beyond standard care' (Galland et al., 2014, p. 8).

The technico-scientific perspectives discussed above, infer that if families have knowledge of safe sleep practices, then the 'correct' behaviour will logically follow. This dominant worldview sees infant care as a set of logical risk factors to be navigated, and assumes that if mothers are aware of the risks, they will act in a very linear and rational way to mitigate them. The technico-scientific perspective infers that 'experts' know best, and mothers should not challenge this expertise. While it is important that mothers have knowledge of how to safeguard their infants in sleep, this worldview ignores the broader socio-cultural considerations of risk that mothers also consider when deciding on infant care practice.

#### [Navigating Risk with Support of 'Experts'](#)

In my study, several themes emerged about the role of health 'experts' and their advice in mothers' night-time infant care decisions. One dominant theme was that experts were just one of many sources of advice that mothers considered in their decision-making. Other sources of information included family, friends, the internet and ultimately the mother herself. Underpinning the technico-scientific perspective of risk is the idea of an all-powerful 'expert', or group of experts into which lay people place their trust. As described earlier, Giddens (1991) argues that trust in experts, provides a 'protective cocoon' to 'bracket out' potential occurrences, which, were the individual seriously to contemplate them, would produce a paralysis of the will, or feelings of engulfment' (p. 3). With regards to infant sleep, the suggestion here is that without experts, a mother would not know how to act to protect her baby. In turn, this may 'paralyse' the mother into doing nothing but worry about the risk her baby faced at every sleep event.

The comments of some mothers in my research reflected this process of managing risk through engaging in 'trust' in health professionals as scientific

experts. It was common for mothers to talk about receiving advice from health professionals such as their midwife, Plunket nurse, and/or hospital staff. For example, Keira explains why she placed trust in her midwife:

*I'm not one to go Google everything because how do you know if Google's right and what book's right, you know...you trust your midwife I guess...and all the information, all the tips she's helped us with have worked...so yeah we just trust everything she says really...but she left after 6 weeks so...Plunketline's been helpful*

The role of midwives appears to be an important one in the lives of new mothers in this study. Keira placed high trust in her midwife's advice, seeing her as the 'expert'. Rachel also talked about her dependence on her midwife in the early days: *'My midwife was amazing; saw us every day for the first week and then every couple of days after that... and you text her and she'll reply within an hour or call you just to see how you were going...she was really supportive, you could ask her anything.'* Since the mid-1990s in New Zealand, maternity care has predominantly been provided by Lead Maternity Carers (LMCs), most of whom are midwives and work independently (Jaye, Mason, & Miller, 2012). Over 90% of midwives are voluntarily registered with the NZ College of Midwives who provide professional standards and education to their members (NZ College of Midwives, 2015). This professional body has a consensus statement on infant safe sleep (see Appendix G), that is consistent with Ministry of Health recommendations on this topic. LMCs therefore, have access to scientifically based 'expert' information on safe sleep. Regardless, how they interpret and share this information with mothers is filtered by their own worldview, their perspectives on infant sleeping as a risk, and the relationship they build with each pregnant woman, as it is for all health professionals.

Another key source of information for mothers in my study was Plunket, which is understandable as all the women were recruited through a local Plunket service. Similarly to the NZ College of Midwives, Plunket have guidelines on safe sleep, which adhere to MOH recommendations, and in addition they have a focus on engaging mothers in discussions about the mechanisms of breathing. The education, a programme of Change for our

Children, is called 'Through the Tubes'. It aims to reduce rates of accidental suffocation by enabling understanding of the mechanism and importance of breathing for babies in utero and after birth<sup>8</sup>.

Some mothers engaged in 'front stage' work, using the language of Plunket education when explaining why they acted in certain ways. For example, when Rachel explained why she placed her baby on its back to sleep, she used the words '*clear breathing, clear passageway*' and Rae mentioned '*when you wrap her make sure that she can breathe*'. However, I cannot make assumptions about how Plunket nurses, or indeed any other health 'experts' such as midwives, discuss the often sensitive topic of infant sleep, with mothers.

As just discussed, despite guidelines, it is unlikely that discussions around safe sleep will be homogenous or necessarily led by technico-scientific worldviews as the reality is often more complex. Beck (1992), is critical of the viewpoint that 'positions lay people as ignorant, merely requiring more information about risk to respond appropriately' (Lupton, 2013b, p. 87). As mothers processed expert advice and made decisions about the level of trust they placed in health professionals, they also engaged in reflexivity. This is highlighted in Carlee's comments about advice she received from her Plunket nurse:

*Yeah, I mean like I'm always happy to take advice from Plunket and people like that because...otherwise it gets so confused when there's... cause you get lots of advice from mother in law, mother dah dah, and even people in the street will stop you and say something (laughs)...it can get too overwhelming and a bit annoying as well and so I've always thought I'll just listen to them [Plunket] because they have the latest research...they know, they must know best so I just go...although I probably don't go exactly but I try and just go with what they say*

Similar to other mothers, Carlee received advice from many different people and sources, but saw her Plunket nurse as a source of advice she could trust.

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<sup>8</sup> For educational material see:

[http://www.changeforourchildren.co.nz/safe\\_start\\_programme/through\\_the\\_tubes/champions](http://www.changeforourchildren.co.nz/safe_start_programme/through_the_tubes/champions)

Her comments reflect the complex nature of mothering, and highlight one of the ways that reliance on the technico-scientific understanding of risk is limited. While Carlee was 'happy' to take advice, she did not feel compelled to necessarily follow this advice. This is in stark contrast with what a women attempting to live up to the intensive mothering ideal 'should' be doing; that is, using expert advice to monitor her own behaviour.

Trusting in experts is a reflective process. As Wolf (2010) notes:

People align with science, the 'truth' that confirms what they want to believe, based on personal values; what they are socially inclined to embrace. [This is] based on such ascriptions as race, class or gender; and what they are disciplined to believe, based on their various professional and communal commitments' (Wolf, 2010, p. 60).

This reflective process hints at the complexity of the decisions mothers must make, and again places them as active rather than passive participants. It was not enough for Carlee to receive the information, she also had to contextualize it with her own worldview and other infant care considerations before deciding which elements of the advice she might follow. A study by Abel et al. (2001) found that younger Māori mothers were less likely to trust experts and more likely to consult friends and family and use their own intuition to assess risk. A similar theme emerged in my study. Talia was a young Māori mother aged 24. She had her first baby at 22 and was currently living at home with her partner and extended family. While she was happy to listen to advice from her 'mum and nan', she thought expert advice was 'nutty':

*T: Um, I've heard it all, but I've listened to nothing...*

*J: So what sort of things have you heard?*

*T: Sleep the baby on its back, um don't cover it in too much blankets, its own bed or in a pēpi-pod...oh just all of it, it's too...nutty (laughs)*

*J: So tell me more about that, that's really interesting*



*T: I just... I work better off, just common sense, and intuition and stuff, um...like with her, I tried to listen to all of it, all that advice, but nah it didn't work, like she was a tummy sleeper...very early and so I just rolled with her needs, she was happy to do it...(baby screaming)...yeah I just didn't listen, I just went with what I felt they needed, and um worked off that...not that I didn't listen, I just didn't follow any advice from anybody...*

Talia was the only mother who explicitly shared her thoughts about 'experts' not knowing best, and I cannot know if other mothers had similar thoughts. Mia (23), was another younger (New Zealand European) mother whose discourse suggested she also had little trust in experts. When I asked her whose advice she trusted, she replied *'I guess my mum and my friend...I wouldn't trust randoms.... I did get given a book by my mum (laughs)...I haven't really read it yet...it's over there...I wasn't going to, just cause...'* Mia didn't elaborate, but her comments do suggest that a book with 'expert' advice' would not be of use to her. Mia sometimes placed her baby on the side to sleep, which is perceived to be a risky position. She says *'oh they say back is best, but I think if the baby is happy (laughs) then it's fine... I just kept an eye on him at the start...and he was fine'*. Mia's comments suggest an engagement in reflexivity and a trust in her own intuition over 'experts'.

While some scholars would argue that Mia's and Talia's responses are an irrational lay persons' assessment of risk (Lupton & Tulloch, 2002), others have argued that 'lay perceptions of risk are founded on sources of knowledge that should be acknowledged as being equally as important and rational as scientific expert assessments' (Lupton, 2013b, p. 148).

The comments above highlight a key area that was not examined in my study; that of exploring how advice is given to mothers by experts. The technico-scientific perspective would suggest that it is a relatively simple process of telling mothers of risks which the 'good mother' will obediently follow. The comments of the mothers above, highlight that the process is more complex than this.

Just as we cannot predict how mothers will assess risk, we also cannot predict how people will interpret information about risks. For example, in the excerpt below, Rae describes her partner's logic in not buying an infant cot:

*Like the whole cot death thing, that freaked me out...my partner's pretty big with that, like, he thinks you could get cot death if you get a cot and like, baby's too small you could get cot death, and I was like I think, it's not cot death, like baby could be anywhere and like die.. and so that's what I tried to get through to him...that's why we didn't buy a cot because he was scared of the idea...it is a bit frightening eh, like that it is a possibility, like if you don't go through these procedures then something could happen...*

To Rae's partner, this interpretation of information is a rational and logical thought process, for him, on how to protect his baby. It also highlights how terminology can be misinterpreted and cause confusion. Although the term 'cot death' is rarely used these days by experts in discussing infant death, it is a commonly known term, which was used in the early days of sudden infant death study and health promotion (Cowan, 2010; Mitchell, Ford, et al., 1992). It is understandable therefore that if Rae's partner did not have conversations with others about sleep related risks, that he would make the logical assumption that 'cot death' happens in cots. He is not alone in thinking that SIDS is a 'location' issue; a belief that the 'cot' itself is the mechanism of death. While Rae's partner was the only person to discuss this in my study, a similar theme was identified in a study of new immigrants to Australia (see Aslam, Kemp, Harris, & Gilbert, 2009). In the Australian study, it was suggested that making the assumption that babies mostly die in cots, allowed one mother to dismiss expert advice and legitimized her decision to sleep with her baby. Rae also brought her baby into bed with her for the first few months of life. However the complex nature of infant night-time care makes it difficult to determine how much this decision was based on the belief that 'cots' were dangerous, and how much was due to other factors such as her being excessively tired and having a very unsettled baby.

Sometimes however, it was the health professionals themselves who undermined the expert advice. Several mothers talked about midwives,

hospital staff and paediatricians who advised them to do things differently to the recommended advice. For example, several mothers talked about the confusion they felt when hospital midwives let them sleep with their baby. Below Sally describes her confusion when this happened to her:

*In hospital she wouldn't sleep in her bassinet so she was on me...um and even at the very beginning I knew they were supposed to be in their own bed so I was kind of terrified about her sleeping on me in bed because it wasn't safe, um...but it was the only way that we could both get some sleep, so the hospital I thought wouldn't let it happen because of the whole safety thing, but they put the rails up on the bed or tucked her in beside me or...it was very confusing, but I wasn't in a state to be thinking about it too much, sleep was the priority*

This excerpt highlights the complexity that mothers face when making decisions about infant care practices. It is difficult for mothers to know who and what to trust when they receive conflicting advice from those they consider to be experts. It is understandable that they will then look to themselves and others to decide how best to mitigate any perceived risks. Indeed, if health professionals, such as the midwives above, are using their own judgement to assess and manage risk at a personal level, it hints at an undermining of the technico-specific perspective that risks are even 'objective facts' (Bradbury, 1989, p. 382). Rather it suggests, as does Lupton (2013b), that the identification of 'risks' takes place in the specific sociocultural, political and historical contexts in which we are located' (p. 21). As such, it questions the assumption that 'risks' as defined by scientists within a technico-scientific worldview, will always be viewed as 'risks' by people with different epistemological and ontological positions.

### Anxious Mothers

As expected in a risk society, the narratives of many of the mothers in my study reflected high levels of anxiety and fear around the risk of their baby dying during sleep. This is an unintended outcome of the dominant worldview

that sees risks as calculable and manageable, and of an intensive mothering ideology that holds the mother accountable for any danger in which the infant may find themselves. There have been several cases in the past few years of mothers in New Zealand being jailed for ‘...omitting to provide their child with a safe sleeping environment’ (Change for our Children Ltd, 2014, p. 6). Mothers have been prosecuted under section 152 of the Crimes Act 1961, entitled: ‘Duty of parent or guardian to provide necessities and protect from injury’ (Crimes Act, 1961). Two cases that have been made public involved women who were intoxicated and whose babies died while sleeping in the same space as themselves; one, on a makeshift bed on the floor and another in the back seat of a car. A summary of the sentencing has been published as part of an education package supporting health professionals to have conversations with mothers to avoid such deaths<sup>9</sup>. In sentencing, the judge stated:

You failed him [2 month old baby] completely in the manner in which you attended to his sleeping arrangements on that night. He trusted you for his security, and you failed to provide him with it. The price that he paid was his death...you need to be held accountable for what you did that night’ (as cited in Change for our Children Ltd, 2014, p. 17).

Both these cases presented complex issues that were broader than the sleep environment. It was the mother, and not the father who was prosecuted in both cases. While the fear of prosecution was not a theme in my study, it does highlight a change in our society to a more litigious view of mothering practices.

One of the mothers in my study linked her high levels of anxiety about something dangerous happening to her baby, to her smoking in pregnancy:

*I was so paranoid because people had drilled it into my head, smokers, their children are a lot more at risk of um sudden infant death syndrome, I swear that was probably the worst thing I got*

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<sup>9</sup> For educational resources see: [http://www.changeforourchildren.co.nz/our\\_projects/safe\\_hands](http://www.changeforourchildren.co.nz/our_projects/safe_hands)

*told, 'cause it was so drilled in my head that my son is not going to breathe if he sleeps (Lauren)*

Lauren was well aware that her baby was at an increased risk for SUDI. However, this knowledge only led to heightened anxiety, not smoking cessation. Tulloch (2003) explains this juxtaposition whereby risk strategies are developed to ease uncertainty, but 'often have the paradoxical effect of increasing anxiety about risk through the intensity of their focus and concern' (p. 20).

Regardless of how 'real' or otherwise the risk of SUDI was, anxiety was an issue for many women in my study. Mothers of infants who were full term, smokefree, and sleeping in the ways recommended by the experts also experienced high levels of anxiety about the risk of their baby dying. This suggests that mothers' anxiety levels are not related to the risk status of an infant, but rather to a mothers' perception of risk. Sara was one such mother; her infant did not appear to have any potential risk factors, yet Sara had very high levels of anxiety. She said:

*I'm always real paranoid, even when I'm still up like before I've gone to bed and she's gone down, I'll go and check her like probably like every 5 minutes (laughs)...I'm just checking she's still breathing, yeah, that's my biggest worry....I dunno, it's just, like that's what P (Partner) said to me before, he was like what are you so worried about, and I'm like I dunno, I think it's just one of those fears...*

Sara was concerned that her baby might stop breathing in her sleep, however this anxiety did not extend to her partner. Several overseas studies have described similar findings, with mothers seeing themselves as responsible for protecting their infant from the risk of dying (Lauritzen, 1997; Lupton, 2011; Moon, Oden, Joyner, & Ajao, 2010). One study in particular noted that mothers saw 'being vigilant' as a way to navigate danger (Moon et al., 2010). In much the same way, Sara invoked 'keeping vigilant' as a way to mitigate the risk of her baby no longer breathing.

Several mothers' comments reflect their belief that despite what they do, their baby may still die:

*I dunno know I'm just ....really paranoid about yeah, about baby sleeping... I didn't just go through the whole pregnancy and birth to, I dunno have them die in their cot (laughs)...as sad as it sounds, not that, like I could be doing everything right and it still happen but I'm just yeah...yeah I want them to wake up in the morning (Amy)*

*I just tell myself, nothing's gonna happen, but really, I couldn't, I wouldn't even know, you know, you'd never know if something like that would happen...(Ngairé)*

A similar theme was found in a study of African American mothers' perceptions of SIDS, which revealed a belief that SIDS was 'random' and if it was to happen it would be 'God's will' (Moon et al., 2010). In Moon et al.'s study, mothers differentiated between suffocation, which they saw as preventable, and SIDS which was random. I did not perceive any differentiation in my study, but there was clear evidence that some mothers' anxiety did lead them to make attempts to follow expert advice to reduce the risks associated with infant sleep. For example, when I asked Fiona, why she placed her baby on its back to sleep, she replied: *'because it's the safest spot to put them, so they teach you, and she's quite happy being on her back'*. Fiona was just one of many mothers to explain the decision to follow expert advice because it was what they had heard was safest. In these instances, mothers could manage risk and their own anxiety by following expert advice; there was no cost to Fiona in placing her baby on its back, and her baby settled and slept well in this position. As mentioned previously, Amy had high levels of anxiety about her infant suddenly dying. This was a key driver for Amy in her narratives around why she placed her baby to sleep on its back:

*[I put my baby to sleep on her back]... 'cause I don't want her to die (laughs). I'm really like, I get real scared about kids sleeping I don't know, on their tummy, or you know like I'm just always one to you know (laughs)... she's in her own bed on her back, nothing around her, no teddies no nothing...no pillow...just blankets and her (laughs)*

In following the advice of experts, Amy believed she was mitigating the risk of her baby dying. Amy had a baby that slept well and she commented that

*'she's been really good'*. Again, for Amy, there was no cost to either herself or the baby to place her to sleep on her back as suggested by the experts.

Attempting to follow expert advice did not necessarily stop mothers from feeling anxious about their babies during sleep, as highlighted by Sara earlier in the chapter, who was vigilant about checking her baby's breathing. However, what did become evident from the analysis of my interviews, was that mothers' anxiety reduced over time:

*Yeah and eventually as he got older and I got more comfortable with him, we got to know each other, and know each other's routines I kind of realized I didn't have to be so paranoid, I didn't have to be so tense about it and feel so guilty 'cause it's just what it is, I can't change it [smoking], well I can but it's not ideal, it's not what I plan to do just yet, so I just got over that anxiety and now we're pretty good (Lauren)*

Lauren felt she could not make changes to her smoking behaviour, and thus to her infant's risk profile. This led to what Rippetoe and Rogers (1987), have described as 'health fatalism'; a 'there's nothing I can do about the threat anyway' attitude (as cited in Hastings, Stead, & Webb, 2004, p. 975). As such Lauren's anxiety over the threat also reduced.

The reduction in anxiety over time was common among the mothers in my study. While many talked about being aware of risks, and vigilant to any signs of danger in the new-born period, their anxiety lessened as their babies became older and more robust. Carlee spoke of only being worried in the *'first 3-5 weeks but not now because he's a bit more robust and he'll be fine'*. Fiona, whose baby was three months old at the time of our interview talked about bringing the baby into bed with her now that she was older: *'we wouldn't have probably done that in the early stages... she's very strong now in her breathing and everything like that, there's no issues of her potentially coming to harm herself'*. These comments suggest that mothers' confidence increases and their anxiety decreases as they experience more successful sleep episodes. If continued exposure to risk does not result in any harm, it is understandable that a mother would no longer view the practice as risky

for her infant. This would then become a consideration when mothers make their decisions about how and where their infants will sleep at night.

However, once again not all mothers thought the same way about risk, and infant sleep did not create anxiety in all mothers. When I asked Talia if she had any safety concerns with regards to how her baby slept, she replied '*nah, nope, not at all...*' She told me that she hardly gave any thought to something dangerous happening to her baby while he slept and said '*I just trust...I just trust that it won't 'cause they're alright, how they've been.*' Talia's intuition and her view of herself as the expert may explain her low levels of anxiety. It is ironic that according to the technico-scientific perspective of risk, Talia, who would be most in need of advice given the 'high risk' profile of her infant, is the mother in my study who was least likely to respond to this dominant perspective. Again, it highlights how mothers' thinking about night-time care is not homogenous. Decision-making is not just about following 'expert' advice for these mothers, and knowledge in itself does not lead to behaviour change.

### Summary

This chapter has highlighted some of the confusion mothers experience as recipients of expert advice. On one hand, most mothers are open to being given advice from experts, with most trusting health professionals such as their midwife and Plunket nurse. On the other hand, mothers are conscious that the enigma that is SUDI still hovers over them despite this expert advice or their infants' risk profile. In addition, advice from health experts can be conflicting and therefore confusing to mothers. It is too simplistic to assume that knowledge of risks leads to behaviour change, or that mothers are passive recipients of 'expert' advice, or that 'expert' advice is necessarily reliable. As will be discussed in the next chapter, there are much wider socio-cultural factors that mothers consider in their decisions of night-time infant care, and risk of death is only one of these.



## Chapter 6. 'The reality of doing it...that's the hard bit': Managing the Complexity of Night-time Infant Care

Night-time care of a baby can be unpredictable, and sleep-deprived mothers are often required to make decisions throughout the night as events unfold. Complex factors such as the biological needs and temperaments of both mother and infant, socially constructed beliefs and expectations, and practical realities influence mothers' infant care decisions. Using concepts from a socio-cultural understanding of risk, this chapter will explore the complexities that mothers in my study faced when caring for their infant at night and how this complexity impacted on their decision making.

### Theoretical Background: Socio-cultural Perspective of Risk

In understanding risk from a socio-cultural perspective, Arnoldi (2009) acknowledges that the way lay people understand and manage potential risk is not prompted by the 'intrinsic characteristics of the danger itself' (as cited in Hammer & Inglin, 2013, p. 23). Rather, perceived risks are understood and managed in the social and cultural contexts of everyday life, and are developed through being part of a cultural group (Tulloch & Lupton, 2003).

Mary Douglas was one of the first to explore the notion that the way certain risks are identified is related to social and cultural influences (Zinn, 2009). Douglas' early work on pollution and danger highlighted the importance of social and cultural influences to 'maintain the boundary between 'self' and 'other', deal with social deviance and achieve social order' (Lupton, 2013b, p. 52). With regard to decision making, Douglas maintained that it is not that lay people cannot think rationally in terms of expert generated probabilities. Rather, there are cultural concerns which come into play in both the processing and acting on knowledge, and these need to be given value (Douglas, 1992).

Researchers who use this framework believe that 'the ways people perceive and manage risks differ because they hold distinct beliefs, values and worldviews that are shaped by the various social and cultural contexts of their everyday lives' (Hammer & Inglin, 2013, p. 23). Mothers in my study,

although not homogenous, share a period of time, a geographical location, and a similar well child health service (Plunket), which have each contributed in some way to their worldviews of how best to care for their infant at night.

As discussed in the previous chapter, Beck and Giddens' theories on risk society suggested a need for 'expert' guidance. However, both these scholars are also critical of the ways in which 'experts' position those they are advising as 'ignorant' and only in need of further information to be able to assess risks 'rationally' (Beck, 1992; Giddens, 1991). Beck's (1992) concept of engaging in 'reflective practice' whereby expert advice is evaluated by lay persons, was also discussed in the previous chapter. The individual is central to this process, but as Lupton notes 'individualization refers not to alienation or loneliness. Instead, it means the requirement in late modernity that individuals must create their own biographies' (p. 89). Individualism requires decision-making and assumes that people can shape their own destiny, although this process is neither simple nor unambiguous (Beck 1992). Beck (1992) and Beck-Gersheim (1995) assert that 'seen from one angle it [individualism] means freedom to choose, and from another, pressure to conform to internalized demands, on the one hand being responsible for yourself and on the other being dependent on conditions which completely elude your grasp' (as cited in Lupton, 2013b, p. 90). Extending these concepts to infant sleep, it suggests that mothers engage in 'reflexivity' as a response to the anxieties that arise with infant care, in particular sleep. Reflexivity requires them to continually assess expert advice in light of their own material reality.

Lupton sums up the body of sociological research investigating the ways in which people make sense of and mitigate risks by noting that 'lay knowledge of risk... tends to be highly contextual, localized and individualized and reflexively aware of diversity and change' (Tulloch & Lupton, 2003, p. 8). These concepts provide a useful way to examine how mothers in my study navigated risks for their infant within the context of other night-time parenting issues they encountered.

Embedded socio-cultural perspectives, such as the understanding that people behave as rational economic units, that is, that we receive information, we

make evaluative judgments and act accordingly, and the idea of where and how babies 'should' sleep at night, are also linked to societal discourses. Language plays an important role in embedding socio-cultural practices. The way that risks and behaviours are discussed in everyday life, not only shape beliefs and norms, but also influence how embedded they become. Anthropological understandings view language as a 'powerful semiotic tool for evoking social and moral sentiments, collective and personal identities tied to place and situation, and bodies of knowledge and belief' (Ochs & Schieffelin, 2008, p. 8). This suggests that when and how ideas are communicated are as important as the ideas themselves. For example, with regard to safe sleep education, Cowan (2010) argues that 'language that creates images of hope and possibility, is likely to encourage talk of change. When talk is about 'pursuing protection, rather than 'reducing risk', of 'confidence in the gagging reflex' rather than 'fear of choking'...then the context of the discussion is changed' (p.91). In such ways, socio-cultural norms around infant sleep and infant safety can be influenced.

The previous chapter highlighted how mothers in my study had high levels of awareness and anxiety around the potential risk of their baby dying during sleep. Against a backdrop of heightened anxiety, minimising risk was a factor in decisions that mothers made. However, as this chapter will explore, decision making was made more complex by the realities associated with caring for a young and dependent infant at night.

### Practical Realities

The MOH suggests the safest place for a baby to sleep in the first six months is in their own bed in the same room as a carer (Ministry of Health, 2014). For some mothers in my study, the decision on where their baby slept was dictated more by the practical reality of limited space than by any other factor. Sally talked about how her baby slept in their room for the first 12 weeks, and then moved to a separate room because '*she grew out of her bassinet and we can't fit the cot in our room*'. Not being able to follow expert advice caused Sally some anxiety. When I asked her what her concerns were, she replied: '*The whole cot death thing, you know, how Plunket says they should be in your room for the first 6 months, and I wanted her in our room*'.

*for the first 6 months...* She then went on to say: *'but the baby was fine [sleeping in the other room]'*. Another mother, Rachel, had the baby's bassinet in a different room from the beginning due to lack of space in the parents' bedroom. She talked of *'feeling bad'* because she wanted her baby next to her *'for the safety thing'*, but also about how relieved she felt when her midwife, a perceived 'expert', said *'as long as we keep the doors open it doesn't matter'*.

In many cultures, it is common for infants to sleep in the same room as their parents for the first few years of life (Giannotti & Cortesi, 2009). Similarly in New Zealand, Pacific Island and Māori mothers have traditionally kept their babies close at night (Abel et al., 2001). Conversely, in Western society, the trend over the last century has been for babies to sleep in their own room, to, among other things, promote independence and autonomy (Ball, 2006; McKenna & McDade, 2005). However, a recent study by Hutchison et al. (2015) suggests the practice of placing the baby to sleep in a separate room is changing in New Zealand. Their study surveyed predominantly European mothers who had recently given birth in a major New Zealand birthing unit. The study compared rates of room sharing (babies sleeping in the same room as a caregiver), with an earlier survey from 2005 of mothers from the same birthing unit. It was revealed that 61% of respondents were room sharing in 2013; a 20% increase in the practice since 2005.

In my study also, most mothers attempted to sleep with their baby in the same room as themselves, even if only for the first few weeks. The intention to have the baby in the same room needs to be considered within a context of intensive mothering, whereby mothers are encouraged to breastfeed, always be available for their infant, and follow MOH 'expert' advice. Sally and Rachel's comments above, expressing guilt over not meeting these expectations around same room sleeping, demonstrate how ingrained into Western New Zealand culture room sharing has quickly become. Both of these mothers were nervous about resisting the dominant discourse of having the baby in the same room. The two mothers' inability to act in a way they perceived to be 'right' links to the intensive mothering ideology of what it means to be a 'good mother'.

However, as suggested by Hammer and Inglin (2013), within the socio-cultural perspective of risk, life experiences shape how risk is assessed and managed. Sally's experience of the baby sleeping well in a separate room, coupled with affirmations from an 'expert' that having the door open was acceptable, helped her manage the tension between high level advice and her material reality. Blair et al. (1999) suggest that the protective factor of having the baby in the same room is actually due to the ability of the adult to be in close proximity and therefore to react to an infant in distress. Being in close proximity was still important to these mothers. They both used infant monitors as a safety surveillance measure, and spoke of their babies being close enough to hear, suggesting perhaps, a belief that if they can hear their babies they can protect them.

The themes of convenience, safety and space are often cited as reasons why parents choose to place their babies either in the same room and/or in the same bed as themselves for sleep (see Aslam et al., 2009; Hutchison et al., 2015; Joyner, Oden, Ajao, & Moon, 2010). Similarly, in my study the sub-theme of convenience for monitoring, feeding and settling a baby as well as the need for sleep, was commonly cited by mothers as to where and how their baby slept. Ngaire talked about the convenience of checking her baby when it was in the same room as her:

*Ah...it was just easy to put her right next to me [in bassinet beside bed] (Laughs)...I didn't, well I didn't want her like all the way over there in case I didn't hear her or...you know, cause I didn't know what I'd be like in the night, like if I could hear her or not...but I think I was pretty good...if I didn't her dad could hear her 'cause he's a pretty light sleeper...but yeah that's why I put her next to me, and 'cause I feel better with her right next to me, 'cause then I can feel her and see if she's cold or not...or still breathing (Laughs), 'cause I get...I was getting those feelings like something might happen...'cause it does happen, but it won't...I was just being over protective I think*

Other mothers discussed the convenience of being able to quickly get back to sleep when the baby was in the same room. For example:

*because I have to get up...do all this [feeding, changing nappies etc.], I don't want to walk down the hall (laughs), you know...then you're wide awake but you also need a bit of sleep yourself, so I just sort of thought, look, its best if she's right here next to me...I try and be very quiet, we got a light, or he [partner] changed the bedside lamp to a very dim light...so he doesn't get so disturbed and its working okay, yeah (Carlee)*

However, what was convenient for one mother was not necessarily convenient for another. For example, several mothers chose to have their babies sleep in a different room after the first few weeks. The reality of a noisy infant and mothers' need for sleep were cited as reasons for the choice of sleep location. Keira said:

*He was in his room after 3 weeks, just 'cause he's such a noisy sleeper and it kept me up the whole night 'cause I'd hear a noise and I'd freak out, so I'd be thinking he's hungry, but he's just sleep talking...and that's when I was waking up to the sleep talking and I was feeding him when he sleep talked*

The motivating factor in Keira's decision to move her baby to a separate room was to reduce the levels of anxiety she was experiencing whenever her baby woke, and to get a better quality of sleep.

While having the baby in the same room was inconvenient for Keira, other mothers found that it was more convenient to not only have the baby in the same room as themselves but also to share the same sleep surface. This has been noted in other studies from New Zealand (Abel et al., 2001; Hutchison et al., 2006; Hutchison et al., 2015), and overseas (Aslam et al., 2009; Ball, 2002; McKenna & Volpe, 2007). Sally spoke about the convenience of sleeping with her baby, which highlights the biological imperative of the need for sleep. The decision for Sally came down to physical exhaustion:

*S: The decision making was purely down to, I can't stay up any more, I'm down to the end of what I can do, so I'm gonna feed her lying down and we're both gonna fall asleep and then we'll both get some sleep, um and that was the basis for the decision, I did as much as I possibly could, and then I went, 'that's me' I literally, if I*

*feed her sitting her up, I'm gonna drop her (laughs) because I'm gonna fall asleep sitting up, so I fell asleep feeding her when we were both lying down and she kept waking up and feeding and going back to sleep and feeding and going back to sleep, and usually when she does that she'll sleep in till 9 so I'd get a 5 till 9, and after a disrupted night...*

*J: How did it feel doing that with her?*

*S: Like it was against the rules and I shouldn't be doing it, and it was unsafe, but it was nice as well, just to have her there, and know that she wasn't crying and sad and lonely...*

For Sally, the practical reality of needing sleep outweighed the potential risk. She was torn between enjoying the experience and feeling guilty about disregarding 'expert' advice. Sally's comments highlight the very real tensions that mothers in my study experienced between 'expert advice' and the realities of caring for an infant at night. It is within this context that mothers are making decisions about night-time infant care practices.

Other mothers talked about the convenience of being able to breastfeed and sleep when the baby shared their bed. It allowed them to balance the needs of their baby to be fed and to sleep, with their own needs for sleep:

*J: And where do you feed him then?*

*M: Just in bed...and then either try to put him back in his bassinet, or sometimes he sleeps with us...I just fall asleep feeding...or (laughs) I dunno, he likes it in our bed, he just falls asleep instantly...sometimes if I put him back in his bassinet he won't go to sleep...um yeah it's just easier (Mia)*

The motivation for sharing the bed with an infant because it enables breastfeeding has been noted in many studies (see for example: Aslam et al., 2009; Ball, 2002; McKenna & Volpe, 2007). It has been found that mothers who breastfeed in bed have more positive sleep, despite nursing for longer than mothers who sleep separately from their baby (McKenna (1997) in Ball, 2002), and are more likely to breastfeed for longer (Ball et al., 2012; Wailoo, Ball, Fleming, Ward Platt, & Platt, 2004). As discussed earlier in this

thesis, there is also a possible link between breastfeeding and a reduction in SUDI risk. Along with the academic literature, the dominant discourse in our society is that breastfeeding is the most appropriate nutrition for infants (see for example: Ministry of Health, 2015a; Plunket, 2015a).

Another reason that mothers brought their babies into bed with them was the convenience it provided for bonding with their baby:

*I don't know 'cause I don't know if what I do is right...um... I dunno, just do what makes your baby happy...um yeah.....like they just want to be close to you, so I think that's why he sleeps so well in bed with us (laughs)....(Mia)*

The opportunity for bonding when sharing a sleep space is also cited in many other studies (see for example: Dodd, 2012; Rowe, 2003; Tipene-Leach et al., 2010), and bonding is regularly linked with reasons for breastfeeding and bed sharing (Ward & Salm, 2015). In 2005 the American Academy of Pediatrics (AAP) recognized the relationship between bonding and having the baby in bed. In their policy on safe infant sleep they recommended that 'infants may be brought to bed for nursing or comforting but should be returned to their own crib or bassinet when the parent is ready to return to sleep' (Task Force on Sudden Infant Death Syndrome, 2005). When the AAP recommendations were updated in 2011, the advice to breastfeed remained, but the advice to breastfeed or comfort the baby in an adult bed was removed. In fact, the new recommendation was that it was never safe to bring a baby into an adult bed (Task Force on Sudden Infant Death Syndrome, 2011). Again this highlights the conflict for mothers between the developmental needs of the child to bond with the mother, and the need to protect against the risk of danger when sleeping in the same bed.

Having an unsettled baby added to the complexity of night-time care decisions. For many mothers, the intention was to follow 'expert' advice. However, the reality of having an unsettled baby influenced the actions that mothers took during the night. Several mothers in my study had babies they described as being 'colicky', meaning their baby appeared to be in pain, cried a great deal, and did not like to be laid down to sleep. The mothers sought a variety of ways to try and alleviate the pain they perceived their infants were



in. For Fiona, who had a particularly unsettled baby, her infant care decisions were based on doing whatever it took to stop her baby crying and to get her to sleep for a few hours at a time. For example, Fiona talked about the process she went through to get her baby to sleep in the cot during the night:

*To get her to bed in her cot when we finally did get to that stage...for a couple of hours in the cot, you'd pretty much be like this [demonstrates rocking with arms] day and night...if you're lucky you'd get her in by 12 o'clock...in the night, put her down finally and that would be after her being asleep in your arms for a good 2 or 3 hours before you could possibly get a chance to put her down, 'cause as soon as you started putting her down she would wake and she'd scream murder again (laughs)*

The impact of sleep deprivation led Fiona to sleep with her baby on her chest and in her own bed. It was not necessarily the case that Fiona was unaware of risks, but more that the reality of her unsettled baby and its need for support was more important. Lupton (2013a) describes how children have traditionally been 'represented as closer to 'nature' than adults in their wildness, lack of civilized decorum but also their purity and innocence, supposedly uncontaminated by the influences of society' (p. 39). Fiona saw her baby as 'pure' and in need of protecting. In fact, she says '*so you know when they are new-born they can't cope with anything, so...yeah she didn't understand the pain*'. When Fiona followed expert advice and placed her baby on its back in the bassinet and the baby screamed, it is understandable that within the context of needing to protect her innocent baby, that she would therefore engage in 'reflexivity' as described by Beck (1992), and re-evaluate advice for her own situation.

Rae was another mother with an unsettled baby. She talked about her intent to have her baby sleep in her own bassinet, but describes a combination of factors that led to her decision to sleep with her baby in her bed:

*They give you a whole lot of advice, yeah um, do this and this and this and you'll be sweet...and when you come to reality it's not the same...it's easy being said, you know...and so when we came back home and I was like, yep, I'm gonna put her in her bassinet it'll be*

*fine you know, and then I was like, ok, she was waking up every 2 hours, and I was like, ok, my back's getting a bit sore...and I was getting restless and I decided ok, I'll just put you in our bed, you can sleep next to me and I'll just breastfeed you lying down...that way it's like a comfort for both of us...yeah and so it got like and she was in our bed for um a long while*

The complex needs of her baby and her own discomfort breastfeeding at night, led to a solution that allowed Rae to meet her own and her baby's needs. Again, Rae did not dismiss the risks involved. She was very aware of the risks of rolling on to her baby, as her midwife and doctor had both warned her of this danger. She also talked about how her partner slept in a different room for the first few months. She described how important it was for her that the baby had her own space in the bed, with her own blankets so that she 'couldn't get caught up in the adult blankets'. Rae therefore, was not only aware of the risks, she assessed and managed these risks to fit the reality of her complex night-time situation.

Other mothers in my study, talked about their babies as mostly settling into a routine 'of sorts' at night and who normally followed expert advice around where and how their baby slept. This in itself is a reflection of the socio-cultural norm that exists around good babies being those who 'sleep well' at night. However, these same mothers also spoke of nights where their 'usual' infant care practices changed because of an unsettled baby. Several studies (for example: Ball, 2002, 2007; McKenna & Volpe, 2007) have shown how the complex nature of night-time infant care results in parents adopting 'strategies and behaviours that they had not planned' (Volpe et al., 2013, p. 93). For mothers in my study, unsettled nights with their baby often resulted in unplanned 'risk taking' (whether perceived as such or not), including sleeping with their baby on bean bags, on couches or in armchairs in an attempt to soothe their unsettled baby and achieve the goal of sleep. For example, Rachel talked about her baby having something stuck in her eye one night and not being able to sleep:

*I couldn't get her to sleep till about 3 o'clock in the morning, so that was just constant letting her suckle, then taking her off and trying*

*to wind her...and then we've got a big armchair upstairs so I just stuck pillows all round me and just slept with her on me...so it wasn't a good sleep for either of us, but at least it was something, it was better than nothing...*

Makeshift sleep environments such as those listed above have been identified as increasing the risk of SIDS (Blair et al., 2009; Tappin et al., 2005). In fact, Blair and Fleming (2012) argue that 'sleeping on a sofa is a far more dangerous practice than using the parental bed' (p.947). Mothers in my study did not discuss potential risks in their decision to settle their baby in these makeshift ways. Rather, their narrative focused on creating environments that were conducive to sleep. The actions that mothers took to achieve this goal was by no means homogenous. An overnight observation study of mothers' infant care practices, undertaken by several prominent anthropologists, concluded that mothers weigh up the costs and benefits of their options for care of infants at night (Volpe et al., 2013). The authors suggest that 'sleep related risks to infants may not always arise as the result of negligent maternal choices, but may form a functional and rational (whether conscious or not) strategy to negotiate the complex compromises that are inherent to parenting' (Volpe et al., 2013, p. 98).

Many of the practical realities of night-time infant care led to the occasional and often incidental sharing of the same sleep surface. The often contradictory socio-cultural expectations surrounding this practice can be confusing for mothers. On one hand, mothers can see the benefits of bringing the baby into bed with them and this is backed up by anthropological evidence promoting the practice. On the other hand, mothers can feel guilty when they do not act in ways that follow prescribed advice to reduce risk of infant death.

### Trust in Self

One way that mothers manage this process is by looking to themselves as the expert; the notion that mothers intuitively know how to safeguard their children. Intuition is defined as the 'ability to understand something instinctively without the need for conscious reasoning (2015). It is outside

the scope of this thesis to explore if intuition is 'real', but suffice to note that Hays (1996) argues it is 'difficult to distinguish a 'mother's intuition from ideas arising from a woman's social role, a woman's upbringing, and the culture of motherhood' (p.72).

With regard to 'maternal intuition', Delany (2009) notes that academic literature has generally focused on two key, but often contradictory ideas. The first is that mothers' intuition comes from the essential biological nature of being female. Accordingly, mothers are either born with, or develop through pregnancy, a natural intuition over which they have no agency. A second approach argues that through the journey of pregnancy, mothers 'develop intuitive knowledge' about their child (Delany, 2009, p. 112). The essentialist nature of both these theories has been seen as anti-feminist; in that it undermines the versions of feminist scholarship that have focused on freeing mothers from the 'compulsion to reproduce and the demands of and constraints of motherhood' (Kawash, 2011, p. 989).

What is clear from my study, is that some mothers do trust their 'maternal intuition' to guide their decisions about what is best for their baby. For example, Rae talked about trusting her instincts:

*R: Yeah it kind of felt like a natural thing [bed sharing]... It does, it does, I felt like you know, she's safer this way*

*J: Why do you think it felt safer?*

*R: 'Cause she's with me, 'cause you trust yourself and you know you're not gonna do anything to harm your baby...and that's what I thought... and my partner was like 'is she ok, can she breathe' and I was like, 'I've got this man, I know what I'm doing' and he was like ' yeah yeah but the cot death', and I was like 'she's fine, you have to relax..*

In their study of Māori and Pacific Island mothers, Abel et al. (2001) identified a tension for mothers between negotiating what they instinctively felt and 'doing it by the book' (p. 1147). However, this tension is not culturally exclusive, and applies to all mothers, as is evident in this thesis. Rae's trust in her own ability to protect her baby could be seen as naïve or in denial of

potential 'risks' or it could be seen as empowering. In a world of risk and probability calculations, mothers' beliefs in their ability to intuitively protect their infants, provides a way to manage and mitigate risk by exercising agency around decision-making and belief in their own expertise. As Fiona noted:

*'It's 'cause you're a mum I think...it's natural intuition to protect your child...as they say, don't get between a mother and her child...mother tiger'*

The comments of Rae and Fiona could be seen as supporting the essentialist theory of maternal intuition, in that both mothers believe they have an insight into their babies that their partners do not. Delany (2009), highlights the socially constructed nature of this theory, arguing that:

A belief in the ability of women to intuitively know certain things about their child on the basis of their biological sex *naturalizes*, and therefore *reinforces*, women's role as the primary carer. This is because through their biological capabilities, the mother of the child becomes viewed as being able to provide a higher standard of care for the child than any other person' (p. 115, emphasis in original).

On the other hand, the concept could be seen as growing maternal expertise rather than intuition. The idea that expertise is achieved by simply spending time with and around the baby, and learning what works and what does not is also a plausible explanation, and one that Lauren alludes to:

*You're just bombarded with information and ideas, and it took, like the first four weeks of trying to just do everything and try everything and then I was like stuff it, I'm done listening to others, I'm gonna do what I think is right, and that's when I think I really started to listen to my maternal instincts and I just started to try and read my baby...there wasn't a miracle answer it was just a case of trial and error, what I thought, what I could see, it's easy for other people to say, when they see your baby when they visit quickly, but they don't see it all hours of the night and day*

Although Lauren describes it as listening to her 'maternal instincts', she was in fact developing her maternal expertise, by spending time listening to and learning to read her baby's cues. This sets maternal expertise up against or alongside other forms of expertise, such as the scientific expertise mothers are encouraged to follow.

Being intuitively aware of a baby's needs also links to being a good mother. A woman who is so well attuned to her baby's requirements that she instinctively knows if the baby is in danger, must surely be seen as meeting the requirements of a 'good intensive mother'. Carlee highlights this, as well as her self-sacrifice, when she talks about being attuned to her baby when sleeping in the bed with her:

*I wake up as soon as she moves or there's something I have this awareness... I think, and I just never rolled onto her or squashed her, I knew she was there and even held my arm up... I don't know, I woke up really awkward and with pain in my neck or my back sometimes, it wasn't a good thing to do, but um, I just ..I never squashed her or anything like that*

Carlee was aware of the potential risk, but citing 'intuition', she trusted herself to act in a way that she believed would mitigate any potential risk. Carlee went on to say however, that the physical discomfort of sleeping in this way was the reason that she did not routinely sleep in the same space as her baby.

Using their intuition, mothers in turn trusted themselves to assess and mitigate risk for their baby. It was common for mothers to talk about ways in which they believed they made the baby's sleep environment 'safe', when they did not follow 'expert' advice. The extract from Fiona below, highlights how important beliefs are in decisions mothers make:

*F: If I'm really tired and she won't go back down to her own cot I will chuck her in bed with me...I'll basically sandwich her between us... I know you're not supposed to put the baby in with you...but you know you get to a point, particularly at sort of 5 o'clock in the morning, I'm like, oh it's only for an hour or 2 it's fine...I don't like doing it for the rest of the night though...um.. and I'll put the pillow*

*between my legs, put myself in a way that you know, almost the recovery position so you can't sort of roll, so I'm sort of cocooning her, protecting her, but still in a safe sort of way, ... It's in the Plunket books and that, where it's like if you put baby in the bed, put them in a safe...in a separate safe, what they call Kete or whatever, you know for Pacific Islanders and things like that.... I guess it depends how deep a sleeper you are; personally you know what you are like when you sleep...*

*J: So for you, you don't really see it as any big issue.*

*F: Nope, we're always very aware, and like...yeah, and because the way my body's wrapped around her, there's never any worry if you know what I mean...but we wouldn't have probably done that in the early stages either, she's very strong now in her breathing and everything like that, there's no issues of her...potentially coming to harm herself*

Zinn (2008) suggests that 'in everyday life there is rarely enough time and knowledge available for fully rational decision-making...and therefore strategies such as trust, intuition and emotions are of central importance to individuals risk balancing activities' (p. 446). Zinn refers to these strategies as 'in between' strategies, which are 'neither rational nor irrational' (p.446). While Fiona's decision to bring her baby into bed with her was based on the physical reality of needing sleep, her rationality for it being safe was based on her beliefs. Zinn would classify this as an 'in between' strategy of assessing and managing risk. Fiona's strategy was based on several beliefs; primarily, a belief that it was less risky to sleep with her baby in the early hours of the morning and that the need for a dedicated sleep space only applied to 'other' cultures. In addition, she believed that she was not a deep sleeper so would sense danger and wake, and that her baby was robust enough to be less at risk. Fiona's comments highlight the importance of understanding what is behind decisions mothers' make in order to develop more empathetic health interventions.

Living in a 'risk society', mothers are reminded of the dangers that lurk during infant sleep, and the importance of being in close, but not too close, proximity

to their baby. Within this context, mothers in my study found that using products such as baby monitors reduced their anxiety:

*When I put him in his cot, for the first couple of nights I was checking him constantly, and then I realised with the monitor I had I could hear him breathing, I could see him breathing, so if I did wake up, I could look over and go back to sleep, and now I just sleep right through and I feel a lot more comfortable (Lauren)*

*And she's got the camera on her cot, and she's got the breathing apparatus thing that monitors her heart rate and everything as well...so I've got no [safety] issues there (Fiona)*

Infant monitors first became popular in Western cultures during the 1980s and 1990s as a response to the rise in awareness of SIDS. A popular theory at the time was that SIDS was in some way connected to prolonged episodes of apnoea and bradycardia in susceptible infants (Ramanathan, Corwin, Hunt, & et al., 2001). However, any claims that monitors protected infants against SIDS were soon refuted (see Ramanathan et al., 2001; Ward et al., 1986). Over time, infant monitors have developed from basic audio, video and sensory monitors, to smart phone applications.<sup>10</sup> The most recent development in the USA is a 'smart sock' that is worn by an infant and connects with a smart phone to allow parents to check a baby's vital signs and be alerted if the baby rolls over (King, 2014).

A quick review of just one company selling baby monitors online in New Zealand, reveals that the marketing by the company avoids any claim that the products can protect against SIDS. However, they are promoted as providing 'peace of mind' and in more expensive models of being equipped with sensory devices to 'alert if no movement is detected for 20 seconds or more' (Babycity.co.nz, 2015). In this way, the promotional language is being used to support a socio-culturally embedded belief that these products not only promote safety, but are necessary if you are a 'good mother' who prioritises her child's welfare. In a study examining parental reviews of baby monitors, Nelson (2008), noted that 'as reviewers participate in the

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<sup>10</sup> Popular baby monitor apps include 'cloud baby monitor', iSitter' and 'Baby Monitor and alarm'



promotion of consumer goods [baby monitors], they also participate in the selling of anxiety and of attitudes towards the appropriateness of careful monitoring –or surveillance- of children’ (p. 519). Parents seem to accept that anxiety and monitoring babies with products is ‘normal’. In a way, the use of monitors could be seen to undermine ‘maternal intuition’ as discussed above, in that mothers are using products rather than their own instincts to listen out for and alert them to their baby’s needs. Fiona’s narrative highlights this complexity. By using a baby monitor, Fiona is adhering to the technico-scientific notion that risks can be managed, despite the fact that in this case, there is actually no evidence to suggest that these products can reduce an infant’s risk of SUDI. At the same time, she also employs her maternal intuition as a way to protect her baby when she is in bed with her.

In assessing risk, mothers in my study were continuously engaged in negotiating which risks they gave value to, based on their own beliefs and experiences, as well as the reality of the moment they were in. For example, Rae listened to expert advice to place her baby to sleep on the back. However, she explained that if the baby fell asleep while she was feeding her, that she then placed her on her side to sleep. This was because of a fear that she might choke on excess milk that had not been brought up through burping. This decision was based on her own rationality that: ‘*if she ever does spew it’ll just come out, like not on her back and it’ll be stuck in her throat...*’ When I asked her how she knew to do that, she replied:

*I just thought like being an adult, if you were like really really, like if you went out for a good time and you were pretty hammered and you come back home and you feel like spewing, if you lie down and you spew obviously its gonna get stuck in your throat, like lying down on your back, yeah and so I thought it’d probably be the same, so I was like, well I’ll put her on her side and that way when she does spew it’ll come right out...*

This logic made sense to Rae. Such beliefs about parents choosing a non-supine sleep position based on the fear of a baby choking have also been found in other studies (Fetherston & Leach, 2012; Oden, Joyner, Ajao, & Moon, 2010; Von Kohorn et al., 2010). The myth of babies choking in this

way may well stem from Dr. Spock, who first advised parents in 1958 to place their babies on their front to sleep, because 'if he [sic] vomits, he is more likely to choke on the vomitus' (cited in Gilbert et al., 2005, p. 876). In addition it is common first aid practice to place an 'unconscious' person on their side to keep their airways clear (2015). However, infants are not unconscious when they sleep, and much like the evidence on baby monitors, studies have failed to find any link between infants sleeping on their back and dying from choking on vomit (Byard & Beal, 2000). Despite evidence to the contrary, mothers are looking for ways that allow them to manage risk and mitigate their own levels of anxiety around the chance of their infant dying.

### Summary

This chapter has highlighted the complexity of infant night-time care and decision-making that is the reality for women in my study. Mothers are continuously navigating risks within their own contexts, and these contexts are not homogenous. Engaging, whether consciously or not, in reflexive thinking, mothers interpret population level 'expert' advice and translate this for their individual lived realities. As the needs of mother and baby change, so too do the ways in which a mother responds. Mothers are influenced in a variety of complementary and contradictory ways, and often these occur simultaneously. For those mothers who experienced anxiety over the risk of their baby dying, awareness and assessment of risk was important. However, in some circumstances, the lived reality of the moment dictated the responses that mothers made. The decision-making was then based on their own and their baby's needs, as well as a trust in 'maternal intuition' and socio-culturally constructed beliefs around how to mitigate risk.

## Chapter 7. Implications and Concluding Comments

There is no argument that the first months of life require intense emotional and physical investment from mothers. The cultural expectations of what it means to be a 'good mother' are juxtaposed against the complex reality of life with a new-born baby completely dependent on others for its survival. In our society, mothers are bombarded with advice about all facets of their infants' care. This is not new, but as Wolf (2010) notes, today 'mothers must not only protect their children from immediate threats, but are also expected to predict and prevent any circumstances that might interfere with putatively normal development' (p. xv). Mothers are walking a tight-rope, between desires to protect their vulnerable infants from actual or potential danger, and ensuring optimal physical and psychological development. Both of these are part of the performance of good mothering that is expected of mothers in our society.

In this chapter I will explore the implications of my research findings at a broader level. This thesis has shown that despite the presence of fathers at night, their role is limited, resulting in infant care decision-making being an individualized and privatized process for mothers. It is a process that is linked to neoliberal worldviews whereby individuals are expected to be responsible for their own (and their infants) health and wellbeing. The chapter will explore how the ideology of neoliberalism is reflected in the discourse of mothers, and the extent to which the notion of personal responsibility is assumed by both mothers and 'experts' alike. I will also discuss how fear is used as a tool to persuade mothers to adhere to recommended practice, and the potential impacts of this approach. Lastly, recommendations for future research in this area will be described.

### Gender, Care and the Individualization of Responsibility

For the group of mothers in my study, the strong beliefs they held around self-sacrifice and night-time care being their responsibility is little different from that found by Hays in her seminal work *The Cultural Contradictions of Motherhood*, back in 1996. The absence of discourse from mothers on resisting assumptions about maternal roles, only serves to heighten the

dominance of intensive mothering as a culturally embedded ideology. Whilst several mothers expressed annoyance that their partners were not more involved at night, they did not resist the notion of themselves as key decision-makers. This perception of the mother as taking on the primary responsibility for the infant may be due to notions of essentialism that still exist in Western culture, whereby mothering is viewed as an instinctive, inevitable, and therefore unchangeable part of being a woman (DiQuinzio, 2013). Alternatively, it could be due to the social and political structures that dictate the female as the main caregiver in our society. For example, in New Zealand, eligible mothers<sup>11</sup> are entitled to 18 weeks of government-funded maternity leave payments, and up to one year's unpaid leave from their employer. However, New Zealand is one of nine OECD countries that does not provide paid paternity leave (OECD, 2015). While parental legislation in New Zealand is more generous than countries such as the United States (which has very limited legislation mandating parental leave), it is not as generous as countries such as Norway (which has government-funded paternity leave of up to 14 weeks (OECD, 2015). Milkie and Warner (2014) note:

The fact that restructuring so that the state, workplaces and fathers become more responsible for the future livelihoods of all children is largely absent from political and cultural discourses, helps maintain views that individual mothers should continue their exhaustive investments [in intensive mothering] (Section 7, para. 4).

However, the response is more complex than simply changing parental leave legislation. Indeed, while breastfeeding continues to be promoted as the best source of nutrition, the pressure for mothers to be readily available for their infant reinforces the belief of mothers as best carers. If the discourse does change, so that political and social structures allow for fathers to be more involved in the early months, it does not necessarily follow that it will reduce the dominance of intensive mothering ideology. It may, as Palladino (2014)

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<sup>11</sup> To Be eligible for parental leave, the mother must have been employed for either 6 or 12 months with the same employer, and worked an average of 10 hours per week before the baby was born/adopted (Ministry of Business Innovation and Employment, 2015)

suggests, merely escalate standards of 'intensive parenting' as fathers deal with the same cultural contradictions that mothers face. It is also difficult to know how intensive mothering is moderated when a mother returns to the workforce.

This is not to say that mothers do not want to be the main carers. Mothers in my study spoke with great pride, joy and love when they talked of their mothering role. It is the notion of judging mothers as 'good' or 'bad' that is the issue. It is inevitable that a new-born requires 'intensive' care in the first few months of life. Nonetheless, the pressure to conform to societal standards of what makes mothering 'good' or 'bad', can undermine a mother's ability to respond to her infant in developmentally appropriate ways, without feelings of guilt. The situation in my study however, was that fathers had very limited roles during the night, resulting in infant care decision-making being a very individualized process for mothers.

As well as being individualized, infant care decision-making is also privatized, or as Goffman (1959) notes, the decision-making is 'backstage' and away from public view. There are no experts, professionals, or public present when mothers make their decisions. In the early hours of the morning, it is often just the mother and her child that are privy to decision making; the 'front stage' persona is shed. Metaphorically, 'society', with all its norms and intensive mothering ideals, is present, but it is in the relationship between the mother and her child where the decisions are made. The most women may do at night, is discuss a course of action with their families or ring a health helpline (or midwife in the early days), for advice. Evident in my study is the powerful influence that the social constructs of the good mothering ideology have had on decision making. Although 'backstage' work, mothers' sense of being 'good' or 'bad' is often intrinsically woven into whether or not 'expert' advice is followed. Currently, there is an expectation that health professionals will advise mothers on safe ways for their babies to sleep, and it is anticipated that these recommendations will be followed by all mothers. As such, society places responsibility on mothers to make the 'right' decision in every circumstance, with no societal responsibility other than to provide the information.

This focus on intensive mothering and individual responsibility fits within the neoliberal worldview, that has dominated economic and health policy in New Zealand since the 1980s. Neoliberalism is primarily an economic model promoting the privatized, deregulated free market over state intervention, as a way to promote economic growth (McGregor, 2001). At the same time, it is embedded in social and moral philosophies which impact on beliefs of how a society is governed and governs itself (Ayo, 2011). An outcome of the shift to neoliberalism has been the requirement for individuals to self-regulate and take personal responsibility for themselves (Ayo, 2011; Lupton, 2012; Petersen & Lupton, 2000). Accordingly, the duty of protection has devolved from the state to the individual (Petersen & Lupton, 2000). With regard to personal health, the focus on self-regulation is one in which 'individuals are required to take personal responsibility for their actions, and in the case of pregnant women or mothers, for the health and wellbeing of their children' (Lupton, 2012, p. 336). The pressure to allow infants to self-soothe, for example, suggests this responsibility has even passed to infants.

Freedom of choice is a key tenet of neoliberalism (Ayo, 2011) but although mothers are free to choose where and how they place their babies to sleep, there is an assumption, that a 'good' neoliberal mother will follow 'expert' advice. As Wolf notes, 'the state creates the conditions that enable people to choose to behave in ways it has determined are best for the collective good, thereby manipulating individual choice...[As such], neoliberal individuals choose to do what they are supposed to do' (p.61). This is highlighted in the way the good/bad mother dichotomy has become embedded in infant care decisions.

A new intervention is currently being developed to aid mothers in following expert advice regarding their infants' sleep. It highlights how neoliberal thinking has influenced the direction of public health promotion. A digital SIDS risk assessment application (app) is currently being developed for use by New Zealand General Practitioners (GPs). It will assess an individual infant's risk for SIDS, and allow a GP to discuss changes that can be made to reduce an infant's risk profile (Stephenson, 2015). A recent review of evidence for using digital technologies for health promotion over more traditional methods, found benefits such as: being able to reach more people,

including 'hard to reach' populations; reduced expense, and the ability to individualize messages to targeted groups more easily (Chou, Prestin, Lyons, & Wen, 2013). However, the use of apps as a form of health promotion has also been viewed as contributing to the neoliberal requirement of making personal health a priority and an individual responsibility (Lupton, 2014).

From a technico-scientific perspective, an app to identify high risk infants is a logical solution. It provides another way for experts to advise mothers of their infants individual risk profile, and for the good neoliberal mother to then change her behaviours accordingly to reduce the risk. The same issues as previously discussed in my study, will however continue to exist despite the addition of an app; most predominantly that night-time care is more complex and mothers do not necessarily calculate or act on risk in ways determined by technico-scientific thinking. In addition, the use of apps to identify an infant's risk for SIDS must be considered in the context of the impact to mothers' anxiety levels. It would also need to be cognizant of the social and cultural complexity within which the risk profile itself had developed.

While awareness of risk, may, and often does, lead mothers to follow expert advice, the challenges of an unsettled baby and a sleep deprived mother will not disappear as a result of knowing the risk status of an infant. Such challenges will need to be dealt with regardless of a baby's risk profile. Several mothers in my study talked of their colicky and unsettled babies, and for these mothers, their sleep deprivation was at times extreme. There has been a large amount of research on the importance of sleep, with maternal sleep deprivation having been linked to a host of negative events including diabetes (Gottlieb, Punjabi, Newman, & et al., 2005), car accidents (Williamson & Feyer, 2000), hallucinations (Basics, 2006) and reduced working memory (Alhola & Polo-Kantola, 2007). Maternal sleep deprivation is also linked negatively to maternal moods and stress (Meltzer & Mindell, 2007). The requirement for maternal sleep, and its influence on infant care decision-making is important. It has perhaps not been given the recognition it deserves as a factor in mothers' decision-making, nor in the advice that is given to mothers.

The fact that a baby wakes up and needs attention at night, requires mothers to make decisions on how they will act and then how and where they put their baby back to sleep. Neoliberal expectations demand that mothers monitor their infants' sleep in the ways provided by MOH advice in an attempt to engineer out all potential risk. However, as evident in my study, the reality is often quite different, and the complexity of night-time care requires mothers to think and act in more discrete ways. This is important, because the unintended consequence of not being able to live up to the neoliberal good mothering ideal, is an increase in the anxiety levels of mothers. Inherent in not living up to this ideal is victim-blaming, whereby the individual is blamed for not taking enough responsibility for their health (Crawford, 1977). In this instance the blame is for non-compliance with safe sleep advice. It suggests a mother's inability to 'do the right thing' and for 'every' sleep, stems from her own shortcomings, rather than the social or economic system at large.

### Anxiety and Reality

It is generally accepted in our society that an infant's life is precious, and in our risk-averse world, it seems unethical not to advise parents of ways to protect their infants. However, it would appear that one of the biggest issues for mothers in my study as well as researchers and professionals generally, is that a definitive 'cause' of SIDS remains, by its own definition, unknown. Population level advice is crafted predominantly from case-control epidemiological studies focusing on risk elimination strategies, especially for the most vulnerable. In contrast, families are trying to interpret this advice, applying it to the care of their own babies, whose risk profiles may be very different, while being aware that sudden death could occur regardless of their actions.

As identified in the literature (see for example: Lupton, 1995; Moon et al., 2010), mothers' anxiety around fear of their babies dying suddenly and unexpectedly was also common in my study. As the rates of infant mortality reduce in New Zealand, I had expected to find that mothers were also less concerned about such an event occurring. I was intrigued to discover then, that many mothers in my study experienced high levels of anxiety, despite



them saying they mostly following expert advice. It has been suggested that anxiety is 'rooted in deep-seated but reclassified convictions about maternal responsibility... [based on a] moral code in which individual mothers are ultimately held responsible for any harm that befalls their children' (Wolf, 2010, p. 73). It is hardly surprising then, that where there is ambiguity over how to protect an infant during sleep, there is anxiety. This is most evident in the advice that it is unsafe for a baby to sleep in an adult bed. Research shows that most babies who sleep in this environment do not die, yet the public health message assumes the risk is equal for all who bring a baby into bed.

The technico-scientific worldview did not set out to engender fear, although it appears that fear has become a by-product of infant sleep advice. Since 2013, there has been at least one mother prosecuted each year in New Zealand for sleeping with her baby, and the baby subsequently dying (see APNZ, 2013; Court reporter, 2014; Sharpe, 2015). Comments from professionals such as Coroner Bain, who called bed sharing 'child abuse' (see Fuatai, 2013), fuel the fear, as do recent media headlines such as 'Baby dies after mother disregards repeated advice against bed sharing' (Sharpe, 2015). In the article published on the Fairfax media website (stuff.co.nz), the Children's Commissioner made the following statement:

'Every sleep must be a safe sleep and we will do everything we can to help you –if you choose not to take that advice and have baby in bed with you and baby died, *you can and will be prosecuted* [emphasis added] and that matters because these deaths are preventable' (Sharpe, 2015 para. 2).

Such comments suggest that the threat of prosecution is real. Pressure from coroners for the MOH to do more about risks associated with infant sleep (see Mitchell, 2009b), may be the reason for the change in MOH bed sharing recommendations. The coroners' worldview is one that is solely concerned with stopping infants from dying. As McKenna and Volpe (2007) note, given that coroners only encounter negative bed sharing situations i.e. an infant death, their negative view of bed sharing is understandable. It does not help mothers' anxiety however, when the implication is that a mother could face

punitive action if she does not act as a good neoliberal citizen and follow recommended advice. More consideration needs to be given to the possible implications of using fear as a tool for compliance.

In discussing the use of appeals to fear in social marketing, Hastings et al. (2004) debate the ethics of such marketing. They suggest that 'deontological or 'duty theory', which is concerned with the inherent morality, humaneness and intentionality of the act, would reject the use of fear appeals outright on the grounds that regardless of the ultimate societal consequences, it is wrong to engender anxiety and distress' (p.973). On the other hand, these authors argue that 'utilitarian theory' would allow for fear-based marketing if it produced a net balance of 'good' over 'bad' (p. 973). Infant sleep advice as provided by the 'experts' above, employs population level advice which supersedes individual risk profiles for the greater good. Thus, parents are advised to keep all babies out of the parental bed, despite this not necessarily being a risky environment for every baby. It raises the question of whether the perceived net benefit of saved lives from SIDS, outweighs the increased anxiety of mothers whose infants are unlikely to be at risk. Given that mothers have been prosecuted for failing to 'provide the necessities [sic] of life' (Sharpe, 2015) for example, a safe sleeping place, such legislative action could be seen as setting a precedent for future prosecutions of mothers. It also risks stigmatizing certain groups of people. For example, it is possible that mothers' who smoke in pregnancy could be targeted as they 'fail to provide' necessary oxygen to their unborn infant. This would be taking the neoliberal tenet of personal responsibility to the extreme, but it is not outside the realm of possibility. The use of fear as a compliance method also places health professionals in a difficult situation. They must decide whether to warn parents of the possible prosecution risk if they partake in activities such as bringing their baby to bed with them, or ignore such recommendations and discuss how to make all environments as safe as possible.

Rather than viewing parents as technico-scientific, rational units, we need to be more mindful of some of the other ways of working with parents that incorporate the social and cultural contexts within which they make decisions. My findings suggest that rather than telling mothers what to do, we need to enable them to act in ways that support their lived realities. An

example of an enabler in action, is the innovative option, offered in New Zealand, of *Wahakura* and *Pēpi-Pod*<sup>®</sup> programmes for safer bed sharing with babies deemed at increased risk of sudden infant death. These initiatives enable mothers to reconcile the relational need for mother and baby to share a bed for feeding, sleep, bonding and/or comfort, with the advice that babies always need their own safe space to sleep in.

The *Wahakura* is an infant-sized basket that is hand-woven from flax and based on Māori weaving methods. It comes with a mattress, a set of rules for safe use, and 'seeks to provide a safer sleeping place for infants, particularly within a shared parental or caregiver bed' (Abel et al., 2015, p. 3). The requirement to weave the basket by hand is time consuming, and therefore supply is limited. However, the *Wahakura* is actively promoted and is sometimes woven by pregnant women themselves. It has been found to be culturally acceptable to Māori families, and a useful way for midwives to provide health related messages (Abel et al., 2015).

The *Pēpi-Pod*<sup>®</sup> programme has scaled up this concept through the 'targeted supply of low-cost polypropylene portable sleep spaces (PSS) to families of babies more vulnerable to accidental suffocation' (Cowan, 2014b, p. 5). Intended recipients for these largely health-funded devices include babies exposed to smoking, especially in pregnancy, born prematurely, of low birth weight, or where alcohol and drug use is prevalent in their families (Cowan, 2014a). The *Pēpi-pod*<sup>®</sup> programme is currently integrated into infant health policy and practice across 18 of 20 district health board regions in New Zealand. Three core components of the programme are: the offer of the PSS to enable babies to sleep in or on adult beds or when away from home; participation in education to learn about infant physiological development and safe use of the PSS; and encouragement to talk with friends and families about safe infant sleep. (S. Cowan, personal communication, December 14, 2015). Monitoring reports suggest that devices are reaching intended infants, are valued by recipients, and are being used to enhance infant safety (Cowan, 2015b).

Post perinatal (1-52 weeks) mortality rates are reducing in New Zealand, especially for Māori infants and in the regions with the most intensive

application of portable sleep space programmes (Cowan, 2015a; Gordon, Rowe, & Garcia, 2014; Voxy.co.nz, 2015). The MOH advises the use of such a portable space whenever a baby sleeps in or on an adult bed<sup>12</sup>. Whilst over 15000 have been distributed since 2012, it is estimated that only about 5% of the total infant population currently have access to a PSS (S. Cowan, personal communication, December 14, 2015). The use of a PSS is not intended as a solution for all families or situations. Nor is it likely to be acceptable to mothers who do not perceive a risk, or for whom skin-to-skin contact, or breastfeeding while sleeping, is a highly valued practice. Also, mothers who may not have planned to bed share, so would not have seen a need to get a Pēpi-pod or Wahakura, may find they do bed share on occasion once the baby arrives, thus needing to manage safety in some other way.

While some mothers are offered a PSS to support safe sleeping at night, most are finding other ways to navigate the complexity of their night-time infant care. As Lupton (2013b) notes, there is often contempt for lay people when they 'respond unscientifically to risk, using inferior and unsophisticated sources of knowledge such as 'intuition' (p. 28). However, as we have seen in this thesis, mothers are not responding naively; they have access to information and are able to mitigate risks in ways they find acceptable.

In this study, mothers did not intend to bed-share, neither did they describe themselves as routine bed-sharers. Nonetheless, on occasion, and for a variety of reasons, babies were sometimes brought into the adult bed. This was often for a short period of time, and most predominantly towards the end of the night when the mothers' need for sleep was greatest. As Ball (2002), noted in her qualitative study of mothers who bed shared: 'all parents are potential bed sharers; that bed-sharing may sometimes be unplanned, and may not always be practiced out of choice...[has] obvious implications for the dissemination of information regarding safe bed-sharing practices' (p. 8).

A review of the evidence by the National Health Guidance Agency in the United Kingdom (NICE), suggested that as the evidence does not suggest a

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<sup>12</sup> See <http://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/first-6-weeks/keeping-baby-safe-bed-first-6-weeks>

causal relationship, parents should instead be advised of the 'association' between bed sharing and SUDI, especially when there is smoking, drinking or drugs involved, or the baby is pre-term or of low birth weight (Fleming, Blair, et al., 2015). Parents have a right to know there is an increased risk associated with bed sharing in some circumstances. However, the new MOH recommendation in New Zealand suggests this practice is dangerous in all circumstances, unless a Pēpi-pod, Wahakura or other portable sleep space is used. As these enablers are not currently an option for all families, a population level message of 'risk minimisation' rather than 'risk elimination' may provide more scope for health professionals in New Zealand to discuss individualized care around bed sharing when and if it is needed. Such a strategy may reduce anxiety levels when unplanned bed sharing inevitably occurs.

### Future Research

The focus of my research has been on mothers and their experiences with night-time infant care. An obvious extension of my research would be to interview fathers/partners to gain insight into how they perceive themselves and their role during the night. Whilst there are many studies on fathers, especially around transitioning to fatherhood (Barclay & Lupton, 1999; Genesoni & Tallandini, 2009), bonding (Mercer & Ferkehch, 1990) and their influence in breastfeeding uptake, (Pisacane, Continisio, Aldinucci, D'Amora, & Continisio, 2005), there is little qualitative research exploring fathers' influence on infant sleep decisions, although a study has recently been published on fathers' roles in bed sharing decisions (Dodd & Jackiewicz, 2015). In addition, one of the topics that could be further explored is how night-time care is shared in families if and when the mother returns to full-time work. My study has identified that the intensive mothering ideology is strong, and I would be curious to explore how, or if, this might change if the father was more involved.

Another voice that is missing from my research is that of the health professional who is tasked with providing safe sleep information to parents. Most of the literature is focused on understanding infant care from a mother's perspective. However, a greater understanding of how health professionals

conduct discussions and how they negotiate their obligations to provide recommended infant safety advice, with the lived reality of mothers, would add another layer of understanding to the issue. In particular, an exploration of how health professionals balance these elements where infant care practices differ from recommended advice would be useful.

I used social deprivation by geographical area to recruit participants. Within the group of mothers I interviewed, no mothers discussed or alluded to issues around postnatal depression. However, around 15% of mothers are thought to experience postnatal depression symptoms (Craig & Howard, 2009), and a recent New Zealand study by Galland et al. (2014), suggested an increased risk of SUDI where the mother had experienced symptoms of depression in the antenatal period. Exploring how mothers make decisions at night when also dealing with their own psychological issues could shed more light on this risk factor.

Another area that does not appear to have been explored in relation to infant sleep safety, is the role that domestic violence plays in mothers' night-time infant care decisions. It is reported that in 2014 around 100,000 family violence investigations, with predominantly female victims, were undertaken by New Zealand Police (New Zealand Family Violence Clearinghouse, 2014). Infants are not immune to the impact of family violence, with one child reportedly killed every five weeks in New Zealand; the majority of whom are killed in their first year of life and by someone they know (Child Matters, n.d.). Research exploring how mothers negotiate and protect their infant whilst experiencing abuse themselves, or how they attempt to protect their infant from harm at the hands of an abuser, would be useful. Such research is necessary to counteract calls for prosecuting mothers for situations where perceived 'risks' may be taken to avoid, or because of, family violence. It will also add to the broader understanding of the complexity of maternal decision-making at night.

## Concluding Comments

I have examined night-time parenting within a broader socio-political context; one that is dominated by neoliberal views, is highly risk averse and is trying to influence externally, the decisions that mothers make internally. Within this socio-political context, scant regard is given to the environment in which decisions are made, and public health messages are often narrowed to focus on one aspect of what is thought to be the 'greater good' at the expense of other maternal-infant needs. The result is tension and anxiety for mothers when they do not act in prescribed ways.

It is unrealistic to assume that babies are always settled, healthy and happy. For many mothers, sleep is elusive, exhaustion is real, and support systems are not always accessible in the middle of the night. Making decisions around where, when and how an infant sleeps at night, becomes complex. In attempting to be a 'good mother', many women in my study were torn between following 'expert' advice, and listening to their own intuition when issues arose with their baby at night. At these times, the maternal-infant relationship, and responding to the needs of their infant, over-rode 'expert' advice. For some, feelings of self-worth attached to being a 'good mother', and neoliberal expectations, raised anxiety. This was most obvious when the immediate need for sleep, food or comfort (either their own or their baby's), led them to act in ways that conflicted with 'expert' advice. There is often tension between the 'front-stage' persona of mothers, who listen and follow 'expert' advice, and the 'back-stage' persona, where mothers respond to intuition and pragmatic needs.

In New Zealand, when translating evidence, more care needs to be taken in designing recommendations that fit with mothers' individual realities, and acceptance needed about the complex existence of life with a new-born. There is no one way that mothers make decisions at night, and as such there is no one optimal way to discuss safe infant sleep. Consequently, this creates a problem for a public health approach designed to address whole populations. At the same time, we also need to be mindful of population level advice that impacts on anxiety levels of mothers in a society where the myth of intensive mothering continues to dominate. Further prosecutions of

mothers who do not follow recommended advice, will not change the complex realities within which mothers are making their decisions. Rather, it is likely to only increase already high levels of anxiety. Greater empathy when working with families, and individualizing population level safe sleep recommendations, may alleviate maternal guilt and anxiety. Ultimately this may work to align mother's front and back stage persona's to build confidence and empower mothers.

The women in this study have shown that night-time care of babies requires consideration of a variety of complex, inter-relating and sometimes competing needs. Despite the overlay of judgement about 'good' and 'bad' mothering, participating mothers displayed extraordinary resilience and profound love for their babies in meeting these needs. These are the strengths on which to build when supporting families so that anxiety transforms into confidence for mothers.



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## Appendices

### Appendix A: Ministry of Health Recommendations (2014)



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HEALTH  
MANATŪ HAUORA

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## Keeping baby safe and warm in bed

A safe, warm and uncluttered sleep place for your baby is important. Otherwise they could roll face-down and suffocate on soft surfaces (such as couches, chairs or adult beds).

Settling your baby to sleep in their own safe place **on their back**, with their face clear, helps reduce the risk of suffocation.

### Safe sleeping space

In the first year of life, babies should have their own sleeping space. Every sleep should be in baby's own bed.

- Don't let baby sleep on a sofa, alone or with an adult or child.
- If baby falls asleep in a car seat or capsule, make sure you take them out and put them to sleep in their own bed when you get home.
- Babies are safest when they sleep in the same room that their parents sleep in for the first six months.


Be careful where you lie with your baby – parents of young babies are often tired, and you could accidentally fall asleep with baby in an unsafe sleeping space.

Always allow babies to breathe air free of smoke – never allow anyone to smoke in baby's bedroom or in the car with baby.

### Safe cot and mattress

For the first year of life, baby should sleep on a firm, flat and level surface with no pillow.

#### Resources



[Keep Your Baby Safe during Sleep](#)

Available on HealthEd.

#### Related websites

[Plunket](#)  
Plunket have information about keeping your baby safe.

> [Safety](#)

> [Sudden Unexpected Death in Infancy](#)

[Whakawhetu: National SUDI Prevention for Māori](#)  
An organisation supporting whānau to nurture and protect their babies from the risk of SUDI.

> [Safe sleep messages](#)

> [Safe sleep devices](#)

#### Baby's cot

Make sure baby's cot is away from walls, windows and heaters, and is freestanding in the room.

To keep baby's cot safe, make sure that:

- baby can't get their arms, legs or head trapped – the bars of the cot should be 5–8.5 cm apart
- the cot has no loose or missing pieces – broken cots are dangerous cots
- baby's clothes can't get caught on high corner posts (or they might strangle) – the corner posts of the cot should not stick up more than 5 cm
- the top of the cot side is at least 50 cm above the top of the mattress
- the paint on the cot is not lead based – if you're using an old cot, get information on lead-based paints from your Well Child nurse.

#### Taha: Well Pacific Mother and Infant Service

An organisation dedicated to improving the health and wellbeing of Pacific mothers and infants.

#### Change for Our Children

An organisation that develops innovative products and programmes to keep babies safe.


> [Cot card \(PDF, 964 KB\)](#)

> [Safe start programme](#)

> [Pepi-pods](#)

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## Ministry of Health Recommendations (continued)

<p><b>Baby's mattress</b></p> <p>Make sure the mattress:</p> <ul style="list-style-type: none"><li>• is clean, firm, flat and comfortable</li><li>• fits the cot snugly – the gap between the mattress and the cot should be less than 2.5 cm, so that baby can't get trapped or wedged in the gap</li><li>• doesn't get damp – put it in the sunshine, or take it out of the bed regularly.</li></ul> <p>If you've got a new mattress, make sure to remove the plastic wrapping – this could suffocate your baby.</p> <p>Waterbeds are not suitable for a baby, because they may suffocate by rolling onto their stomach with their face into the mattress.</p> <p><b>Keep baby's face clear</b></p> <p>Always place baby to sleep on their back.</p> <p>Keep your baby's face clear of the covers by:</p> <ul style="list-style-type: none"><li>• tucking them in</li><li>• making up the cot so that your baby sleeps with their feet at the foot of the cot, to stop them slipping down under the covers.</li></ul> <p>Cot bumper pads may suffocate or strangle a baby. Pillows and toys are also dangerous and should be kept out the cot.</p> <p>Loose ribbons, ties or threads on a baby's clothes may also be dangerous.</p> <p><b>Keeping baby warm and comfortable</b></p> <p>Your baby should be warm in bed, not too hot or too cold.</p> <p>Make sure that the room they sleep in:</p> <ul style="list-style-type: none"><li>• is well aired, with the door open (especially if you use a heater)</li><li>• is at a temperature that feels comfortable to you without wearing extra layers</li><li>• is not too hot – if you're using a heater, an electric heater with a thermostat is best (fan heaters may overheat the room and gas heaters can give off dangerous fumes).</li></ul> <p>To make sure your baby is warm enough in bed:</p> <ul style="list-style-type: none"><li>• put a blanket under the bottom sheet, and a blanket or blankets on top to keep them warm</li><li>• check your baby's back using two fingers. If it's warm, your baby is warm enough. If their back is hot, take off some covers</li><li>• you can heat the bed with a hot-water bottle, but make sure you remove it before you put baby to bed</li><li>• don't use a wheat bag to heat baby's bed – wheat bags can overheat and burn.</li></ul> <p>Sheepskins can collect dust mites, so they're not suitable if your family/whānau has a history of asthma or allergy. If you want to use a sheepskin, use a short-hair type and cover it with a sheet.</p>	<p><b>Related areas</b></p> <p><a href="#">&gt; Baby sleep and settling</a></p> <p><a href="#">&gt; Stop smoking</a></p> <div><p>Free phone support from a PlunketLine Nurse, 24 / 7!</p><p><b>0800 933 922</b></p></div>
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## Sharing a bed with baby (bed-sharing/co-sleeping)

Sharing a bed with baby puts them at risk of suffocating.

If you choose to sleep in a bed with your baby, give them their own sleep space – for example, a pēpi-pod, wahakura or Moses basket. This will help reduce their risk of suffocating while they are asleep.

Don't let your baby share a bed with anyone who:

- smokes
- is very tired
- takes sleeping pills
- is under the influence of alcohol or social drugs.

Babies should not bed-share if their mother smoked during pregnancy.

## Swaddling

Swaddling can reduce crying, and help babies sleep better. It can also stop baby being able to move freely and affect their temperature control.

How you swaddle your baby can make it a safe or unsafe practice.

If you do swaddle your baby make sure:

- baby is on their back
- you use a lightweight wrap
- the wrap is not too tight (or it could stop baby from moving easily)
- the wrap is not too loose (or it could cover baby's face)
- baby is only swaddled when sleeping in their own bed.

Once baby tries to roll over then stop swaddling, or swaddle with arms free.

## Baby needs a sober caregiver

To keep baby safe, they need a caregiver who is alert to their needs and free from drugs and alcohol.

Safe sleep routines are especially important if you and baby are away for home or at a social gathering. Baby always needs to be able to sleep safely.

## If you have concerns

If you're worried about your baby's room, cot or mattress, talk to your Well Child nurse.

[promote to YourHealth gateway](#)





## Appendix B: Advertisement for Participants



Is your baby less  
than 6 months  
old?

**WE ARE INTERESTED IN EXPLORING HOW MUMS MAKE DECISIONS  
ABOUT CARING FOR THEIR BABIES AT NIGHT.**

**We are looking for mums aged 16 and over, currently living in  
Linwood Christchurch, with a baby aged less than 6 months old to  
be part of this research study.**

**Participation involves a face to face interview, which will take  
about an hour. We are interested in hearing about your experience  
of caring for your baby at night. You will receive a \$30 grocery  
voucher for your participation.**

**To find out more, please contact the researcher, Judith Clarke  
email: [henju310@student.otago.ac.nz](mailto:henju310@student.otago.ac.nz)**

**ph: 385 8910 txt: 021 052 5682**

**[This project has been reviewed and approved by the University of Otago Human Ethics Committee,  
(Health). Reference H15/007 and the Plunket Ethics Committee**

<i>How do Mums make decisions about caring for their babies at night?</i>	Research contact: Judith Clarke txt: 021 0525 682 <a href="mailto:henju310@student.otago.ac.nz">henju310@student.otago.ac.nz</a>
<i>How do Mums make decisions about caring for their babies at night?</i>	Research contact: Judith Clarke txt: 021 0525 682 <a href="mailto:henju310@student.otago.ac.nz">henju310@student.otago.ac.nz</a>
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<i>How do Mums make decisions about caring for their babies at night?</i>	Research contact: Judith Clarke txt: 021 0525 682 <a href="mailto:henju310@student.otago.ac.nz">henju310@student.otago.ac.nz</a>

## Appendix C: Participant Information Sheet

<b>Study title:</b>	<b>What motivates mothers' decisions when they care for their baby at night?</b>	
<b>Student researcher</b>	<b>Judith Clarke</b> Department of Population Health University of Otago, Christchurch	Contact phone number:  364 3644
<b>Supervisor 1</b>	<b>Dr. Lee Thompson</b> Postgraduate Course Director, Department of Population Health University of Otago, Christchurch	Contact phone number:  364 3644
<b>Supervisor 2</b>	<b>Jen Desrosiers</b> Lecturer Department of Population Health University of Otago, Christchurch	Contact phone number:  364 3644

## Introduction

Thank you for showing an interest in this project. Please read this information sheet carefully. Take time to consider and, if you wish, talk with relatives or friends, before deciding whether or not to participate.

If you decide to participate, we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

## What is the aim of this research project?

This study aims to explore how mothers care for their babies at night. Mothers must balance their own and their baby's needs for sleep, comfort and emotional wellbeing, with the need to keep their baby safe when sleeping. If we can better understand how parents balance these different needs, it may improve the way that health professionals and others discuss safe sleep for babies, with parents. This project is being undertaken as part of the requirements for Judith Clarke's Masters of Public Health.

## Who is funding this project?

This project is funded by the University of Otago. It has been approved by the University of Otago Ethics committee and the Plunket Ethics committee.

## **Who are we seeking to participate in the project?**

We are looking for twelve Mums, aged 16 or older, who live in Linwood, Christchurch, and currently have a baby who is under 6 months of age. You will need to speak English, to avoid misinterpretations as the funding for this study does not extend to a translator. Mums who have experienced the death of a baby are not included in the study to avoid causing any added grief. You may be approached by your Plunket or Tamaki Ora nurse about this project on my behalf. You will receive a \$30 grocery voucher as a koha for your participation and can request a brief summary of the project when it is completed.

## **If you participate, what will you be asked to do?**

If you choose to participate in this study, you will be asked to have one interview with me (Judith), which will take about an hour of your time and will be at a time that suits you. We can have the interview at your home or in another mutually agreed location. You are welcome to bring someone else with you to the interview if you wish.

This project involves an open-questioning technique. The general line of questioning includes your experiences and decision making in caring for your baby at night, and your sources of information about caring for your baby. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although both ethics committees are aware of the general areas to be explored in the interview, the committees have not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind, or to the care you receive from Plunket or any other provider.

## **Is there any risk of discomfort or harm from participation?**

Talking about your new baby, may raise issues that are upsetting for you. You are free to stop the interview at any time if you do not wish to continue. If you feel you would like additional support after the interview, you will find services to access at no cost to you, listed on the back of this information sheet.

## What about anonymity and confidentiality?

This interview will be audio recorded, with your permission, so I can type up our interview later. Other than me, my two supervisors will be the only people able to see the record of our interview. Your responses will be treated with full confidentiality and you will be given a false name when reference is made to your interview in the thesis and any publications that might result from this work. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity. You can request a copy of the interview transcript and/or a brief summary of the final thesis if you wish.

The data collected will be securely stored in such a way that only those mentioned above will be able to gain access to it. Data obtained as a result of the research will be retained for 10 years in secure storage. Any personal information held about you, such as contact details, may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

## If you agree to participate, can you withdraw later?

You may withdraw from participation in the project up to 4 weeks after the interview and without any disadvantage to yourself or to the care you receive from Plunket or any other provider.

## Any questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:

Student researcher: Judith Clarke  
Department of Population Health  
University Telephone Number: 364 3644  
Email: [henju310@student.otago.ac.nz](mailto:henju310@student.otago.ac.nz)

or

Supervisor: Dr. Lee Thompson  
Department of Population Health  
Telephone Number: 364 3644  
Email: [lee.thompson@otago.ac.nz](mailto:lee.thompson@otago.ac.nz)

*This study has been approved by both the Plunket Ethics Committee and University of Otago Human Ethics Committee (Health). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (phone +64 3 479 8256 or email [gary.witte@otago.ac.nz](mailto:gary.witte@otago.ac.nz)). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.*

## SUPPORT FOR MOTHERS

**If you would like further support with any issues raised in our interview, below is a list of organisations available for you to contact at no cost.**

- Healthline Advice from trained nurses. 24 hours a day, 7 days a week 0800 611 116
- Plunket provides well child and family and whanau health support services through free home and clinic visits. Linwood/Avonside Plunket Clinic cnr Woodham Rd and Rowcliffe Crescent. Ph: 3898726 for an appointment
  - Plunketline Advice on your child's health and wellbeing from Plunketline nurses 24 hours a day, 7 days a week 0800 933 922
  - Plunket Family centres Extra support for sleep related issues. Contact your Plunket nurse for a referral.
  - Plunket postnatal adjustment programme. If you are experiencing distress or depression following the birth of your baby, this programme may be able to help. The service offers assessments at home, follow up phone support and group programmes. These programmes include the Oranga Whakamomori programme for Māori families. You do not need to be accessing Plunket's well child service to access the programme. You can self- refer by calling 3651646 Mon- Friday.

### Breastfeeding support:

- La Leche League: 24 hour breastfeeding helpline 338 8447
- Te Mahura Breastfeeding groups for young parents under 24 years. Mondays 10.30-12. Woolston Plunket Rooms 640 Ferry Road. Contact Jenny 0278984802 email: jenny.dewar@earlystart.co.nz
- St. Georges Maternity Free breastfeeding drop in centre open every weekday (except Wed and public holidays) 0930-1130. Maternity Unit St. Georges Hospital. Lactation consultant available Ph. 3559102 for enquiries.

### Websites

- Mothers Matter Local support and information for postnatal depression <http://www.mothersmatter.co.nz>
- Crying over spilt milk Support for families coping with Gastric reflux <http://www.cryingoverspiltmilk.co.nz/> (also on Facebook)
- Ministry of Health Safe sleep support <http://www.health.govt.nz/your-health/healthy-living/babies-and-toddlers/keeping-baby-safe-and-warm-bed>
- Facebook support: 'Young Parents breastfeeding support group'
- Facebook support: 'Supportive Community when breastfeeding doesn't work out'



What motivates mothers' decisions when they care for their baby at night?

<b><i>Student Researcher: Judith Clarke</i></b> <b><i>Email: henju310@student.otago.ac.nz</i></b> <b><i>Ph. 364 3644</i></b>	<b><i>Student Supervisor : Dr Lee Thompson</i></b> <b><i>Email: lee.thompson@otago.ac.nz</i></b> <b><i>Ph. 364 3644</i></b>
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## CONSENT FORM FOR PARTICIPANTS

Following signature and return to the research team this form will be stored in a secure place for ten years.

Name of participant:.....

1. I have read the Information Sheet concerning this study and understand the aims of this research project.
2. I have had sufficient time to talk with other people of my choice about participating in the study.
3. I confirm that I meet the criteria for participation which are explained in the Information Sheet.
4. All my questions about the project have been answered to my satisfaction, and I understand that I am free to request further information at any stage.
5. I know that my participation in the project is entirely voluntary, and that I am free to withdraw from the project at any time without disadvantage.
6. I know that as a participant I will provide the researcher with time for a one-off interview that will last for about an hour.

7. I know that the interview will explore the motivations behind the decisions I have made in the night time care of my baby, and that if the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s), and /or may withdraw from the project without disadvantage of any kind.
8. I understand the nature and size of the risks of discomfort or harm which are explained in the Information Sheet.
9. I know that when the project is completed all personal identifying information will be removed from the paper records and electronic files which represent the data from the project, and that these will be placed in secure storage and kept for at least ten years.
10. I understand that the results of the project may be published and be available in the University of Otago Library, but that I agree that any personal identifying information will remain confidential between myself and the researchers during the study, and will not appear in any spoken or written report of the study.
11. I know that I can request to view my interview transcript and/or a brief summary of the study findings.
12. I know that there is no remuneration offered for this study, but that I will receive a \$30 grocery voucher for my participation, and that no commercial use will be made of the data.

Signature of participant:

Date:

### **Audio Recordings:**

With your permission, we would also like to audio record the interview to make it easier to transcribe. Please sign below if you agree to be audio recorded. In any use of the audio recording your name will be not be identified. You may choose to stop the recording at any time or to erase any portion of your recording.

I hereby give my consent for audio recording:

\_\_\_\_\_ Signature  
 \_\_\_\_\_ Date

## Appendix E: Ethnicity Question



Which ethnic group do you belong to?

*Mark the space or spaces which apply to you.*

- ☐ New Zealand European
- ☐ Maori
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other such as DUTCH, JAPANESE, TOKELAUN.

Please state: \_\_\_\_\_



## Appendix F: Semi-Structured Interview Guide

### **Introductory Questions:**

- What have the first few months with X been like?
- As a new mum, there are lots of decisions you need to make about caring for X at night. Did you give this much thought before you had X?
- Before X was born, were there any aspects of night time caring that you had concerns about?

### **Topic 1: Night time:**

- Talk me through a typical night with X
- Partner involvement: How did you decide about who does what at night? How's that working out for you?
- Can you think of a night when things were a bit more challenging? Talk me through it (If risky - Tell me more about doing x...)
- What it's been like for you as a mum having to make all these decisions?

### **TOPIC 2: Advice**

- What have you heard about the good and not so good things that you can do to keep your baby safe at night? Who from? What do you think of that?
- Where else do you look for advice about caring for X at night?
- Are there some people whose advice about sleep that you'd trust more than others? What makes you trust their advice?
- What kind of conflicting advice have you had?
- How much do you think about something dangerous happening to x while he/she sleeps?

### **Topic 3: Good mothering**

- What do you think makes a mum a 'good mum'?
- How does safety fit into this?
- How would you see yourself as a mum in relation to how you sleep your baby? Can you tell me more about that- what's it based on?
- Others: Have other mums told you about things they do at night, that you'd consider risky yourself?

- Self: (if appropriate): Can you think of a time when you might have done something with X at night that made you feel uncomfortable? What was going on? How did you decide that was a risk you were willing to take- what would have stopped you?

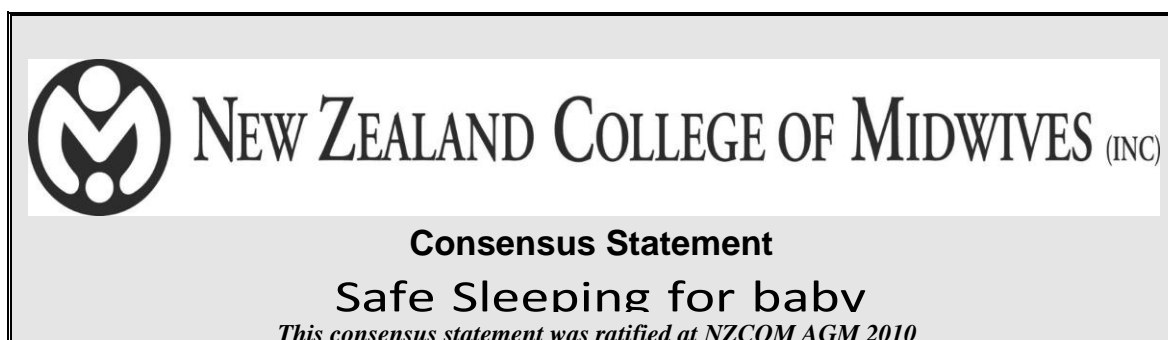
**Closing:**

- Is there any advice you'd give new mums on caring for their baby at night?
- I've got no further questions, is there anything else you'd like to add about how you've made decisions about caring for x at night?
- Any questions for me?

- **Demographic Information:**

Interview date: _____	Mum's name: _____
Age: _____	Ethnicity: _____
Address: _____ _____	Highest academic qualification: _____
Age at first baby: _____	Community services card: Y N
No of other people in house: _____	Live with baby's dad: Y N
Renting/home owner/other: _____	

Baby's name: _____	Baby's DOB: _____
Girl or boy: _____	Baby prem/low birth weight Y N
Smoking/in pregnancy: _____	Breastfeeding/formula feeding: _____



The NZCOM supports the following recommendations to ensure every New Zealand baby has a safe sleep, in every place, at every sleep. The College supports the current public health messages about safe sleeping and considers that midwives have a key role in informing mothers/ families/ whanau about the following recommendations.

**Recommendations**

Midwives should advise women/ partners/whanau to ensure all of the following:

- Position: place baby to sleep lying face up (on their back)
- Airway: ensure baby's face is clear and will stay clear throughout the period of sleep
- Development: ensure baby is smokefree both during pregnancy and after birth
- Environment: place baby to sleep in their own safe space, preferably one designed for babies such as a cot, bassinet, wahakura or other types of 'baby bed'.
- Closeness: have baby in the same room as a parent (when the parent is also sleeping) until the baby is at least six months old.
- Nutrition: exclusively breastfeed baby
- Watchful: check for potential hazards (what might change) in a baby's sleeping environment

Face-up + face clear + smokefree

Face-up position protects arousal in babies during a critical stage of development, Face clear protects from asphyxia in the sleeping environment, Smokefree reduces vulnerability.

Further practice advice for the newborn period:

- Ensuring skin to skin contact at birth (within safety guidelines). Placing an unsettled baby next to mother or skin to skin is an option if the woman is alert and orientated.
- Assess vulnerability of babies, women and situations when considering settling a baby with the mother. Avoid having a baby in bed with the woman in hospital and /or at home if she has:
  - had a long labour;
  - had a general anaesthetic;
  - been given drugs that cause drowsiness;
  - is excessively tired and cannot respond to her baby;
  - is obese

- is under the influence of tobacco, drugs and/ or alcohol.

Avoid having a baby in bed if the baby:

- has been exposed to any smoking in pregnancy
- is premature or of low birthweight
- is formula fed
- is unwell

Support breastfeeding

When a woman is tired and breastfeeding her baby in bed, reinforce to the woman and her family/ whanau that:

- someone needs to remain with a woman to assist her
- the baby needs to be put back to his/ her own sleeping space following a breastfeed with the help of partner/ family
- breastfeeding in a single hospital bed may not be ideal. Clip on cots may assist this.

Promote a smokefree start

Encourage women/ whanau who continue to smoke to use nicotine replacement products during pregnancy and a baby's first years and refer them to a smoking cessation service.

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Child and Youth Mortality Review Committee

[www.cymrc.health.govt.nz/moh.nsf/pagescm](http://www.cymrc.health.govt.nz/moh.nsf/pagescm)

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The purpose of New Zealand College of Midwives Consensus Statements is to provide women, midwives and the maternity services with the profession's position on any given situation. The guidelines are designed to educate and support best practice. All position statements are regularly reviewed and updated in line with evidence-based practice.