Journal of the Motherhood Initiative

Social Work, Motherhood, and Mothering: Critical Feminist Perspectives

Spring / Summer 2022
Volume 13, Number 1

Hee-Jeong Yoo, Laura Lewis, Deepy Sur, Dawn Thurman, Erin Kuri, Janis Favel, Christine Walsh, and many more

DIANNE FIERHELLER

"Good" Mothers, "Risky" Mothers, and Children's Health

Within a North American context, promoting and maintaining individual health and wellness have become a central focus and social expectation over the last several decades. Various systems and institutions that comprise a mother's social network—including family, friends, school, social media, healthcare and social services, food, and recreation spaces—all produce daily health messages that encourage the surveillance and practice of healthy lifestyle behaviours. Health promotion directed at families within these spaces often target and question everyday mothering practices, such as food preparation, physical activity, screen time, sleep, mental health, and overall parenting. This article seeks to examine the dominant biomedical discourses that have constructed categories of "good" and "risky" mothering practices within the area of child health. Weaving together my individual experience and knowledge as a Canadian paediatric healthcare social worker and mother, I will draw on feminist poststructuralism and maternal theory to explore how everyday mothering practices are often compared to ideal and normative mothering discourses that position mothers as individually responsible and blamed for their children's health outcomes. The article also explores the tool of self-reflexivity, which can offer social workers and service providers working alongside mothers the opportunity to consider new ways they might resist and challenge the truths and assumptions of so-called "good" mothering across social systems and reimagine new systems of support for children, mothers, and families.

Introduction

In today's Western world, mothers are increasingly bombarded with conflicting advice and opinions about ideal caregiving practices. As neoliberal ideologies of individual responsibility intersect with the trillion-dollar health and wellness industry, mothers are urged to take control of their own lifestyle

behaviours and the overall health of their children and families (Maher et al. 233-35). The multitude of systems and institutions within a mother's social network—such as family, friends, school, social media, healthcare, social services, food, and recreation spaces—all produce dominant health messages that influence and question everyday mothering. In Sara Ahmed's book *Living a Feminist Life*, she describes how individuals become inundated with questions throughout their daily lives: "You might be asked questions; you might be made to feel questionable" (115). Questions directed at mothers in their daily lives might be: "Did you take prenatal vitamins?" "Are you sure you should be eating that?" "Are you exercising regularly?" "Are you breastfeeding?" "Did you get enough sleep?" "Are you are cosleeping?" "Are you feeding them that?" "You let them play video games?" "You let them watch YouTube?" "You allow them many hours of screen time?" "You let them play outside unsupervised?" "You work a part-time job?" "You drink alcohol?" Questioning becomes an everyday occurrence for many mothers, as their bodies and behaviours are compared to the ideal social standards that construct the "good" mother.

I have practiced as a social worker in paediatric healthcare for many years, and my ways of knowing have been shaped by the stories, experiences, and knowledge that mothers and their families have shared with me over this time. I also come to this writing with my own lived experience as a mother of two school-age children. As a sole caregiver, who struggles and battles the pressures and expectations of normative mothering every day, I write this article from multiple subjectivities, But I also recognize that my own position of power and privilege as a white, settler, cisgender, able-bodied, and educated mother and social worker have provided me the opportunity to share my own unique story.

Throughout this article, I examine the dominant biomedical discourses that have constructed categories of "good" and "risky" mothering practices within the area of child health. Drawing on feminist poststructuralism and maternal theory, I examine how everyday mothering practices are compared to normative mothering discourses that position mothers as individually responsible and blamed for their children's health outcomes. Lastly, I explore how the process of self-reflexivity can be an important tool for social workers and service providers to resist and challenge the truths and assumptions of "good" mothering within healthcare settings and the many spaces that intersect with mothers in their everyday lives.

"Good" Mothers, "Risky" Mothers, and Children's Health

Dominant biomedical discourses have greatly affected my understanding of mothering and caregiving. My own mother was a nurse, and I began working in paediatric healthcare as a social work intern in my early twenties. I have

spent my career working alongside children, caregivers, and families within the Canadian healthcare system. Over this time, I have come to understand the strong connection between power and knowledge, and the ways of knowing that are considered superior and more valuable than others within social systems and institutions (Foucault 109; Weedon 109-10). I have learned from experts in the field what so-called "good" mothering should look like in order to promote child health and wellbeing as well as the perceived risks associated with mothers' bodies and behaviours that are understood to contribute to poor physical and mental health outcomes in children. I have also learned important knowledge from the mothers that I have walked alongside in these healthcare spaces. Although each mothering story is unique, a common thread among these diverse maternal narratives is how difficult and overwhelming the navigation of child health promotion and care can be and the tremendous shame and guilt that ensue when a child is labelled unhealthy.

During my first pregnancy, I worked in the neonatal intensive care unit at a children's hospital. I remember watching the small, fragile bodies around me while feeling my own child growing inside me. The intense pressure and responsibility to be a "good" mother also grew stronger with each passing day. Was I making the right choices? Was I going to be a "good" mother? I remember thinking I need to do everything I possibly can to protect my child and to ensure they are healthy. As a cisgender woman, I was aware of the dominant patriarchal discourses that told me how I should manage and control my own body and behaviour in order to be a "good" girl and woman, but the surveillance and control over my body, mind, and spirit was amplified during pregnancy. I began watching, regulating, and questioning everything I did—from the food that I ate, to my exercise and physical activity, my weight, stress levels, and sleep. The list of expectations was endless, exhausting, and overwhelming. Through feelings of guilt and shame, I was reminded daily that even before my child's birth, I was already failing to be a "good" mother.

I quickly became aware of the tension that exists between lived experience and the expert scientific knowledge that I had learned over the years in textbooks, manuals, journals, workshops, and conferences. These tensions continued after the birth of my first son. I was physically recovering from an unplanned C-section in the hospital bed, less than twenty-four hours postpartum. I struggled to breastfeed and endured the emotional and physical exhaustion that no one can ever prepare you for. My son was feeding well but just could not settle and go to sleep. I would pick him up and hold him against my tired, wounded body, the only home he knew prior to his birth, and he would instantly fall asleep. His bassinet was beside my hospital bed. I knew the risks of cosleeping that I had heard repeatedly in my professional work. Yet everything inside me said, "Hold your baby. Let him fall asleep. Close your eyes and sleep." And so I did. We did.

No one can prepare you for the guilt and shame that you feel as a mother as you attempt to navigate the world of motherhood—the ongoing questioning of every decision you make as you strive to be the best mom and to have healthy children. In my experience, no matter what you do, every decision you make, feeling that you are always questioning the decision. While I have many privileges that impact my unique mothering experiences, one common theme continues to emerge across diverse maternal narratives that I encounter in my daily life as social worker and mother; intense guilt and shame that mothers feel when they are unable to meet the societal expectations of the "good" mother.

Are You a "Good" Mother?

Western society's institutional practices, policies, research, and education in the area of child health have historically silenced and devalued maternal knowledges and experiences. Rima Apple explains that "Throughout the nineteenth century, increasingly women were told that they required scientific and medical knowledge in order to raise their children appropriately and healthfully" (115). Feminist theoretical perspectives offer the ability to centre and value the lived experience and voice of mothers as knowledge holders (Rich xi). In this section of the article, I draw on poststructural feminism to explore the social construction of "good" and "bad" mothering that exists within child healthcare systems and institutions.

Poststructural Feminism

Poststructural feminism encourages the questioning of fixed categories and assumptions of "women" and "mother" (Weedon 37). Kelly Ward and Lisa Wolf-Wendel explain the following: "Feminist poststructuralism as an analytical tool digs deeper and focuses on gender in relationship to societal structures, language, power, and discourse. Such a view allows for the examination of women's experiences relative to social practices and power by looking at language, power, difference, and subjectivity" (14). Poststructural feminism offers the ability to examine the relationship that exists between power and knowledge and explore how "good" mothering discourses intersect with multiple subject positions based on categories of race, gender, class, sexuality, fatness, age, or ability (Weedon 35).

Biopower, Maternal Responsibility, and Children's Health

Poststructural feminist thought often draws on the work of French philosopher Michel Foucault to understand the relationship between power and knowledge. More specifically, Foucault demonstrates how social control through language and discourse affects the everyday experiences of individual bodies (Weedon

12). Foucault argues that "each society has its regime of truth, its 'general' politics of truth: that is the type of discourse which it accepts and makes function as true" (131). Within Western society, truths about the category "mother" are informed by diverse academic fields—such as medicine, psychology, social work, and education—become embedded and reproduced across social spaces, institutions, and systems.

Foucault uses the term "biopower" or the "calculated management of life" (262) to describe the classification, control, and regulation of individual bodies and populations. According to Foucault, capitalism and the drive to have productive bodies in the workforce drove society to focus on improving the overall health of individuals and populations. This categorization process developed through scientific disciplines provided the mechanism to screen bodies for perceived normalcy and ideal health outcomes, simultaneously identifying at-risk behaviours, individuals, and populations. Biopower positions the family as a key system in health promotion, as "the health of children becomes one of the family's most demanding objectives" (280). In *The Birth of Biopolitics,* Foucault describes mothering as follows:

> The mother-child relationship [is] concretely characterized by the time spent by the mother with the child, the quality of the care she gives, the affection she shows, the vigilance with which she follows its development, its education, and not only its scholastic but also its physical progress, the way in which she not only gives it food but also imparts a particular style to eating patterns. (243-44)

Biopower encourages a mother to be responsible for every aspect of a child's health through surveillance and management of their bodies and behaviours. Although Foucault's work fails to reflect on the "gendering of responsibilization" (Johnson 33) placed on mothers, biopower is a useful concept to illustrate how the family became central to sustaining and maintaining the healthy development of the child.

The "Good" Mother

Similar to Foucault's description of "truth," Chris Weedon uses the term "common sense" to describe a natural phenomenon that is supported by scientific evidence (73). Within Western society, there is a common belief that mothering is the natural responsibility and a primary role of all women (Weedon 37). As Weedon explains, within this natural role, a "good" mother is, "supposed to meet all the child's needs single handed, to care for and stimulate the child's physical, emotional and mental development and to feel fulfilled in doing so" (33). Although other caregivers and individuals may comprise a child's social support network—such as extended family, friends, neighbours, and teachers—and impact their wellbeing, the primary

responsibility of children's health often continues to fall on mothers.

Who is the "good" mother? She represents normalcy as a white, cisgender, heteronormative, married, middle-class, educated, and able-bodied woman. A "good" mother is feminine, calm, and patient. She is child focused at all times and is continuously making personal sacrifices in the best interests of her children and family (Weedon 38, Rock 21-23). Healthy, fit, and thin, she is considered one of the most influential role models in a child's life and must monitor and regulate all individual choices and behaviours accordingly (Maher et al. 235-36).

"Good" mothering discourses are connected to what Sharon Hays refers to as "intensive mothering" (410) practices, which involve spending extensive amounts of time, money, emotional, and physical energy through caregiving. The ideology of intensive mothering may influence mothers to feel pressured to practice continuous self-surveillance and regulation in order to manage every aspect of their children's health and wellbeing. With the rise of consumerism and the neoliberal drive for individual responsibility, tools and resources empower caregivers to take individual responsibility for the health and wellness of their families (Maher et al. 234). Technology offers mothers the ability to monitor and manage every aspect of their children's health at all times, such as sleep, mood, steps, screen time, calories—the list is endless. The performance of intensive mothering and management creates financial burden and is therefore unattainable to many mothers that do not have access to resources, such as healthy food, recreational activities, healthcare, outdoor space, safe neighbourhoods, or housing. Good mothering ideologies fail to recognize the social determinants and health inequality that impact an individual's health and wellbeing. In addition, normative discourses of mothering intersect with categories of race, gender, gender identity, class, ability, weight, and age to produce the ideal mother, often labelling non-normative bodies as risky. Mothers are constantly judged by individual health practitioners and experience systemic discrimination through everyday practices that produce patriarchal, white, heteronormative, and able-bodied constructions of motherhood. The reality is that the good mother does not exist, and no matter how we all try, no mother will ever be able to perform the role. What happens when mothers are unable to meet these unrealistic expectations? How does striving to reach this unrealistic goal while carrying the heavy burden of guilt and shame affect the minds, bodies, and spirits of mothers in their daily lives?

The "Risky" Mother

The concept of "risk" is a central theme within parenting discourses (Ward 22). As particular mothering behaviours become normalized and accepted within social policies, systems, and institutions, those that fail to meet these

standards are often labelled as "at risk" and may become subjects of surveillance, management, and regulation (Henderson 2, Rock 23-24). Maternal categories of risk can range from age, eating habits, body weight, sleep patterns, sexuality, madness, disability, race, poverty, class, trauma history, domestic violence, or drug use (Clare 69, Singh 1193-1194, Rich xiv-xxii). Any aspect of a mother's subjectivity can be identified by health professionals as a risk factor to their child's health when it challenges the status quo. This obsession with risk can result in mother blaming, as Paula Caplan explains: "I became interested in mother blaming when I was working in a clinic where we were evaluating families, and I noticed that no matter what was wrong, no matter what the reason for the family's coming to clinic, it turned out that the mother was always assumed to be responsible for the problem" (592). Caplan's work illustrates how mothering behaviours and practices become pathologized, devalued, and identified as at risk within medical discourses. These normative assumptions and judgments create categories of "good" and "bad" mothering, which become embedded throughout their social networks. Since Caplan's work was first published (Caplan & McCorquodale 345-53) I would argue that although gender-based analysis has emerged within healthcare education, research, and practice, little progress has been made to recognize and dismantle the systemic discrimination that is experienced by mothers within the healthcare and mental health system.

JaneMaree Maher et al. use the concept of "interlinked bodies" (233) to describe mother and child when examining maternal risk and responsibility associated with children's health and fatness. As mother's bodies and behaviours are positioned as responsible for children's health and wellbeing, they are expected to manage these risks. Maher et al. explain that mothers are encouraged to become "managers" (234) of their own and their children's bodies. Caplan argues that no mother is safe from judgment, as any negative outcome associated with a child falls on the shoulders of mothers (593). Women are judged by society in how well they are able to perform motherhood or wear the "mask of motherhood" (Maushart 460). All of these assumptions and judgments about mothering however are grounded in dominant ideologies of patriarchy, heteronormativity, racism, classism, ableism, and neoliberalism. Moral judgments about a mother's personal choices and behaviours are influenced by these multiple forms of power and oppression in their daily life. Although every mother is blamed, some mothers are identified as a greater risk based on their individual identities, whereas some mothers have access to power and privilege that may allow them to perform the role of the good mother.

As someone who has worked in the area of child health over the years, I am not arguing that child health and wellbeing are unimportant; however, I am questioning the enormous individual responsibility that falls on the shoulders of mothers while disregarding the important role that society as a collective

must play in child and family health. I am also questioning how these truths and assumptions about "good" mothering that consistently ask mothers to put their own needs last affect their overall maternal health and wellness. What are alternative ways of thinking that might consider the health and wellbeing of mother and child, family and society, as a collective? And what role might social workers play in supporting this change?

Implications for Social Work Practice

As social workers, we often find ourselves surrounded by mothering narratives in our daily practice through assessments, counselling sessions, reading, and report writing. How we collect and retell a mother's story within our practice can have a significant impact on the families we work with. Historically, the social work profession has been influenced by dominant biomedical discourses and has engaged with children, mothers, and families that are identified by society as at-risk. As Amy Rossiter explains: "Social work theory is an outgrowth of an Enlightenment inheritance: it calls on totalizing 'truths' which seek to provide unitary explanations of human nature. These explanations provide rough normative expectations for people, and those who fall outside these expectations, either by individual flaw, or the impress of bad social conditions become targets of social work intervention" (24-25). So-called truths about the "good" mother are deeply embedded within social work practice, policy, and research and knowledge production. Self-reflective practice and questioning are therefore required within everyday social work in order to understand how social work contributes to the systemic discrimination of mothers (Rossiter 33). This commitment to reflexivity not only includes understanding our own individual practices but also requires questioning the assumptions of "good" mothering discourses that are embedded within the larger systemic and institutional practices within healthcare and the multiple systems that intersect with mothers' daily lives.

How might we take a step back and destabilize the myths that exist within "good" mothering discourses that are produced within child and family health, including social work practices? How do we begin to value maternal lived experience and knowledge, creating space for the important voices of all mothers? How do we resist dominant discourses that blame mothers for their children's health outcomes, which lead to guilt, shame, impacting maternal health and wellbeing? Can we disrupt neoliberal ideologies of individual responsibility and encourage systems of support that promote health and wellness of mothers, children, families, and communities? In the final section of the article, I consider how social workers might centre the voices of mothers and their unique lived experiences, rethink the practice of family-centred care, and create social systems of support for caregivers and families.

Centring and Valuing the Voice, Knowledge and Experience of Mothers

The knowledge that I have gained working alongside mothers and listening to their stories has significantly shaped my ways of knowing and understanding child and family health. Throughout conversations, mothers often refer to maternal instinct when describing their child's health or illness. Mothers at their child's bedside in the intensive care unit often know when something is wrong. They can feel and understand their child's health in ways that is inaccessible to science. What I have learned over the years is the importance and value of listening and providing space for mothers to be knowledge holders and valuable members of the team. Maternal instincts and knowledge are able to reach beyond the blood work and weight on the scale, beyond the measurements and questionnaires. Service providers need to create space for maternal instinct and knowledge to be valued within service delivery, research, policy, and education.

Rethinking Family-Centred Care

The concept of family-centred care (FCC) in paediatric healthcare has been present since the 1940s as a way to incorporate the voice of families and caregivers within child health systems (Mirabella 1). FCC is common within Western paediatric healthcare settings and includes practices, such as family advisory committees, codesigning programs, participatory research, and evaluation (Mirabella 1-3; Boaz et al. 9-14; Coulter et al. 3-4). Family-centred care provides the opportunity for healthcare professionals to work with mothers, caregivers, and families to address health inequities and to create system change. Although the concept of FCC reflects my position on including the unique voices of mothers and their experiences within healthcare, my personal experience has been that FCC practices often reinforce "good" mothering ideologies and systemic discrimination. The maternal voices that are often heard within child health systems do not represent diversity, as family advisory committees and research participants are often in positions of privilege based on their race, class, gender, education, age or ability.

Child health systems also appear to struggle with mothers that resist or challenge the "good" mother ideology. What happens when a mother disagrees with the plan of care for their child outlined by the professional? Or what happens if a mother speaks up and does not want their child to participate in a recommended weight loss program? What if they refuse to have their child undergo chemotherapy or take ADHD medications? What if a mother chooses palliative care or advocates for continuing medical intervention and this goes against medical advice? Although FCC provides the opportunity for maternal voices to be acknowledged, often in practice, mothers who disagree with expert knowledge become labelled within the system as at risk or

neglectful, negatively affecting the best interests of their child's health.

In my own clinical experience as a social worker, healthcare providers are happy to incorporate the voice of the "good" mother into policy, practice, and evaluation; however, mothers that resist expert knowledge are labelled as "difficult" and "challenging" and may experience judgment, bias, and discrimination. In addition, the majority of mothers that have the capacity to participate in family advisory committees or codesign programming are white, middle class, educated and able bodied. If we are going to integrate maternal knowledge, we need to be willing to recognize the judgment and assumptions of the "good" mother present within current healthcare systems and practices and create opportunities for the voices of all caregivers to be heard.

Incorporating mothers' voices and lived experience must reach beyond the current practice of FCC and must be implemented at all levels of healthcare, including research, policy, and practice. Multiple forms of oppression that intersect with a mother's daily life due to race, class, poverty, age, ability, and fatness must also be recognized and addressed. Social workers are in the position to take the lead in healthcare spaces advocating for inclusive practices and programming. In addition, healthcare systems need to be willing to critique and challenge current practices, research, and social policies that reinforce the "good" mother stereotype in order to truly be able to listen to the voices of mothers.

Strengthening Caregiving Social Networks and Supports

Patriarchy, capitalism, and neoliberal ideologies can position mothers against one another by encouraging individual responsibility in many aspects of childrearing, including child health and wellbeing (Maushart 472-73; Thurer 338). A mother's social network can have strong and positive influences on both maternal and child health, including at the physical, emotional, and spiritual levels (Balaji et al. 1388; Wright 1). Kim Anderson describes how Indigenous mothering ideologies encourage the building of social networks, sharing knowledge, and helping one another (762-65). Creating networks of support for mothers can shift the individual responsibility and blame that creates feelings of failure, guilt, and shame. Patricia Hill Collins uses the term "othermothers" (277) to describe the collective mothering practices that surround a child to support not only their wellbeing but also the wellbeing of mothers and everyone within the collective society. Othermothers are individuals of both genders and varying ages that reside within a child's social network and help to provide care and ensure their wellbeing. Community mothering practices challenge normative mothering ideologies that position mothers as solely responsible for their children's care and wellbeing. Individualization places blame and responsibility on mothers, whereas collective mothering challenges oppressive systems by recognizing shared

vulnerability and encouraging collective action and support networks. Social workers can work with caregivers to develop support systems throughout their communities.

In my current practice, I belong to a parenting collective—a network of community services that come together to support parents and caregivers throughout the region. Many of the members are mothers themselves, and we are working together to support the health and wellbeing of caregivers, children, and their families in our community. Social workers can work within their communities to encourage and build social networks of support for all families. Collectives can also work together to challenge the systems and structures of oppression that affect the daily lives of mothers in the community and to create social systems of support that are responsible for child health and wellbeing.

Conclusion

In Western society, biomedical discourses have socially constructed mothering in particular ways that often blame individual mothers for not producing the perfect, healthy child. Reimagining mothering in the context of children's health requires challenging the normalized assumptions that have created the "good" and "at-risk" mother and valuing individual and unique mothering experiences. Social workers are in the position to acknowledge the complex systems of power and oppression that affect mothers they are working with and can begin to create systemic change in collaboration with caregivers, families and communities. Service providers can recognize that a mother has their own unique physical, mental, and spiritual health needs that are not inferior to child health and wellbeing.

Dominant discourses of the "good" mother can create continuous stress, guilt, anxiety, shame, and blame within a mother's life that can negatively affect their overall health and wellbeing. There needs to be recognition that there is no perfect parenting strategy or technique that produces a "good" mother or healthy child. Parenting manuals, textbooks, and workshops may offer helpful strategies; however, they may not fit within the lived experience of diverse families. It is important for social workers to engage in self-reflective practice to identify and challenge ways in which we may be reproducing normative mothering discourses within our own practice. Through these opportunities, we may acknowledge the importance of both lived and learned experience and reduce the blame and responsibility placed solely on the shoulders of mothers.

Raising a child is one of the hardest things I have ever done. No mother will ever get it right all the time, and the constant pressure to be a "good" mother only makes the process more difficult. Is there a way that we can offer space

within society for all bodies and caregivers to feel that they can be able to make mistakes, learn, and feel supported from one another without guilt or judgment? As Judith Butler explains, if we can start to acknowledge that as human beings, we are all vulnerable bodies, who experience power and oppression in unique ways, we have the potential to come together to create positive change through coalitions, mutual aid, and support and together challenge the structures and institutions that perpetuate inequality (99-103). As mothers, social workers, and human beings, we are all vulnerable and need to be able to recognize this aspect of our lived experience in order to accept and support one another as a collective.

Works Cited

Ahmed, Sara. *Living a Feminist Life*. Duke University Press, 2017.

Anderson, Kim. "Giving Life to People: An Indigenous Ideology." *Maternal Theory: Essential Readings*, edited by Andrea O'Reilly, Demeter, 2007, pp. 761-781.

Apple, Rima, D. (2014). "Medicalization of Motherhood: Modernization and Resistance in an International Context." *Journal of the Motherhood Initiative*, vol. 5, no.1, 2014, pp. 115-26.

Balaji, Alexandra, et al. "Social Support Networks and Maternal Mental Health and Well-Being. *Journal of Women's Health,* vol. 16, no. 10, 2007, pp. 1386-96.

Boaz, Annette, et al. "What Patients Do and Their Impact on Implementations." *Journal of Health Organ Management*, vol. 30, no. 2, 2016, pp. 258-78.

Butler, Judith. "Bodily Vulnerability, Coalitions, and Street Politics." *Critical Studies*, vol. 37, no. 1, 2014, pp. 99-119.

Caplan, Paula J. and Ian Hall-McCorquodale. "Mother-Blaming in Major Clinical Journals." *American Journal of Orthopsychiatry*, vol. 55, no. 3, 1985, pp. 345-53.

Caplan, Paula J. "Don't Blame Mother: Then and Now." *Maternal Theory: Essential Readings*, edited by Andrea O'Reilly, Demeter, 2007, pp.592-600.

Clare, Eli. *Brilliant Imperfection: Grappling with Cure*. Duke University Press, 2017.

Coulter, Angela, et al. "Collecting Data on Patient Experience Is Not Enough: They Must be Used to Improve Care." *British Journal of Medicine*, vol. 348, 2014, pp. 1-4.

Foucault, Michel. *Power/Knowledge: Selected Interviews & Other Writings 1972-1977*, edited by C. Gordon, Vintage Books, 1980.

Foucault, M. *The Birth of Biopolitics: Lectures at the College de France 1978-1979,* edited by M. Senellart, Picador, 2008.

Foucault, M. *The Foucault Reader*, edited by P. Rabinow, Vintage Books, 2010.

Hays, Sharon. *The Cultural Contradictions of Motherhood*. Yale University Press, 1996.

Henderson, Julie. "Michel Foucault: Governmentality, health policy, and the governance of childhood obesity". *The Palgrave Handbook of Social Theory for Sociology of Health and Medicine*. Palgrave MacMillan, 2015, pp. 324-339.

Hill Collins, Patricia. "The Meaning of Motherhood in Black Culture and Mother-Daughter Relationships." *Maternal Theory: Essential Readings*, edited by Andrea O'Reilly, Demeter, 2007, pp. 274-89.

Johnson, Sophia Alice. "'Maternal Devices,' Social Media and the Self-Management of Pregnancy Mothering and Child Health." *Societies*, vol. 4, no. 2, 2014, pp. 330-50.

Maher, JaneMaree, et al. "Framing the Mother: Childhood Obesity, Maternal Responsibility and Care" *Journal of Gender Studies*, vol. 19, no. 3, 2010, pp. 233-47.

Maushart, Susan. "Faking motherhood: The mask revealed". *Maternal theory: Essential readings,* edited by A. O'Reilly, Demeter, 2007, pp. 460-481.

Mirabella, Angelina. *Perceptions of Mothering, Early Intervention and Family-Centred Care*. Unpublished Master's Thesis, Ithaca College, New York, 2014.

Rich, Adrienne. "*Of Woman Born: Motherhood Experience and Institution*" W.W. Norton & Company Inc, 1986.

Rock, Lindsay. "The 'Good Mother' vs the 'Other' Mother: The Girl-Mom." *Journal of the Association for Research on Mothering*, vol. 9, no. 1, 2007, pp. 20-28.

Rossiter, Amy. "The Postmodern Feminist Condition: New Conditions for Social Work". *Practice and Research in Social Work: Postmodern Feminist Perspectives,* edited by B. Fawcett, et al., Routledge, 2000, pp. 24-38.

Singh, Ilina. "Doing their Jobs: Mothering with Ritalin in a Culture of Mother-blame." *Social Science and Medicine*, vol. 59, no. 6, 2004, pp. 1193-1205.

Thurer, Shari L. "The Myths of motherhood". *Maternal theory: Essential readings,* edited by A. O'Reilly, Demeter, 2007, pp. 331-344.

Ward, Kelly, and Lisa Wolf-Wendel. "Academic Motherhood: Midcareer Perspectives and the Ideal Worker Norm." *New Directions for Higher Education*, vol. 2016, no. 176, 2016, pp. 11-23.

Weedon, Chris. *Feminist Practice & Post-structuralist Theory*. Blackwell Publishers, 1998.

Wright, Kevin. "Social Networks, Interpersonal Social Support and Health Outcomes: A Communication Perspective." *Frontiers of Communication*, vol. 1, no., 10, 2016, pp. 1-6.