

Introduction

The global financial crisis (GFC) has seen governments in developed countries introduce a raft of austerity measures, such as reduced spending in areas of social policy including health, to stabilise weakened economies (Labonte, 2012). In Australia, the impacts of the GFC continue to bite into health and welfare funding as the government targets the delivery of health programs and services as a major area for savings (van Gool, 2009). These cuts amplify measures used by the Australian Government to wind back the welfare state and reflect the emergence of neo-liberal forms of government in late modernity (Lupton, 1999). The rationalities of neo-liberal government are informed by a calculative logic through which governmental strategies administer health. One of the goals of neo-liberalism is to monitor and regulate the 'risks' individuals and target populations pose to the state (Lupton 1999, p. 89). For example, populations (e.g., women, children, families) and individuals are identified through their level of 'risk' and strategies of intervention rely on an individual's voluntary management of their conduct (and that of others for whom they might be deemed responsible) to reduce that 'risk' (Lupton, 1999). In the Australian context, women are positioned as a 'risk' population due to their lack of physical activity (PA) (Australia Bureau of Statistics (ABS), 2010, 2012). Furthermore, women with young children are seen to be at higher risk as they are even less likely to engage in adequate PA to manage their own health (Brown, Brown, Miller & Hansen 2001). Of specific concern in this paper is the propensity for the government to place responsibility for family health firmly in the hands of mothers.

We argue that in this process women's 'ethic of care' has been reconfigured and co-opted by neo-liberal forms of rule to create a greater expectation that 'women will shoulder the burden of care (of children and the family)' (Petersen, 2003, p. 195). Thus, while Lewis

and Ridge (2005) believe that women's 'ethic of care' has legitimated and opened up opportunities for women's own PA, on further examination this relationship is far more complex. For instance, the neo-liberal assumptions of responsibility, management and optimisation, particularly in the areas of child and family health, have positioned mothers as a population that is more 'at risk' due to the greater burden of responsibility to model active lifestyle behaviours. Research suggests that children, and in particular very young children, may not be inclined to participate in PA if habitually sedentary lifestyles are reinforced by parents (Franks, Ravussin & Hanso, 2005). Thus, children's dependency on parents to be 'responsible adults' and encourage family-based activities that facilitate PA, places an added burden on mothers to act as role models for acceptable behaviour (Hills, King & Armstrong, 2007) and to deliver health policy outcomes.

As Fullagar (2008, p. 113) concludes, although women are themselves deemed to be an 'at risk' population they have now assumed the 'moral weight' of ensuring they take appropriate measures to eliminate not only their own health risks but any health risks within their families. An important aspect of this 'duties discourse' (Greco, 1993) is the responsibility for instilling in the members of the family a healthy lifestyle. In this paper, we argue that this additional burden of care has the potential to impact negatively on women's own well-being and create a further layer of risk.

Governing mothers and family health

Foucault's (1991) work on governmentality and its contemporary use by theorists such as Rose (1999) and Petersen (2003) provides a useful framework for analysing how women are urged to govern both themselves and their family's activity levels as part of responsible citizenship. Governmentality is concerned with the 'conduct of conduct', the governing of the self and others and how contemporary forms of rule attempt to control or shape our

conduct to align with particular goals of government (Foucault, 1991). In relation to the women in this study, a governmentality approach is used to highlight how the rationalities and strategies of neo-liberal rule are mobilised to urge those in targeted population groups, such as sedentary mothers, to self-manage to minimise their contribution to the burden of disease (Petersen, 2003). The political rationalities of neo-liberalism direct citizens 'through their freedom ... [to] ... make their decisions, pursue their preferences and seek to maximize the quality of their lives' in line with the goals of those who govern' (Rose & Miller, 1992, p. 201). Thus within contemporary health care regimes, individuals are positioned as entrepreneurial and active consumers who assume responsibility for their own health and well-being.

These rationalities are apparent in Australian health policy. Here health initiatives produce a range of truths and norms that are directed at individual lifestyles and behaviour and the exercise of responsibility to prevent the burden of disease associated with 'modifiable risk factors' such as sedentary lifestyle and poor nutrition (Commonwealth of Australia, 2009, p. 7). As Lupton (1995) argues these campaigns rely on individuals identifying that they are 'at risk' and voluntarily self-managing themselves to ensure they reduce their risk. In the case of Australian mothers this also extends to their family, especially their children. Three specific initiatives; 'Healthy Children', 'Measure Up' and 'Swap it don't Stop it' have been produced to facilitate lifestyle changes to reduce the growing epidemic of overweight and obese Australians. 'Healthy Children' was a response to research that indicated one in four children were overweight and one third of children did not meet national physical activity guidelines (Commonwealth of Australia, 2008a). This initiative was an interventionist program to ensure children from birth to 16 engage in appropriate levels of physical activity (60 minutes a day) and to improve the provision of

fruit and vegetables at schools, childcare centres and preschools. In addition, ‘family based interventions’ such as ‘Get Set 4 Life’ targeted the parents of children under four, and highlighted parent’s influence on reducing lifestyle health related risks for their children (Commonwealth of Australia, 2008b).

Parents aged 25 to 50 were also targeted in the social marketing campaigns ‘Measure Up’ and ‘Swap It Don’t Stop It’ which aimed to increase awareness of the link between lifestyle risk factors, such as physical inactivity, unhealthy waist measurements, poor diet and chronic disease. The campaigns also provided information on ‘what to do’ and ‘how to do it’ including 30 minutes of exercise per day and swapping unhealthy food options for healthy. Women in the 25 to 34 age range were a specific target population and were identified as having a higher prevalence of obesity and overweight when compared to other groups within the population (ABS, 2009). However, research into the effectiveness of the ‘Measure Up’ campaign indicated that women rarely focused on their own health, but as primary caregivers the health of their children was of greater importance (GFK Blue Moon, 2010). As stated earlier, women with children are less likely than their husbands or partners to engage in the necessary PA levels in order to ‘measure up’. Further analysis of the campaign illustrated how women assumed responsibility for the health of their family (GFK Blue Moon, 2010).

We argue that these health policies target men and women equally, universalising the masculine experience as the norm, yet mobilise gendered assumptions, such as the ‘ethic of care’ to facilitate lifestyle modification (Fullagar, 2003). This paper draws on Fullagar’s (2003, 2008) work connecting a governmentality approach with feminist theories, to analyse how powerful discourses, such as the ‘ethic of care’ and ‘good mother’ urge women to exercise regulation, discipline and management in relation to their health and PA

levels as well as their children's. Thus, in line with government policy the children also become healthy citizens (Fullagar, 2003). Implied within neo-liberal rationalities is a calculative logic that measures both 'risk' and 'benefits' of PA for women and children's health and locates responsibility for management of family health with individual mothers. This paper examines the influence of public health discourses on women's assumption of responsibility for managing family health outcomes and how this impacts their perceptions and experiences of participation in PA and their health and well-being.

Method

Data presented in this paper were collected from semi-structured, one-on-one interviews conducted in the final stage of a three-stage project. The overall study process was iterative, for example in stage one, focus groups allowed the broad questions to be piloted with respondents. In stage two, time diaries gave potential interviewees the opportunity to document and reflect on their PA experiences and the researchers the ability to identify points of difference between the women and further refine the interview questions. In each stage, a qualitative and interpretive paradigm was adopted with the focus being on ensuring participants were encouraged to express their views and describe and interpret their personal experiences freely (Denzin, 2001).

Initially, a convenience sample of women who were members of mothers groups run by a local community service provider was invited to take part in three focus groups. Each focus group comprised 10 participants. The mother's groups were situated in three different geographic locations with varying socioeconomic demo-graphs in South East Queensland, Australia. After each focus group, participants were given an information sheet which described the next stage of the study and were asked to consider taking part in a further interview. The information sheet outlined: the purpose of the next phase of the project, a

sample of the questions that would be asked, our intention to contact them in one week's time to confirm their participation and arrange a time and place for the interview and their right to withdraw from the study at this stage by telephoning or emailing the chief investigator listed on the information sheet. The project received ethical approval from its institutional review board.

The follow-up phone calls were conducted by the researchers who had led the focus groups in order to establish a level of rapport and trust during the conversation based on these prior shared experiences. Of the initial 30 respondents, 18 women participated in stage three of the project. All interviews were conducted at a time and place convenient to the women. In each case this meant the family home. The majority of the women had at least one child under two, with four women having more than one child and one woman had five. Nine women were pregnant at the time of interview. The majority were married, only one woman indicating she was in a de-facto relationship. Two mothers in the sample were employed full-time, nine were employed part-time and six were currently not engaged in paid employment and one woman was studying part-time. Respondents ranged in age from 26 years to 41 years.

The in-depth, semi-structured interview format was selected in order to find a balance between being able to understand respondents (Fontana & Frey, 2000), listen without evaluating (Converse & Schuman, 1974) and avoid treating the women as objects of data (Reinharz, 1992). An interview schedule was compiled to guide (Patton, 1980), but not direct, discussion. In this way, respondent and interviewer were engaged in a conversation and were able to follow interesting lines of inquiry where relevant which 'allowed for greater rapport and continuity for the interviewee' (Miller & Brown, 2005, p. 409).

Interviews ranged in duration from 60 to 90 minutes and were taped and transcribed

verbatim with the permission of the participants. In each transcript, pseudonyms were used to provide anonymity for the women.

Transcripts were analysed through a process of constant comparison in search for major themes and concepts (Strauss & Corbin, 1998). Three interviews were independently coded by the researchers and comparisons made to determine consistency and shared understanding and to limit personal bias. A coding framework was then developed, with the three researchers comparing and reviewing the coding to ensure that the range of women's experiences was captured. The coding framework was applied across the remaining interviews by the first author to ensure consistency in interpretation. This process was done by hand to remain close to the data and to engage with the women's full text and context. The series of coding passes retained the essential meaning from each interview and allowed the iterative reduction of the data to manageable and meaningful themes (Neuman, 1997). We present our findings through three major themes: 'Modelling health and well-being'; 'Being a better mother' and 'Family health as a burden of care'.

Findings and discussion

Modelling health and well-being

Women who participated in this research assumed the task of role modelling health behaviours for their children. For instance, early intervention, a focus of healthy policy, was seen as a key to instilling appropriate lifestyle behaviours in children in relation to their individual attitude towards being part of an active family unit. Parents and the family environment is increasingly understood as a powerful site through which children's health habits are governed (Coveney, 2006; McDermott, 2008). In particular, the PA of mothers who are at home with young children is suggested to be a strong influence on children's activity levels (Spurrier, Magarey, Golley, Curnow & Sawyer, 2008). Through the discourse of

feminised responsibility, the burden of care and the reduction of health risks associated with sedentary lifestyles are shifted to women (Petersen, 2003). Becky's (married, one child, employed part-time), account illustrates the pervasiveness of the 'active' discourse underpinning health promotion initiatives. Her assumption of responsibility also illustrates how the 'ethic of care' has extended to ensuring her child was also sufficiently 'active'.

I think that, like, I'd like ... as a mother I do feel pressured into being that role model in making sure that (child's name) life is active and I think because in the beginning you sort of think, 'oh, who's he going to be like? Is he going to be, you know, my physique or the husband's physique?'... I think that if I can promote to (child's name) an active life then I would hope that he would be interested in us being active in his family and his life, if that ... if I haven't said 'active' enough.

In a similar vein to Wall's (2010) assertion that mothers felt that they could control and shape their child's brain development, participants also felt their ethic of care extended to responsibility for shaping their child's eating and PA patterns. Women therefore placed a great deal of importance on setting an example, not only in terms of eating healthily, but also in relation to being an active mother. They were fully aware of public health concerns in relation to the consequences of sedentary lifestyles, and most women were conscious of modelling appropriate behaviours while their children were still babies. For Eva (one child, stay at home mother), whose husband worked away from home, the sooner her daughter saw and experienced the outdoors the better. Leaving it until later was seen as having missed the opportunity to 'create' a child who is naturally active as opposed to one who needs to be convinced at a later stage to take up appropriate PA lifestyles and behaviours. Women therefore assumed the task of creating children who were 'good' citizens, who were active as opposed to inactive and who were able to contribute to the collective health of the nation. Eva was therefore very committed to ensuring that her daughter was exposed on a daily basis to her mother's exercise routine. She also quantified her activity levels to

reinforce that she went beyond the recommended minimum of 30 minutes a day. Eva's comment illustrates the calculative techniques that are mobilised by health promotion discourses that quantify PA through emphasising measurement.

Yeah, I think so cause it shows just you as a healthy person, like, showing them that it's important. Like, it's part of (baby's name) everyday life now that she sits in the pram for 45 minutes while I do my walk. And she doesn't ... and then as she get older she might ride and all that sort of thing so it just is a part of our everyday life. Whereas if you tried to introduce to her when she goes to primary school to go and do a sport it might be harder, I think. Because they haven't seen it and if they don't enjoy it then they might not want to do it.

Other women expressed similar sentiments about modelling lifestyle behaviours early in their children's lives that they deemed appropriate and which they hoped their children would maintain as they grew older. Early childhood is increasingly recognised as a time when behaviours are established which may follow the child throughout their life and that will prevent lifestyle related diseases (Campbell & Hesketh, 2007; Hills, King & Armstrong, 2007). As mentioned previously, early childhood is also targeted in health promotion interventions such as 'Healthy Children' and 'Get Set 4 Life'. By extension, mothers are positioned as responsible for governing the health and activity levels of children, which they should ensure meet health promotion guidelines in the name of healthy citizenship.

Not surprisingly the pressure to present a role model to their children also proved to be a motivating factor for women to engage in more PA themselves. For example, Lewis and Ridge (2005) argue that women contribute to family well-being through active role modelling and this enabled them to strengthen family relationships. However, we contend that underlying women's PA-modelling behaviour is a deep sense of responsibility for ensuring that they are modelling the 'correct' levels of activity. In this sense while their perceived responsibility motivated women to do more, they were also uncertain about how much more they had to do. Nevertheless respondents were aware that they had to engage

in PA for both their own health and their children's. Bea (married, two children, part-time employment) struggled with the responsibility of ensuring both she and her children spent enough time engaging in PA. She felt that she was falling short, but her sense of responsibility in 'setting an example' pushed her to do more despite the struggles she encountered to organise the time in which to go walking. In this sense, prescriptive notions of PA engagement ignore the time pressure women already experience as they try to juggle multiple roles and responsibilities. Other women were only participating in PA because of their children. Candy (married, one child, pregnant), for example, felt that role modelling an appropriate 'image' of what it meant to be active for her daughter was 'a natural draw card' that provided the primary motivation for her involvement in PA, otherwise she was simply 'not interested in physical activity.'

Public health warnings about increasing levels of childhood obesity had also fuelled concerns and increased the sense of responsibility for mothers to ensure their children were active and not overweight. The reduction of 'risks' associated with obesity has become the target for government policies which position healthy behaviours, such as healthy eating and physical activities as an imperative of individual choice and action (Fullagar, 2009). However, an attribution of blame and morality is inherent in obesity discourses that position lifestyle related illness as a failure to manage diet and PA. Leanne (married, part-time study) for example, an older mother with two children, spoke about her heightened awareness of the perils of sedentary lifestyles for her children's health and how she wanted to ensure her children,

understand just the benefits of being active. Last thing you want is an obese couch potato really. As a child, especially given that obesity rates are getting worse and worse and having type two diabetes in childhood and you know, it's just incredible that is existing. Um, so yeah, so give them an appreciation of that.

Parents, and more particularly women, are urged to assume responsibility for governing the health and activity patterns of their children. In doing so, they take on the burden of care to educate themselves and their family, provide a healthy environment and motivation for activity, monitor family practices and role model behaviour (Fullagar, 2009) despite, in some cases, their personal ambivalence toward PA. Tammy (married, one child, pregnant, part-time employment) felt that it was her responsibility to provide the motivation for both herself and her family to make sure that they engaged in PA. As she explained 'it's so important to me and I think it's important to the family as well. I try and make sure it happens and I want it to happen. And that's a start ... that's a good start, I think. To actually want it and think it's important.' Mothers therefore engaged in self-discipline to maximise their own health, but also the discipline and maximisation of their children's health.

The assumption of responsibility added to women's 'ethic of care' and the many tasks that mothers of newborns and young children feel constantly pressured to undertake. While respondents spoke with confidence about their role in guiding children to a healthy future, they also referred to, often with less confidence, the social pressure to project the image of a physically active mum. This pressure was complex and had a positive and negative side. First, it created opportunities and legitimated their involvement in PA, similar to findings of previous research (e.g., Lewis & Ridge, 2005; Miller & Brown, 2005). In contrast, a number of tensions arose in relation to women's self-perceptions. For instance, if a mother felt she was not fit, healthy or active enough, it appeared that it would be impossible for them to be a role model for their children regardless of all the activities they did. Bonnie (married, one child), described how in her work as a school teacher she saw

mothers constantly running their children from one activity to another, but not looking after themselves, hence not setting an appropriate example. This was not the type of mother she aspired to be.

Yes I don't want to be this mother who is overweight and doesn't look after herself, cos they spend all the time, as a teacher you see it all the time, these kids that are pampered and go to dance class, to this class and this class, then there's this mother that's not doing anything to instil that in the children.

Women's PA therefore assumed a regulative ethos as their efforts were directed at calculating risk and benefits for both themselves and their children (Rose, 1999). The regulative aspect translated into both a calculative logic and a duties discourse (Greco, 1993), which often left women feeling that it wasn't enough to simply engage in PA, their participation had to be directed at achieving optimisation of their activity. Women therefore measured their activity levels against public health discourses that indicated how much and how often they should engage in PA. Elise (married, one child, stay at home mother) strove to be a 'duty' driven active mother mobilising public health discourses that prescribed what to do and how much to do. She had set aside three mornings a week where she would walk to keep her fitness and felt that she was following recommended guidelines in regard to what 'they tell you, you have to do.'

Duty and optimisation driven PA then created an additional pressure in women's role modelling which often overrode their ability to look after their own needs. It also negated the possible pleasurable aspects of involvement in PA (Fullagar, 2009). Thus, in terms of public health discourses and guidelines, the physical health 'outcomes' of PA appeared to be considered more important than an alternative ethos that embraces intrinsic pleasure and social relationships. Lisa (married, one child, pregnant, part-time employment) was trying to ensure that PA became a 'normal' part of her children's lifestyle.

She also thought that through emphasising the fun aspect they would be more inclined to participate. Yet for Lisa herself, PA was a 'chore' and something she had to do. Not only did Lisa not enjoy PA she felt that she had to change her attitude towards it so that she would enjoy it more. Deciding she didn't have the time to go to the gym (she was juggling work and a young baby) to exercise, Lisa purchased an expensive treadmill in the hope that she would be able to find the time to use it at home however, 'it just sits there and gathers dust.'

In role modelling appropriate behaviour for their children it seemed that some women attempted to subvert health imperatives through notions of pleasure and choice, while at the same time were also concerned that they were making an investment in their child's future health. Women negotiated a double edged-sword, as they tried to maintain a healthy weight range for themselves, with the child bearing years recognised as representing a risk for weight gain (Gunderson & Abrams, 2000), while ensuring that they were conveying to their children they were exercising for pleasure and not necessarily to maintain a particular body shape. Given the concern in relation to eating disorders in children, particularly girls (American Psychiatric Association, 2000), women with daughters were very conscious of the effect of social pressures to maintain the 'ideal' slender body. Eva (married, one child, part-time employment) wanted to convey to her daughter that she was engaging in PA for pleasure, and that losing weight was not her focus. At the same time, self-management strategies of maintaining a healthy lifestyle sit alongside Eva's emphasis on pleasure and show how enjoyment has been co-opted as the maintenance of a fit body.

And even with (child's name) I don't say stuff like that around her. So I make sure that when I say 'exercise' it's enjoyment and to keep fit and so that I can do things as I get older and not ... yeah, so I just make sure I say the right thing. I might be thinking I'm doing this to tone up and to lose weight and that but I wouldn't communicate that to her.

Eva's comment about being able to 'do things' as she gets older, alludes to another important aspect of women's PA, that is, being active helped them be a better mother.

Being a better mother

Certainly for many mothers, their own physical and mental health was central to being a good role model and a better mother. As discussed previously, of greater significance was how wanting to be a better mother legitimated women's participation in PA (Lewis & Ridge, 2005). However, women still had to feel that their participation in PA aligned with discourses of healthy and active lifestyles that emphasise constant self-improvement rather than an ethos focused on their own enjoyment. In an extension of the logic of risk and benefit, women therefore expressed a desire to be physically active so that they could keep up with their children. This made them feel as if they were fulfilling their mothering role well. For example Becky (married, one child, part-time employment) described herself as a 'good mother' and this was very much linked to her perception of herself as an active mother.

Or my role as a mother is probably ... not more important as a ... as physical activity cause I obviously need to be active to be healthy to be a good mother. Cause being active, like you were saying gives you that energy and gives you the brain power to think and be happy to then be a good mother. So I think it all relates to each other.

Being a fit and healthy mother aligned with healthy discourses of motherhood and citizenship. In this sense being a healthy, active and fit mother meant that neither they, nor their families were going to contribute to the burden of disease associated with sedentary living. Di (married, part-time employment) was conscious that with five children and pregnant with her sixth child she had quite a moral responsibility to remain fit, not only for herself, but also so that she could manage her children's activity behaviours. She was driven by a 'moral repertoire of shoulds' (Fullagar, 2002, p. 78), indicating that she felt she 'should'

exercise to 'do my bit' particularly while being pregnant. Pregnancy is a time when both her own health and that of her baby's is considered 'at risk', but is able to be managed through exercise (Nash, 2011). Di also wanted to ensure that she could 'keep up' with her children if they required her to be in a race with them at their sports day or when they were learning to ride their bikes.

Being a responsible mother also extended to monitoring the family's eating behaviours. Respondents felt the burden of ensuring that their children's diet met recommended daily nutritional requirements. Policies such as 'Healthy Children' and interventions such as 'Get Set 4 Life' place a heavy emphasis on parents monitoring and managing their child's nutritional intake. Women felt this constant surveillance of their child's eating habits was an extra burden of responsibility and quite demanding. Thus, simply engaging in PA was not enough. Monica (married, one child, pregnant, stay at home mother) expressed concern that if she didn't maintain a healthy diet, both she and her family might suffer. While she may have been confident of her family's healthy diet, she also thought that perhaps she wasn't optimising the PA behaviours of her family for healthy outcomes. Maintaining the balance of PA and healthy eating was crucial to good mothering and achieving benchmarks of healthy living.

Oh, well you want to be fit to be a mum, to be able to play and run around with them. Also not just short term but long term too, you want to be there for them, like, you know, if you are fit now, then when you're older you're going to be more like not to have as much health problems and you know, you want to be there, seeing them grow up and umm, and food is a priority in our home. Like, healthy eating and umm, good food, like we get organic food and we ... I put a lot of effort into our meals and juicing and stuff like that, yeah, but I probably ... its probably a bit umm ... I put a lot of priority to that but probably not enough to the physical side...

Although physical health dominates most policy agendas for creating healthier individuals and families, the links with psychological well-being and PA are also prevalent

within health policy. Many women legitimised their PA as essential for maintaining their mental health and well-being. Both the BlackDog Institute (<http://www.blackdoginstitute.org.au/>) and BeyondBlue (<http://www.beyondblue.org.au/>) web-based depression information sites strongly advise that exercise may alleviate depression symptoms. Lewis and Ridge (2005, p. 2301) also indicate that women with young children benefit from PA as it helps them stay 'sane' so they can look after their children. With depression identified as the third largest cause of disease burden for women (Noble, 2005) and constant concern expressed in the popular media and women's magazines (Gattuso, Fullagar & Young, 2005) respondents were engaged in PA as a self-management strategy to forestall any threat to their mental health. As Fullagar (2002, p. 78) points out, through the enterprise of active leisure one can attain 'psychotherapeutic notions of freedom through health.' Tammy (married, one child, pregnant, part-time employment) illustrated how she was acting upon herself to ensure that any ill-health caused by her dissatisfactions did not impact on the overall well-being of the family.

Yes, because it makes me umm, happier and healthier and I'm not sick, I'm not umm, angry ... oh, what is it? Crabby, I'm not a crabby person. Because you know, it lifts your spirits and makes you feel better. Yeah. And then, the whole family doing it, it benefit's the whole family and it's something you can do together sometimes and its fun. And everyone's happy, and healthy. Yeah, it reduces I think ... definitely reduces your stress levels, like you can build up and build up stress and then you can go for a run or something or do some physical activity and it just reduces that. Lets off steam and you feel better.

While Tammy may have felt better as a result of her PA, underpinning her legitimations are elements of guilt that she may fail to self-manage her emotions so that they didn't impact negatively on both her own and her family's well-being. Guilt and shame were powerful emotions expressed by these women that worked to extend their ethic of care into a burden of care.

Family health as a burden of care

The goal of being an active, 'good mother' with an active, healthy family often conflicted with respondents' feelings that they were not meeting prescribed levels of PA. However, perhaps more importantly, a number of respondents revealed that they did not want to meet those levels of activity. These women engaged in self-blame for their inability to engage in practices that meet prescribed norms of activity. Women also experienced guilt and shame because they felt they had not fulfilled their obligation to assume the 'burden of care' that has been prescribed to them by the state (Petersen, 2003, p. 195) and were not doing enough both for themselves and their families. The health policy agenda openly employed guilt as a motivating factor in attempting to get women to 'measure up' and keep their family's lifestyle within stated health guidelines. However, the guilt respondents spoke about was intensified by feelings of shame for their perceived 'sedentary' lifestyle and its potential impacts on their family. As Rose (1999) points out, technologies of government work through the calculated administration of shame. Bauman (2005) also argues that health promotion discourses work through the mobilisation of fear and guilt.

While for many women competing priorities didn't allow them to model appropriate behaviours, they also felt that they did not 'measure up' when it came to their own PA levels, evoking feelings of guilt and shame. These emotions, along with self-sacrifice are inherently associated with ideals of motherhood (Sutherland, 2010). Shame in particular is an emotion that involves negative self-evaluation and the prospect that women will feel they are being judged or socially sanctioned by others for failing to live up to ideals of motherhood (Deonna & Teroni, 2008). In addition women also experienced the same sense of social sanction in relation to their inability to prioritise PA. Di, a mother of five children and expecting her sixth, felt she was not meeting norms of PA by failing to find the

prescribed 30 minutes a day, an unrealistic expectation given the priorities of motherhood. Brown, Brown and Powers' (2001) findings from a longitudinal study on Australian's women's health suggests that time pressure impacts on women's mental health. Di felt that she was being judged as lacking in her responsibilities to her family and even described herself as 'lazy' because she was unable to prioritise PA in her busy schedule.

I mean we all know what we should be doing I mean I should be walking an hour a day but you say you're too busy and it's not that we are too busy you just put other things as a priority, the other are mostly things to do with being a mother. Not intentionally but you kinda get lazy about things, especially with the hot weather. I could be walking to school everyday it's only five mins up the road and before I was pregnant I was but now I'm not. I just say Oh I'm pregnant and I'm a mother and I have to get all the kids ready. So yeah I guess I do use it as an excuse. It's terrible isn't it? You said you were not going to be judgemental. I think most people would say if they were honest they do occasionally use motherhood, unless they were those real women who are actually committed to, they have their exercise regime and nothing is going to interrupt that.

The negative evaluation implied within Di's narrative, and her perceived failure to live up to standards of idealised active motherhood, have the potential to intensify feelings of guilt and shame (Liss, Schriffen & Rizzo, 2012).

The self-blame that emerged in Di's narrative is often an aspect of many women's self-relationship (O'Grady, 2005) and as women engage in negative self-surveillance, they shamefully find themselves wanting. In terms of health outcomes, women blame themselves, are blamed by others (including other women) and public policy makers for not regulating their day to find 30 minutes in which to exercise. Thus, women's shame is associated with failing to meet norms of behaviour, both in relation to motherhood (Sutherland, 2010) and PA. Rather than attribute their 'laziness' to the demands that they felt were being made of them, they saw their lack of motivation as a personal failing, a lack of desire to stay healthy or inability to organise themselves better. As Locke (2007, p. 151)

argues the 'shamed subject focuses on changing herself so that she might accommodate the demands of her milieu.' Lewis and Ridge (2005) also found that the stress and disappointment women experienced when they failed to achieve participation goals had the potential to negate any positive benefits of PA. In this study, some respondents saw this as a personal and social failure. Lisa, (married, one child, pregnant, part-time employment) was continually disappointed by her lack of motivation, and thought that she should be motivated enough to 'make the time' for PA.

It's quite embarrassing. Yeah, I've got time. Yeah. But I just make up excuses. Everyone's got time. Everyone can make time. But it's whether you want to or not. Want to enough or if you're motivated enough. No. Just talking about it makes you realize how lazy you are.

This type of negative self-reflection in relation to PA then became an added physical and psychological burden that Lisa and other respondents had assumed because they couldn't find the time and motivation to engage PA. Yet paradoxically, it is well documented that mothers with young children are chronically time poor (Gunthorpe & Lyons, 2004) and unable to find the time to engage in appropriate of PA levels to attain health benefits (Brown, Brown, Miller & Hansen, 2001). In addition, the pressure respondents felt was not simply to participate in approved levels of PA, it was also to ensure that they managed their 'spare' time wisely. Many women engaged in a battle with themselves over feelings that they 'should' be doing something more productive with their time. The demands for productivity are clearly aligned with neo-liberal technologies of government that emphasise active and entrepreneurial citizenship. Women attributed their lack of ability to manage their time in a more productive manner as a personal failing. As Elise (married, one child, stay at home mother) explained, time for PA was fragmented, and for her was something 'you've got to do.' Doing nothing or resting was deemed a waste of time.

We waste ... you can waste time, can't you? You just waste time, especially looking after (child's name) and you can always find something to do or you can just make a choice and go, 'no, not going to do that' and wait and have time for yourself. So yeah, I think we ... there's more time there than you realize as well. It's using it wisely.

As Fullagar (2008) argues, despair, anger and guilt all arise in relation to the demands of managing the family's health. Similar emotions, such as exhaustion and anger are also evident when women believe that they are failing to be a 'good mother' (Warner, 2005) as is required of them, both within contemporary notions of intensive mothering (Rizzo, Schriffin & Liss, 2012) and within contemporary health discourses.

Concluding comments

Public health discourses position both mothers and children as 'at risk' populations requiring interventions to encourage them to adopt healthy lifestyles. For the women in this study, their 'ethic of care' had been appropriated by technologies of government that mobilised a 'duties' discourse which shifted the onus of the long-term health management of the family to them. As a consequence women experienced an ongoing dissonance in relation to their ability to conform to the regulation of health behaviour that is increasingly associated with what it means to be a good mother. Women conveyed a deep sense of responsibility for ensuring they were governing their own behaviours and lifestyle to reflect imperatives of health so that such behaviours became part of their children's health repertoire. They were also very conscious that often their own attempts to remain fit did not measure up, and felt duty driven to regulate their PA so they met prescriptive notions of required activity levels. As a consequence any pleasurable aspects of women's PA were often negated by the regulative injunctions associated with their participation.

Women's engagement in PA was also driven by their desire to fulfil contemporary notions of feminised responsibility and they legitimated prioritising PA as essential for them to fulfil this role. The discourse of a healthy, fit mother, mentally and physically, both now and in the future, ran strongly through the interviews. Participants also felt they should be able to keep up with the regulated measures they were trying to instil into their children. While women may have used their 'ethic of care' to legitimate their own PA, paradoxically they experienced feelings of shame and guilt that signified they had failed to exercise appropriate management strategies to care for themselves and their children. As responsible citizens, mothers should be regularly engaging in their own PA and be enterprising in finding the time to govern their children's PA. For many women this 'ethic of care' then became a 'burden of care' as women felt they were constantly failing to 'measure up'. Women were positioned as lazy, inadequate and lacking in motivation because they didn't manage their time more productively. Women's self-relationship is often already characterised by negative judgments (O'Grady, 2005), and their perceived failure to meet expectations in relation to good mothering and public health discourses intensified this negative relationship. Hence for many women, the 'burden of care' and the accompanying shame and guilt added a layer of psychological strain that has been strongly linked to depression in women (Kim, Thibodeau & Jorgensen, 2011).

We argue that the messages utilised in health promotion discourses can create a sense of fear and guilt for many women who take on the responsibility of managing family health outcomes. The messages require rethinking in light of the continued decline in PA levels of mothers with children, particularly young children, and the increase in overweight and obesity in both at-risk populations. Rather than creating opportunities for women to engage in PA, the intensification of shame women experience when they feel they are

failing to exercise self-discipline to 'measure up' to prescribed levels of activity may also lead to an increase in women's depression. This is a concern given that depression is the leading cause of disease burden for women in both high and middle income countries (WHO, 2008). In addition, the 'burden of care' experienced by the interviewed women left many feeling immobilised as they tried to manage, regulate and discipline themselves and their families to meet the norms of health promotion discourses and the expectations of motherhood. Unfortunately, some women believed they had failed at both.

Policy makers may miss the opportunity to increase engagement in PA and enhance the health of mothers, children and the family as a whole by placing more emphasis on the pleasurable aspects of PA and the range of PA activities that can promote good health but are not linked to a duties discourse and a calculative logic that regulate norms of participation. As Fullagar (2003, p. 58) argues health promotion discourses may 'actually work to suppress different modes of embodiment that can be produced through active leisure in its multiple forms and across the continuum of physical movement.' It is clear that the development and marketing of current health policy and initiatives in Australia needs to focus on a wider range of opportunities for and forms of engagement in PA. Depicting health as a broad spectrum of physical, mental and social relations that emphasise pleasure rather than measured self-improvement opens up other possibilities that are far more achievable ideal for most families. This may lessen the load on mothers who, as our study has shown, struggle to fulfil their duty to comply with PA and dietary regimes prescribed by current government policy, often to the detriment of their own health and well-being.

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