

The University of Bradford Institutional Repository

<http://bradscholars.brad.ac.uk>

This work is made available online in accordance with publisher policies. Please refer to the repository record for this item and our Policy Document available from the repository home page for further information.

To see the final version of this work please visit the publisher's website. Available access to the published online version may require a subscription.

Author(s): Johnson, Sally and Capdevila, Rose.

Title: 'That's just what's expected of you ... so you do it': Mothers discussions around choice and the MMR vaccination.

Publication year: 2014.

Journal title: Psychology & Health.

Link to original published version: <http://dx.doi.org/10.1080/08870446.2014.892940>

Citation: Johnson, S. and Capdevila, R. (2014) 'That's just what's expected of you ... so you do it': Mothers discussions around choice and the MMR vaccination. Psychology & Health, 29 (8); 861-876.

Copyright statement: © 2014 Taylor & Francis. This is an Author's Original Manuscript of an article published by Taylor & Francis in Psychology & Health on Aug. 2014 available online at <http://www.tandfonline.com>
<http://dx.doi.org/10.1080/08870446.2014.892940>

‘That’s just what’s expected of you... so you do it’: Mothers discussions around choice and the MMR vaccination

Abstract

One of the major shifts in the form and experience of contemporary family life has been the increasing insertion of the 'expert' voice into the relationship between parents and children. This paper focuses on an exploration of mothers' engagement with advice around the combined measles, mumps and rubella (MMR) vaccine. Much of the previous literature utilises a 'decision-making' framework, based on 'risk assessment' whereby mothers' decisions are conceptualised as rooted in complex belief systems, and supposes that that by gaining an understanding of these systems, beliefs and behaviour can be modified and uptake improved. However, less attention has been paid to the ways in which mothers negotiate such advice or the ways in which advice is mediated by positionings, practices and relationships. Analysis of data from a focus group with five mothers identified three themes: 1) Sourcing advice and information, 2) Constructing 'Mother knows best' and 3) Negotiating agency. Despite the trustworthiness of advice and information being questioned, an awareness of concerns about the MMR, and health professionals being constructed as remote, ultimate conformity to, and compliance with, the 'system' and 'society' were described as determining MMR 'decisions'.

Keywords: The MMR vaccination, advice to mothers, qualitative analysis, risk, choice, agency

Mothers, Responsibility and Immunisation

Constructions of mothering are not only shaped historically but also through scientific authority (Hays, 1996). As mothering is deemed too important to be left to mothers alone, a shift in the form and experience of contemporary family life has led to the increasing insertion of the 'expert' voice into the relationship between mothers and children. Not only are parents constructed as increasingly in need of this expert, scientific advice but also as a potential source of risk or harm to their children. As well as more obvious and intentional harm, not being aware or being 'out of touch' are represented as forms of harm (Lee, Macvarish & Bristow, 2010, p. 295). In particular, Lee et al. (2010) argue, health concerns associated with children have become pivotal in developing our contemporary risk-averse and risk-aware culture. It is in this context mothers are *expected* to seek advice, research and make 'choices' with regards to issues that affect their child's health. One such 'choice' is in relation to the MMR vaccination.

The MMR decision has been selected because it represents a time-limited choice mothers make, but also because it is an example of a high-profile public controversy, created over a decade ago when a medical journal printed the results of research that linked the combined MMR vaccine to the development of health problems, primarily autism (Wakefield et al., 1998). The research was widely reported in the media, particularly in the UK. Studies have indicated that more concern has been expressed about the MMR than other forms of immunisation (Macoachie & Lewendon, 2004; Smailbegovic, Laing & Bedford, 2003), emphasising the impact of the controversy. The concern has been such that some parents have refused to vaccinate their children, whilst others have sought out and paid for alternative forms of vaccination, such as separate injections (Anderberg, 2011; Brown et al., 2010).

Whilst resistance to the MMR persists, in 2004 uptake began to rise again (Brown et al., 2012) as allegations were raised against Wakefield's research (Ferriman, 2004). In 2010 the journal retracted the original paper (The Editors of the Lancet, 2010) and Wakefield himself was struck off by the UK General Medical Council's Fitness to Practise Panel (GMC, 2010). During this time, a plethora of social scientific research on the uptake of the vaccine has been undertaken. Given this background, we would contend that this controversy brings into sharp focus the ways in which motherhood, science, risk and agency can be brought into relation with each other.

Much of the literature on parents', predominantly mothers' (Brown et al., 2010), choices in relation to the MMR vaccine utilises a 'decision-making' framework based on 'risk assessment' whereby parents are conceptualised as 'weighing up' the risks of contracting measles, mumps or rubella and the severity of these against the perceived side effects and safety concerns of the vaccine (e.g. Pareek & Pattison, 2000; Smailbegovic et al., 2003). Within this decision-making framework, other researchers have argued that parents do more than a risk/benefit assessment of immunization: they overlay 'decisions' with their beliefs and perceptions about vaccine related factors which influence whether to vaccinate or not (e.g. Brown et al. 2010; Evans et al., 2001). In addition, Hilton, Petticrew and Hunt (2006) propose that parents individually assess their child's immune system's ability to 'cope' with either the vaccine or disease in order to reach a decision. The primary assumption of such studies is that parental decisions are rooted in complex belief systems and that through gaining an understanding of these systems, beliefs can be modified leading to better uptake (Brown et al., 2010). Interventions aimed at 'assisting' parents to make a more 'informed choice' in relation to the MMR are being developed in line with this assumption (see for example, Gardner Davies, McAteer & Michie, 2010; Jackson Cheater, Peacock, Leask & Trevena, 2010).

Nonetheless, in their recent review of factors underlying parental decisions about combination childhood vaccinations, including the MMR, Brown et al. (2010, pp. 4246-4247) conclude that though ‘vaccine-acceptors’ and ‘vaccine-decliners’ differ on a number of factors, interventions based on immunisation-related cognitions have only a small effect on behaviour. They suggest that, in part, the lack of impact of interventions is because they are generally based on quantitative studies which may have an incorrect focus. Brown et al. therefore identify qualitative studies as having more potential for exploring ‘decision-making mechanisms’. Furthermore, by adopting a positivist decision-making framework attention is focused on a range of proximate, essentialised individual characteristics of mothers, who are viewed as having the potential for making ill-informed choices. These conceptualisations reinforce dominant notions of mothering as they portray individual mothers as making such decisions and as responsible for their child’s health.

Gross and Pattison (2007) amongst others (e.g. Petts & Neymeyer, 2003; Poltorak, Leach, Fairhead & Cassell, 2005) argue that mothers’ ‘decisions’ in relation to their children are located in broader social contexts and mediated by, for example, lay understandings, interpersonal relationships and the media. Some research on the uptake of the MMR vaccine has engaged with broader contextual issues. This literature indicates that vaccination ‘decisions’ are influenced by a number of misconceptions and lay theories in relation to children’s immune systems and their ability to cope with illness (e.g. Cassell et al, 2006; Gellin, Maibach & Marcuse , 2000; Poltorak et al., 2005). For instance, Poltorak et al. (2005) outline how the mothers in their study conceptualised their child’s health as subject to particular vulnerabilities (or lack of vulnerability) to disease with the effects of immunisation leading to a personalised approach to choice in relation to the MMR. For instance, gender has

been identified as relevant, with mothers of boys less likely to have their child vaccinated with the MMR, as autism is more commonly diagnosed in boys (Casiday, 2006). In addition, a range of studies have focused on issues of trust, highlighting a lack of trust in government sources and medical authority (e.g. Guillaume & Bath, 2004) whilst other parents were seen as more credible sources of advice (e.g. Gardner et al., 2010; Hilton Petticrew & Hunt, 2007). This perception of credibility extended to health professionals who shared information about themselves as parents (Brownlie and Howson, 2005). Certain studies also highlight participants' expressed views on their own GP as a credible source of information (e.g. Casiday Cresswell, Wilson & Panter-Brick, 2006). Perhaps this mismatch between mistrust in medical authority and trust in individual health professionals might be explained in relational terms given a preference for personal, face-to-face engagement with health professionals about the MMR vaccine has been identified as important to parents in facilitating trust (Petts & Niemeyer, 2004).

Furthermore, studies have found that the MMR is imbued with a sense of social responsibility, with many parents disapproving of those who do not immunise their children (e.g. Skea Entwistle, Watt & Russell., 2008; Tickner, 2009) and associating refusal with 'bad' parenting (Brown et al., 2010). This presentation of immunisation as moral obligation and indicator of good citizenship has been equated to notions of population, or 'herd', immunity (Skea et al., 2008; Wood-Harper, 2005). Moreover, Brown et al (2012) identified an explicit tension between parents across and within MMR decision groups which they claim has been infrequently observed elsewhere. A discourse analysis of BBC media coverage highlighted how science was drawn upon to argue for both the safeness and the dangerousness of the MMR vaccine (O'Dell & Brownlow, 2005) thereby creating conflicting understandings. As Poltorak et al. (2005,) put it, 'When parents "talk MMR" they are not merely exposing their

scientific reading, but also what they regard as valued parenthood, their responsibility to their child, their trust in institutions, how they place themselves amongst their friends and so on' (p. 718).

As can be seen, the MMR controversy has given rise to a sizable literature. Whilst every now and again the issue resurfaces, as it did with an outbreak of measles in the spring of 2013 in Swansea, South Wales, a substantial amount of time has now passed since the controversy first erupted raising questions as to how mothers have engaged with it over this period. Brown et al. (2012) highlight the importance of investigating how such a controversy evolves over time. In such complex contexts, it has been argued that mothers both engage with, and resist, professional advice (Murphy, 2003), thereby implying a dynamic, on-going process.

Therefore the aim of this study was to explore the ways in which, in the focus group, mothers make sense of, and work with, varying advice and information (both from professional and non-professional sources), within their specific contexts and circumstances, particularly in relation to the MMR and vaccinations, and identify how this is mediated by positionings, practices and relationships.

Methodology

Ethical approval was firstly gained from both Universities in which the authors are employed for a study involving a focus group with five mothers of preschool children between the ages of 12 and 18 months which took place in 2011. The age of the children was chosen as the MMR vaccine is generally offered and administered when a child is between 12 and 13

months of age in the UK health care system (NHS) and therefore the mothers would have had recent experience.

Participants were recruited through a Children's Centre in the north of England who offered their facilities. A poster inviting participation was placed on a notice board at the Children's Centre and the staff agreed to mention the study to any potential participants, offering them an information sheet explaining the study and outlining their rights as participant (it was also available near the poster). Potential participants were able to contact the researchers directly or provide contact details in a sealed envelope to be passed on to us to arrange a suitable time and date. On the day, participants were briefed verbally at the beginning of the focus group to reiterate the purpose of the study and their rights and asked to complete a participant details form and sign a consent form. See Table 1 for a description of the participants. (Pseudonyms have been used).

Insert Table 1 about here

We note that the research focused on a specific group of women, in a particular location. These women were generally well educated, and, with one exception, not first time mothers.

The discussion was audio recorded for later transcription and both the researchers were present. The focus group explored the participants' experiences of engaging with advice around five broad areas:

1. Views about immunisation and the MMR
2. Decisions in relation to immunisation and MMR
3. Advice about the MMR vaccination

4. Media coverage of the MMR controversy
5. Advice to mothers generally

Participants were not asked if they had vaccinated their children. However, during the discussion all participants told us that they had.

The focus group lasted for one hour and 20 minutes and produced particularly rich data. Though all women were encouraged to participate in the focus group, some inevitably contributed more than others, which is reflected in the quotes presented. However, our observations of the focus group were that it was comfortable and relaxed. All the participants knew each other and none of them seemed to display any concern or distress in relation to the reporting of the more vocal members. Once the discussion was completed, the participants were fully debriefed and given the opportunity to ask any questions about the research, reminded of their rights and provided with a thank you letter which included information about sources of support and advice. Participants were reminded of their right to withdraw themselves or their data from the study at anytime up to a given date, when data analysis began. They were also asked if they would like the opportunity to review the transcript or receive copies of any publications resulting from the research. None of the participants took up any of these options.

Focus groups provide a way of collecting data which more closely resembles 'naturalistic' conversation and interaction (Wilkinson, 2004), thus we chose this data collection method over that of individual interviews.. Given the controversial nature of the MMR vaccination, the dynamic nature of such interaction thus allowed for discussion, debate and sometimes disagreement between participants, enabling them to build upon what others had said and

therefore produce more elaborate responses than might be generated through individual interviews (Wilkinson, 2004). Though the use of the focus group method can provide valuable insights through the analysis of such interactions (Kitzinger, 1994), the purpose of the analysis we present here is to focus on the ways in which language was used by participants to construct MMR 'decisions'. Given the focus of the study on how the controversy has played out over time, the focus of the previous literature on the aftermath of the initial controversy and a method of analysis new to this area of study, conducting a focus group was deemed appropriate. This approach facilitated an empirical exploration of the data collected, but also a conceptual engagement which sought confirmatory data in relation to the existing literature.

The data were transcribed verbatim from the audio recordings and analysed from a feminist and poststructuralist perspective which looks to the construction and positioning of gendered subjectivities through attention to the production of knowledge, power and agency (Gavey 1989, Weedon 1997). As both authors acted as moderators for the focus group, both also contributed to the analysis of the data; discussing, developing and confirming the final analysis, thus enhancing rigour (Meyrick, 2006). Specifically, we each completed an initial independent analysis using thematic analysis (Braun & Clarke, 2006) while also noting relevant discursive features (Parker, 1992, 2005) to afford context for, and provide insight into, the themes identified. This involved listening to the focus group recording while reading and rereading the transcript to identify key patterns. Once the initial analysis was completed the researchers exchanged codes and themes. The joint focus was then to employ these to explore how mothers report their experience of using advice and information in relation to the MMR and vaccinations, and to identify how these are described in relation to how mothers, in particular, are produced.

The process of analysis resulted in the identification of a number of intertwined themes, three of which are discussed in this paper: 1) Sourcing advice and information, 2) Constructing ‘Mother knows best’ and 3) Negotiating agency. On occasion in discussing these themes, we identify certain discursive features such as different constructions of advice and choice, links between these constructions and wider discourses, the subject positions that these constructions and discourses made available and their implications for action and subjectivity.

Analysis & Discussion

Sourcing advice and information

Participants indicated that they had learned about the MMR and vaccinations through media coverage, the internet, health professionals/the NHS, and other mothers. The media coverage was constructed as alerting mothers to potential danger in relation to the MMR. Reference was made to the reported link between the MMR and autism and other conditions by Dr Andrew Wakefield some 13 years earlier. Concerns about the safety of the MMR were discussed using the metaphor of a ‘red flag’ to convey the warning of danger in comparison to other vaccinations:

Anna: I think it’s a red flag, when you see it, a red flag. I remember seeing a news report about that whereas all of the others... (352-353¹)

¹ Numbers in brackets refer to the line numbers on the full transcript.

Even though the link between the MMR and autism has been dispelled it was implied that this is not what people remember today:

Anna: 'but I think a lot of people now just remember there being a scare about it' (73-74)

Offit and Coffin (2003) report that the widespread media coverage of the Wakefield et al. study resulted in a loss of confidence in the MMR and despite subsequent studies finding no evidence of a link between autism and the MMR, some parents still remain concerned that the MMR is not safe. This portrays the power and authority of the media in that this earlier media coverage is still seen as raising concerns about the MMR. In a discussion about using internet forums and sites, there was also a sense of caution about the reliability of information:

Louise: I think I'm quite wary of looking on the internet for things cause... there's no control over it... It's good I think if you just want to get general advice about things but I think things about vaccinations, I don't think I'd...(629-631)

When NHS sources were discussed they were talked about in a somewhat vague way:

Emma: I remember being given the booklet but I don't know who by or when or whether it was the... NHS vaccinations leaflet (502-505)

Jane: I think they [midwives or health visitors] might have mentioned when they'd be but there wasn't much detail about it (507-508)

Though the mothers indicated this sense of a vague awareness of being given and reading leaflets, Emma said she thought that what she had read in the leaflets conveyed ambiguous information. Her concerns about vaccines containing certain ingredients were assuaged: ‘but they don’t tell you what else is actually in it’ (Emma, 271-273). In addition, she said that reading the leaflets had made her aware of potential risks and that things can go wrong as details about the Vaccination Damage Scheme were given. She expressed concerns that there was a lack of information about the MMR to help mothers make informed choices:

Emma: There’s not much information ... to help you weigh the risks and benefits generally... There’s so little information about either. (324-329)

Though information was talked about in a somewhat vague way, here Emma constructs choice within a risk/benefit discourse. Whilst this is dominant in the literature, as we argue above, this was not a common construction within the focus group.

There was little indication of discussions with health professionals:

Anna: ...you don’t get any sort of, like somebody talking to you, you don’t even get any interaction with anybody about them [injections], it’s just ...a very basic letter, you get the booklets (947-950)

In contrast, other mothers were constructed as useful sources of valid advice because outcomes were visible:

Anna: I think that's where most of the advice comes through [from other mothers] ... cause I... look up to other people who've got kids who are older... I look to them for advice about what they've done because they're right in front of me I can see how well rounded their child is (laughter) (584-589)

This supports Gardner et al. (2010) and Hilton et al. (2007) who also found that other parents were seen to be a credible source of advice, specifically in relation to the MMR. Along these lines, relationships were seen as important in terms of who, and where, the women said they would go to for advice. In relation to the MMR and vaccinations, health professionals were portrayed as somewhat remote, being the 'last port of call' (Anna, 1118) or 'last resort' (Emma, 1445). This was because they were seen as too busy or because of the formality and inaccessibility of the system (busy Baby Clinics or having to make an appointment). Petts and Niemeyer (2004) found that only 25% of their participants spoke to their GP. However, younger, white, first-time mothers did so more commonly than Asian mothers, for instance, who expressed somewhat distant relationships with their GPs and a concern with wasting the doctor's time. For our participants, groups run at the Children's Centre were seen as a 'first port of call' for general advice. This space allowed them to build up relationships with other mothers in similar situations which they presented as facilitating trust in the advice received:

Emma: ...it's a safe environment, you've got people you trust [...] and you've seen them over a number of weeks and heard their response to things...and that you're accepted (1133-1136)

Thus, relationships as well as conventions and practices with respect to health professionals were constructed as influential in terms of sourcing advice and information.

When it came to the broader context, however, ‘you put your trust’ in the ‘system’. In part this was explained as a response to the demands of early motherhood. Mothers were constructed as too busy to read and research:

Helen: Mothers are so busy as you said with other things to discover and we trust the NHS... we don't have time to sit on computer discovering what is that (285-291)

However, a sense of mistrust, particularly of science-based advice, was also discussed. In the context of a discussion on the changing advice around weaning, Anna remarked how scientific certainty can suddenly change. As a result she questioned ‘expert’ advice on an important aspect of ‘good’ mothering; protecting ‘your child’s health’:

Anna: It makes me slightly untrusting [...] I think well how can they just say that and just, so confidently, you know, think the atom is the smallest thing until they split it open and then it's not and they can just so quickly just change and I think that's, that's hard when you're trusting these people with your child's health. (715-720)

Conflicting advice was portrayed as causing them to question the validity of ‘expert’ knowledge: ‘you know it was like, if you can't decide, you know, the experts, then...’ (Louise, 935). Confusion was expressed about ‘who to trust’ and ‘how much of what they tell

you' to take 'on board' (Anna, 1506-1507). Correspondingly a range of other studies has highlighted mistrust of government sources and medical authority specifically in relation to the MMR (e.g. Gardner et al., 2010; Guillaume & Bath, 2004; Hilton et al., 2007).

Constructing 'Mother knows best'

Within this confusion, a recurring theme was that of the 'mother' as the final authority – you have to trust yourself. In discussing advice from health visitors, Jane made the point that 'they should say this is a guideline but with *your child you know*' (emphasis added)(757). There are a number of ways in which the 'Mother knows best' construction was sustained in the focus group discussion. One way, probably unsurprisingly, was in terms of a 'biological imperative' discourse as is illustrated in the following extract:

Author 2: Which (source) do you find most trustworthy?

Anna: You listen to everybody's advice and just go and follow your instincts in the end

(701-702)

Here instincts are presented as trumping any type of advice, even professional advice.

'Instincts' appear to function as the mediator that can adjudicate on the multitude of, often contradictory, information and advice that is available. Instinctive behaviour is closely tied to notions of motherhood as pre-existing rational discourse and acquired knowledge. It has a value in our culture that can be presented as incontrovertible. However, the voice of 'maternal instinct' is something that comes into play 'in the end'. Advice is still sought out, so it is in

the arena of information that instinct can arbitrate. The discourse around ‘instinct’ further positions the mother as ultimately having to ‘know best’ to be able to be recognised as legitimate.

Another way in which the ‘Mother knows best’ theme is developed is through the experience of ‘mothering’. For instance, Emma told us that:

Emma: I think I’d question it much more second time round than first time. (26)

And

Emma: ...now I think now as I’ve got an older one I don’t need, feel as if I don’t need to ... (645-646)

According to our participants, the knowledge that comes from experience exists not only in themselves, but in other mothers as well, who then become the source of advice:

Author 2: Yeah, do you tend to get advice from other mums?

Anna: I think that’s where most of the advice comes through
(583-584)

Emma: I definitely think that you talk to other mothers and get advice (596)

With the experience of being a mother comes a certain empowerment for Emma, who explained that, once you’ve had a child...

Emma: ...we can actually challenge because we've got some knowledge to come against them all (1280-1281)

The mothers we talked to spoke of giving, as well as receiving advice (648-650) and the experience of mothering was presented as more relevant than professional qualifications. In this way, health visitors who are mothers, were distinguished from those who are not. The former being more critical of 'official versions' of advice.

Anna: You know with your health visitor whether or not they've had a child, and they're telling you something, but there's a look on their face like, 'I don't really believe what I'm saying to you' (1588-1590)

Thus, within discourses of maternal instinct and experience, Anna presents the 'mother' as knowing better than the 'health visitor', even when both are the same individual. This supports Brownlie and Howson's (2005) notion of 'leaps of faith', in that trust in relation to the MMR is further enhanced when health professionals shared information about themselves as parents. Brownlie and Howson argue that trust is a complex relational practice situated within particular socio-political contexts. This, they suggest, is the reason why educational campaigns alone do not work. Noncompliance is not necessarily based on misinformation; in an age where we are sceptical of information, interaction and relations with health professionals can be centrally important or, alternately, irrelevant. Attention to how this is played out, we would argue, is crucial for informing practice and how to support these relationships.

In an extract we saw earlier, Anna offered both an explanation, but also a qualification of her belief in experience.

Anna: I look up to other people who've got kids who are older and you know and I look to them for advice about what they've done because they're right in front of me I can see how well rounded their child is (586-589)

Whilst Anna is arguing for the importance of experience, not any experience will do and, in making this point, she positions the mother as ultimately responsible for the 'well roundedness' of their child. So, not only does 'mother know best', it is the responsibility of the mother to 'know best' (Lee et al., 2010).

Unsurprisingly, the responsibility of motherhood wove its way through the focus group discussion. So, whilst there was a strong discourse around the authority of 'motherhood', particularly in terms of instinct and experience, these were by no means the only narratives that were drawn on in 'decision-making'. The importance of getting it right - 'it's all your decision' (Anna, 1508) 'it's expected of you, you're the Mother' (Anna, 1511), and what to do when 'Mother doesn't know best' or indeed, simply 'doesn't know' were expressed as key concerns. This led to a more nuanced and complex narrative of decision-making and responsibility in which agency was negotiated in manifold ways.

Negotiating agency

In comparison with other knowledge about their children's needs, knowledge about vaccinations was constructed as beyond a mother's.

Anna: yes you know within yourself when your child's hungry, you don't know within yourself whether they're going to get measles therefore you trust the health care professionals (110-113)

So, whilst, 'mother knows best' may work on an instinctive level 'within yourself', in some arenas, when it comes to vaccinating, the mother has to look outside herself. Therefore, some trust had to be placed in the health care professionals, which, as we discussed above were presented as 'the last port of call' for much advice. However, whilst healthcare professionals were mentioned as providing the service, they were not constructed as particularly agentic either. Agency, rather than being placed in health professionals, was primarily attributed in broader terms to 'the system' or 'society'; as Louise put it 'you are driven by the system' (210). Importantly, then, having a child vaccinated was not constructed as a 'decision' but rather as a form of compliance or conformity.

Anna: It's one of the things you're just expected to do isn't it? You get them weighed and on another day you go and get them jabbed. I don't think I've really thought about it as much as I should have really (15-17)

Immunisation, thus, according to our participants, was something you were prompted to do by the system as part of the routine of having a baby, and you don't really think about.

Mechanistic metaphors such as 'the wheel in motion', 'the cogs that go round' were used to

emphasise the sense of an unstoppable, remote process, that comes into play ‘when you have a child’ (Louise 7-13)

As a systematic, almost mundane, procedure, compliance with the immunisation program was further constructed as something that is ‘expected’ by ‘society’ and by implication something mothers must ensure is carried out – the agents of society, rather than of themselves. As in Anna’s earlier quote, ‘It’s one of the things you’re just expected to do isn’t it?’ (15).

Louise: I think what it still boils down to that’s just what’s expected of you... it’s a society thing isn’t it. This is when your child has these things so you do it (298-300)

In any case, mothers were presented as having very little time to consider information on risk:

Helen: Mothers are so busy as you said with other things to discover [responding to a question about reading information leaflets on vaccinations] (285)

In this context, the process was constructed in a passive way as ‘something that just happened to you’, and that you don’t have to think about in the early stages of motherhood when you’ve ‘got so much on your plate’ (Louise, 980).

Anna: I think it’s something that just happened to you, especially with the very first vaccinations that they had when they were very little, I was just in a trance most of the time I mean, I was barely sleeping, you know he was physically

sucking energy from me...every two hours. I was just you know, vaguely following instructions (972-977)

So, in this sense, the mother is not presented as the one who 'knows best', or indeed 'knows' at all, but simply a subject of more powerful forces.

However, this did not imply that mothers were not held responsible for the outcome of these processes. The guilt and worry that mothers hold was a prevalent theme: 'everything's about feeling guilty' (Louise, 991), 'there's guilt about everything' (Anna, 1308) and 'the responsibility for another person's life, as a parent, is terrifying' (Anna, 1313). Some research has identified guilt as a prevalent experience in motherhood (e.g. Williams Donaghue & Kurz, 2012). Furthermore, the currently popular *intensive mothering ideology* that constructs motherhood as child centred, emotionally involving and time-consuming (Hays, 1996) has become in many senses synonymous with 'good' mothering. To meet their responsibilities, it is argued, mothers should engage in 'maternal practices' including nurturing, protecting and training their children (Arendell, 2000, p. 1194). Women who violate this ideology of intensive mothering risk being judged (Arendell, 2000) as this perspective positions them as morally responsible for 'maternal practices' - including the immunisation of their children.

Concurrently, there was, at times, a sense of gratitude or relief expressed that going along with the 'system' in relation to the MMR was a way of diminishing the worry and guilt that is explicitly linked to motherhood.:

Louise: Well I quite like that though, that I don't have to make that decision...I think, you know, cause you have like you say, got so much on your plate ...

Helen: hmm that's taken care of

Louise: that I think it's right

(979-981)

Anna: If you've got something you blame it makes things a lot easier doesn't it?

Author 1: Yeah

Anna: Especially if it's an outsider and not you as a mother

(1421-1423)

This shifting of agency away from the mother can be a useful way of managing the competing demands of motherhood. This reprieve from guilt could therefore be embraced as a welcome and useful subject position that can be further shored up by the enrolment of a moral rightness discourse. In the context of a discussion about the potential seriousness of measles in relation to the MMR, Louise said 'you are told that you have to have them' (318-319) implying little choice or discussion around immunisation. Complying with the MMR was further constructed as a social responsibility in that 'you are doing the right thing' (Louise, 986-987). This alignment with notions of herd immunity allows mothers to be positioned as good citizens (Skea et al., 2008; Wood-Harper, 2005) and is aligned with the currently dominant neoliberal moral obligation to take personal responsibility for health and make the 'right' choices (Crawford 2006).

Drawing on the 'mother knows best' discourse, participants described how the reported general agreement of other mothers (the ones whose advice they say they trust as we mentioned above) played into this decision. When Anna did discuss vaccinations at a Bumps

and Babies group with other women, vaccination was constructed as something you should comply with:

Anna: But general consensus seems to be ‘oh we’ve been sent a letter so we’d better go do that’. (580-581)

And Louise similarly talks of appealing to conformity when faced with the decision.

Louise: I didn’t know what to do, she put it on the spot [...] I was like I don’t know and I actually hold my hand up and said ‘what do most people do?’ (153-156)

Together with the benefits of ‘going along’ with the system, participants mentioned many disincentives for trying to take back agency. In comparison to other ‘decisions’ mothers make, such as those around feeding and weaning, the MMR ‘choice’ requires one to ‘opt out’ of the ‘system’ which was presented as ‘a huge faff’ (Anna 1082):

Anna: If want to have any sort of alternative it’s er, it’s a huge faff, like you were saying... you have to pay for it, you have to go to a clinic that’s far away if you’ve got another child who’s in school how do you coordinate that ... (1082-1086)

Going along with the established ‘system’ was easier and quicker

Anna: So people just think oh it's just easier...I'll just do this the thing the NHS offer cause it's up the road and it's gonna take twenty minutes (1089-1093)

Overall these conversations conveyed a sense of very little agency, with early childhood vaccinations being presented not as a 'decision' on the part of the mothers but as something they simply 'did'.

Conclusions

Though mothers were constructed as responsible for 'knowing best', in the context of the MMR vaccination, agency was largely placed elsewhere. Despite the trustworthiness of advice and information being questioned, an awareness of concerns about the MMR, and health professionals being constructed as remote, ultimately conformity to, and compliance with, the 'system' and 'society' were described as determining MMR 'decisions'. Of the existing literature, none of the cost/benefit decision-making framework (e.g. Pareek & Pattison, 2000; Smailbegovic et al., 2003;), attitudes and perceptions about vaccines (e.g. Brown et al. 2010; Evans et al., 2001), mothers misconceptions about immunisation (e.g. Cassell et al, 2006; Gellin et al, 2000; Poltorak et al., 2005), nor mother's ability to 'assess' children's immune system (Hilton et al, 2006), which dominate the MMR literature, capture the issues discussed in this focus group. Risk was reportedly managed through notions akin to the intensive mothering ideology (Arendell, 2000; Hays, 1996), the worry and guilt inevitably associated with motherhood (Williams et al., 2012), a desire to be a good citizen (Skea et al., 2008; Wood-Harper, 2005), and neoliberal moral obligation (Crawford, 2006), thereby through giving up agency, rather than through choice (Lee et al., 2010). In this sense,

‘science’ and ‘expert advice’ travelled more easily the path of power than that of knowledge. In line with Murphy (2003) we saw evidence of engagement with, and resistance to, professional advice to varying degrees. However, this engagement was not described as ‘cognitive’ but rather as practical and contextual predicated by issues such as busyness, tiredness, ‘too much on their plate’. So it was the everyday, arguably mundane, processes and practices that the women in our focus group drew on to explain and describe their ‘choices’. In this way, immunisation was produced as a largely mundane and compliant activity in which risk, and as a result practice, was governed through constructions of motherhood, science, authority and guilt.

We would argue that through the use of this exploratory focus group and novel method of analysis in the area of mothers engagement with health advice, specifically surrounding the MMR vaccination, we offer valuable insights into how a high profile controversy has been translated, engaged with, and become embedded over a period of time. As such, the present study provides a substantial challenge the existing wisdom in relation to MMR ‘decisions’ prevalent in the literature to date.

A key question that has been raised for us is, which contexts and what dominant discourses around ‘scientific knowledge’ and ‘expert advice’ function to produce conformity, rather than resistance, as the road most travelled. As such it would be valuable to explore more fully the social processes involved in how scientific evidence, particularly surrounding the MMR controversy, gets translated through different mediums into ‘advice’ and how those who receive this ‘advice’ engage with it. This could be achieved, for instance, by more fully tracing the paths from scientific research, through professional services, key publications, websites and informal sources and networks to the user with a more demographic diversity

sample in terms of geography, culture, SES and ethnicity. This could involve not only the views of mothers but also professionals involved in their care and an analyse literature given or available to parents and popular websites including discussion threads. It is anticipated that such a project would develop further the novel understanding gained in the present study surrounding the social process identified and involved in the embedding of contested knowledge and its translation into practice in a health context.

Word count: 7861

References

- Anderberg, D., Chevalier, A. & Wadsworth, J. (2011). Anatomy of a health scare: Education, income and the MMR controversy in the UK. *Journal of Health Economics*, 30 515-530.
- Arendell, T. (2000). Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage and the Family*, 62, 1192-1207.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Brown, K.F., Kroll, J.S., Hudson, M.J., Ramsay, M., Green, J., Long, S.J., Vincent, C.A., Fraser, G. & Sevdalis, N. (2010). 'Factors underlying parental decisions about combination childhood vaccinations including MMR: A systematic review'. *Vaccine*, 28, 4235-4248.
- Brown, K.F., Long, S.J., Ramsay, M., Hudson, M.J., Green, J., Vincent, C.A., Kroll, J.S., Fraser, G. & Sevdalis, N. (2012). 'UK parents' decision-making about measles-

- mumps–rubella (MMR) vaccine 10 years after the MMR-autism controversy: A qualitative analysis. *Vaccine*, 30, 1855-1864.
- Brownlie, J. & Howson, A. (2005). ‘Leaps of Faith’ and MMR: An Empirical Study of Trust, *Sociology*, 39, 221-239.
- Casiday, R. (2006). Uncertainty, decision-making and trust lessons from the MMR controversy. *Community Practitioner*, 79, 354-357.
- Casiday, R., Cresswell, T., Wilson, D. & Panter-Brick, C. (2006). A survey of UK parental attitudes to the MMR vaccine and trust in medical authority *Vaccine*, 24, 177-184.
- Cassell, J.A., Leach, M., Poltorak, M.S., Mercer, C.H., Iversen, A. & Fairhead, J.R. (2006). ‘Is the cultural context of MMR rejection a key to an effective public health discourse?’ *Public Health*, 120, 783-794.
- Crawford, R. (2006). Health as a meaningful social practice, *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 10, 401-420.
- The Editors of the Lancet (2010) Retraction—Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children. *The Lancet*, 375(9713), 445.
- Evans, M., Stoddart, H., Condon, L., Freeman, E., Grizzell, M. & Mullen, R. (2001). ‘Parent’s perspectives on the MMR immunisation: A focus group study’. *British Journal of General Practice*, 51, 904-910.
- Ferriman, A. (2004). MP raises new allegations against Andrew Wakefield. *BMJ*. 328(7442), 726.
- Gardner, B., Davies, A., McAteer, J. & Michie, S. (2010). ‘Beliefs underlying UK parents’ views towards MMR promotion interventions: A qualitative study’. *Psychology, Health and Medicine*, 15, 220-230.
- Gavey N. (1989). Feminist poststructuralism and discourse analysis. *Psychology of*

Women Quarterly 13, 459-475.

General Medical Council (2010). GMC Fitness to Practise Panel Hearing, 24 May 2010, Andrew Wakefield, Determination of Serious Professional Misconduct. Retrieved from http://www.gmc-uk.org/Wakefield_SPM_and_SANCTION.pdf 32595267.pdf Retrieved 2013-01-21.

Gellin, B. G., Maibach, E. W. & Marcuse, E.K. (2000). Do parents understand immunizations? A national telephone survey'. *Pediatrics*, 106,1097-1102.

Gross, H. & Pattison, H. (2007). *Sanctioning pregnancy: A psychological perspective on the paradoxes and culture of research*. London: Routledge.

Guillaume, L. & Bath, P. A. (2004). The Impact of Health Scares on Parents' Information Needs and Preferred Information Sources: A Case Study of the MMR Vaccine Scare. *Health Informatics Journal*, 10, 5-22.

Hays, S. (1996). *The Cultural Contradictions of Motherhood*. New Hale: Yale University Press.

Hilton, S., Petticrew, M. & Hunt, K. (2006). 'Combined vaccines are like a sudden onslaught to the body's immune system': Parental concerns about vaccine 'overload' and 'immune-vulnerability'. *Vaccine*, 24, 4321-4327.

Hilton, S., Petticrew, M. and Hunt, K. (2007). Parents' champions vs. vested interests: Who do parents believe about MMR? A qualitative study. *BioMed Central Public Health*, 7, 1-8.

Jackson, C., Cheater, F.M., Peacock, R., Leask, J. & Trevena, L. (2010). Evaluating a web-based MMR decision aid to support informed decision-making by UK parents: A before-and-after feasibility study. *Health Education Journal*, 69, 74-83.

Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health and Illness*, 16, 105-121.

- Lee, E. J. (2008). Living with risk in the age of 'intensive motherhood': Maternal identity and infant feeding. *Health, Risk & Society*, 10, 467–477.
- Lee, E. J., Macvarish, J. & Bristow, J. (2010). Risk, health and parenting culture. *Health, Risk & Society*, 12, 293–300.
- Maconachie, M. & Lewendon, G. (2004). Immunising children in primary care in the UK: What are the concerns of principle immunisers? *Health Education Journal*, 63, 40-49.
- Meyrick J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology* 11, 799-808.
- Murphy, E. (2003). Expertise and forms of knowledge in the government of families. *The Sociological Review*, 51, 433-462.
- O'Dell, C. & Brownlow, C. (2005). Media reports of the link between MMR and autism: A discourse analysis. *British Journal of Learning Disabilities*, 33, 194-199.
- Offit, P.A. & Coffin, S.E. (2003). Communicating science to the public: MMR vaccine and autism. *Vaccine*, 22, 1-6.
- Pareek, M. & Pattison, H. M. (2000). The two-dose measles, mumps, and rubella (MMR) immunisation schedule: Factors affecting maternal intention to vaccinate. *British Journal of General Practice*, 50, 969-971.
- Parker, I. (1992). *Discourse dynamics: Critical Analysis for Social and Individual Psychology*. London: Routledge.
- Parker, I. (2005). *Qualitative psychology: Introducing radical research*. Maidenhead: Open University Press.
- Petts, J. & Niemeyer, S. (2004). Health risk communication and amplification: Learning from the MMR vaccination controversy. *Health, Risk and Society*, 6, 7-23.
- Poltorak, M. Leach, M. Fairhead, J. & Cassell, J. (2005). MMR talk' and vaccination choices: An ethnographic study in Brighton. *Social Science and Medicine*, 61, 709-719.

- Skea, Z.C., Entwistle, V.A., Watt, I. & Russell, E. (2008). 'Avoiding harm to others' considerations in relation to parental measles, mumps and rubella (MMR) vaccination discussions - An analysis of an online chat forum. *Social Science and Medicine*, 67, 1382-1390.
- Smailbegovic, M.S., Laing, G.J. & Bedford, H. (2003). 'Why do parents decide against immunization?: The effect of health beliefs and health professionals'. *Child: Care, Health and Development*, 29, 303-311.
- Tickner, S., Leman, P.J. & Woodcock, A. (2009). Parents' views about pre-school immunization: An interview study in Southern England. *Child: Care, Health and Development*, 36, 190-197.
- Wakefield, A. J., Murch, S, H., Anthony, A., Linnell, J., Casson, D, M., Malik, M., Berelowitz, M., Dhillon, A. P., Thomson, M. A., Harvey, P., Valentine, A., Davies, S. E. & Walker-Smith, J. A. (1998). Ileal-lymphoid-nodular hyperplasia, non specific colitis, and pervasive developmental disorder in children. *The Lancet*, 351, 637-41.
- Weedon C. (1997). *Feminist Practice and Poststructuralist Theory*, 2nd edn. Oxford: Blackwell.
- Wilkinson, S. (2004). Focus Group Research. In D. Silverman, (Ed.) (2004) *Qualitative Research: Theory, Method & Practice*. London: Sage.
- Williams, K., Donaghue, N. & Kurz, T. (2012). 'Giving guilt the flick': An investigation of mothers' talk about guilt in relation to infant feeding. *Psychology of Women Quarterly*. Published online before print October 30, 2012, doi: 10.1177/0361684312463000.
- Wood-Harper, J. (2005). Informing Education Policy on MMR: balancing individual freedoms and collective responsibilities for the promotion of public health, *Nursing Ethics* 2005 12, 43-58.

Table 1: Participants

Anna	Aged 26-35, with two children aged 15 months and 6 years. Anna described her current occupation as that of part-time sales assistant. She described her husband/partner as a skilled engineer who worked full-time. She self-defined as working-class. Both Anna and her husband/partner were educated to 'A' Level or equivalent and she described herself as White British.
Emma	Aged 26-35, with two children aged 15 months and 3¾ years. Emma was not currently working and did not give any previous occupational details. She described her husband/partner's occupation as professional and full-time. She self-defined as middle-class. Both Emma and her husband/partner were educated to degree level or equivalent. She described herself as White British.
Helen	Aged 26-35, with one child aged 12 months. Helen described her occupation as that of teacher and though she was not currently working she planned to return to it. She described her husband/partner as not currently employed. She was educated to degree level and her husband/partner to 'A' level or equivalent. She described herself as Eastern European.
Jane	Over 35 years of age, with two children aged 15 months and 5 years. Jane worked part-time in Marketing. Her husband/partner was employed full-time as a skilled trader. She self-identified as working-class. Both Jane and her husband/partner were educated to GCSE level or equivalent and she described herself as White British.
Louise	Over 35 years of age, with two children aged 13 months and 6 years. Louise described her occupation as being that of part-time IT Project Manager. Her husband/partner worked full-time in a skilled occupation. She was educated to

	degree level or equivalent and her husband to GCSE level or equivalent. She described herself as British.
--	---