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DEPENDING ON PARENTING EXPERTS. EXPLORING THE AMBIGUITY OF CARE IN THE RELATIONSHIP BETWEEN NEW PARENTS AND VISITING CHILDREN'S NURSES IN DENMARK.

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Abstract

In recent years, parenting has again become a prominent topic in public debate in the Global North. With ever more studies stressing the importance of the early years to lifelong outcomes and 'success', parenthood has come under scrutiny by public and expert institutions, and the position that parents should rely on expert advice has become prevalent. Based on ethnographic fieldwork among visiting children's nurses (*sundhedsplejersker*) and new parents in a Danish municipality, this paper explores the dynamics between these nurses and parents and how the former reinforce the discourse that parenting must be learned from experts. In Denmark, all new parents are offered visits by a children's nurse who monitors the baby's development and helps guide their care for it. Examining the tensions in the nurses' work between their wish to empower new parents, and how they reinforce the parents' dependency on their help and validation, the paper explores how each group (re)produces the other as 'needed' experts and 'needing' experts.

[1] Postdoc at the Research Unit for General Practice, Aarhus University, Denmark. Contact: as.grauslund@ph.au.dk. – I would like to thank Tatjana Thelen and Ivan Rajković as editors of the *Vienna Working Paper Series* and the two anonymous reviewers for their productive suggestions for revising this paper. This paper is written on the basis of my doctoral dissertation. Therefore, parts of the paper first appeared in my dissertation.

Introduction: Learning to parent

In Denmark, all new mothers (and increasingly, also fathers) are invited to join a mothers' (or fathers') group (*mødregruppe, fædregruppe*), which offers a space to discuss any topic related to parenthood: birth, baby care, in-laws, and so on. These groups are organised by visiting children's nurses, but they are run solely by the mothers: the nurses never attend. At one group meeting, I asked Louise[2], a new mother who had just qualified as a (general practice) nurse, whether she felt that her education had equipped her to care for her infant. "I suppose", Louise answered, then laughed and shook her head. "No, I still don't know if I'm doing it right, and I'm never sure what the little pimples and rashes mean," she said with a smile. Then she continued: "We are just so used to getting responses and acceptance of what we're doing. For someone to tell us 'You're doing that right.' I just think in this society we're so used to there being an answer, a solution (*facit*). And then you have a child. And you just get to take it home and take care of it, and we don't get any comments or marks on how we are doing it." The other mothers there agreed. "And then you have driving licences", one said. "When you want to drive a car, you need to take a lot of both theoretical and practical lessons, practise and pass a test before you get permission. But when it comes to having and taking care of a child, anyone can just go ahead and bring it into the world. No lessons, no practice, no test is needed."

In 2019 and 2020, I carried out fieldwork among visiting children's nurses and the parents who received visits from them in a Danish municipality that I call Vipperup. The parents told me that they found themselves faced with a steep learning curve and eagerly sought expert guidance. They emphasised how they were on completely new territory therefore happy – and even eager – to get support and supervision. As the mothers in this group are hinting when they compare having a child with getting a driving licence, many parents expect to have to learn the theory and practice of being a parent. This position is reflected in the literature on parenting in modern 'Western' societies, which argues that a parent is no longer something you are but something you do (Faircloth et al. 2013; Lee 2014). Being a parent has become a practice rather than a state (Lind et al. 2016, 2). Parenting has thus come to be understood as an area in which one must continuously learn and gain new competencies and knowledge (Faircloth et al. 2013; Furedi 2001; Lee et al. 2014). Alongside this change of perception, new experts in parenting have been sought and emerged in both the public and private sectors (ibid). In most European and North American countries, the topic has increasingly been debated in both the general

[2] I use pseudonyms for all interlocutors and places in this article.

interest media and politics, with municipal initiatives including parental support or educative programmes (Haukanes and Thelen 2010, 15; Widding 2014; Widding 2015). Parents are thus increasingly accustomed to being offered and accepting 'expert' help to take care of and raise their children – and have their parenting practices externally validated.

Returning to the conversation in the mothers' group, three things struck me. The first was how requests for preparational courses and professional help indicated their uncertainty and anxiety about the new role and responsibilities they faced as new parents. Second was how used to evaluations of their practices these mothers seemed to be. Their ideas like introductory courses on 'the infant child' and 'parenting' and their use of words like 'marks and 'licences' indicate a wish for externally approved evidence of a certain skill set that would grant social validation of their competencies and identity as a parent. Third, the mothers' comparison of having a child with getting a driving licence – as well as their talk about preparational courses, tests and getting a licence – indicates that they believe that there are more and less right ways of parenting and also displays a wish to achieve some kind of idealised competence in being a parent and parenting.

The visiting children's nurses and the state institution (*Sundhedsplejen*) they represent play an active part in relation to all three points. In this paper, I will explore how Danish visiting children's nurses reinforce the idea of a 'right' way to parent and the parents' desire for validation, as well as how parents contribute to and reproduce these ideas. I will then examine how both the nurses and the parents contribute to this expert control surrounding modern parenthood and how the nurses despite their reassurances, reinforce the discourse that parenting is something one must learn, preferably with the help of experts, rather than something one 'naturally' knows how to do. In particular, I will examine the tensions and contradictions in the nurses' work between empowering new parents to be independent and making the parents dependent on the nurses' continual help and validations. The nurses meet the parents' anxieties with encouragement about the multiple 'good' ways to care for babies and validations of the parents' inherent knowledge of how to care for their children 'properly'. The nurses assert that they seek to nurture these inherent abilities, to 'empower' the parents and make them confident in their parenthood. Thus, on the one hand, the nurses' wish to help new parents become confident in their own parenting practices, and on the other hand, they reinforce their need for their assistance and guidance on how to care ('properly') for babies. Digging into this tension in the nurses' work with new parents further allows me to look at the different dimensions of 'care work' and challenge the notion of care being inherently good. By understanding the

nurses' validations of the parents' practices as 'acts of care', I show how the nurses and parents reproduce their need for continued 'expert' involvement in parenthood and thus keep themselves 'stuck' in a dependency relation even though the nurses repeatedly state that they intend to empower the parents and make them independent. This tension between the nurses' efforts to make the parents self-reliant and their continuous encouragement of the parents to seek and follow expert guidance from them and the Danish Health Authorities (DHA) renders it almost impossible for parents to be – or to be allowed to be – truly self-reliant in their parenting, I argue. Hence, I seek to complement the existing literature on parenting with a perspective on how expert institutions reinforce a need and moral expectation of actively including and relying on expert advice in their parenting. Moreover, adding a sensitivity to the ambiguity of care to the literature of citizen-state interactions and frontline work, I contribute to the scholarship on parenting and citizen-state interactions, paying special attention to the restrictive effects of (public) care practices and services and how they can act in opposition to the frontline workers' stated intentions.

Before I begin this endeavour, I locate this study in the fields of citizen-state encounters and state impact on family-making and parenting. Then, I present some of the recent perspectives on care within anthropology and disability studies. This is followed by an introduction to the visiting children's nurses in Denmark and a few remarks on the study this paper builds on. Then, I proceed to examine how in their encounters with new families, the Danish visiting children's nurses simultaneously work to make parents self-confident and independent and to make them depend on advice and validation from expert institutions.

Parenting: a public concern

Despite the degree to which the 'family' has been idealised as the child's 'natural' environment (Haukanes and Thelen 2010, 18; LeVine and Norman 2001), in recent decades it has also regularly been "problematised as a reliable context for childrearing", as Faircloth et al. note (2013, 4). Several authors have shown how parenting' increasingly features as a key factor in explanations of so-called anti-social behaviour, the perceived obesity crisis and educational failure (Furedi 2001; Lupton 2011; Faircloth et al. 2013). For instance, Deborah Lupton (2011) points out how health conditions or developmental delays in children have been "attributed to their mothers failing to respond appropriately to expert advice concerning appropriate health-promoting behaviours" (Lupton 2011, 638). As the parental sphere has been problematised, it has grown to become an increasingly public topic. Haldis Haukanes and Tatjana Thelen (2010)

state that societies of the 'Global North' increasingly reflect a "tendency to see child upbringing as a public rather than a purely private concern" (Haukanes and Thelen 2010, 1). They assert that public influence on parenthood and parenting has "increasingly evolved into a subtle but pervasive intrusion of expert knowledge in the daily lives of parents and their children rather than direct state intervention" (Haukanes and Thelen, 15). In their extensive work on family and parenting trends, anthropologists Charlotte Faircloth, Diane Hoffman and Linda Layne (2013) and sociologist Frank Furedi (2001) have also found that new experts in parenting have emerged both on the public and private scene and are increasingly sought out. As already mentioned, parenting has increasingly been a topic of public debate in most European and North American countries, which now offer parental support or education programmes (Haukanes and Thelen 2010, 15; Widding 2014; Widding 2015; Aston 2002). In Denmark, for example, a number of municipalities offer *De Utrolige År*[3] (The Incredible Years), a parenting programme imported from the USA.[4] This programme on good parenting practices is led by family therapists and experts in parenting and child development (Faircloth et al. 2013; Widding 2014). Studies across Europe show how public institutions and services impact and interfere with family-making and parenting practices: for example, public day-care institutions (Larsen 2011; Bundgaard and Olwig 2018; Ellmer 2020) and, as this paper will explore, the institution of visiting children's nurses. As multiple studies have shown, states formulate and enact the roles and practices considered 'proper' for parents through such institutions, programmes and services (Thelen 2012, 46; Howell 2006; Edwards 2018; Humphris 2019), and it is to this field this paper will contribute. Although, the nurses I have worked with have continuously stressed the diversity of good child-caring and child-rearing practices and that there is no one 'best' or 'right' way to parent and take care of a child, I show that through their work of monitoring children – and parents – the nurses do indeed promote a 'right' way to parent and care for children.

Relationships between state workers and citizens

The visiting children's nurses are what the literature refers to as 'frontline workers' (Maynard-Moody and Musheno 2000; Durose 2011; Humphris 2019). They differ from other groups of

[3] https://socialstyrelsen.dk/tvaergaende-omrader/Udviklings-og-Investeringsprogrammerne/dokumenterede-metoder-born-og-unge/om-dokumenterede-metoder-born-og-unge/dua
[4] This programme is also offered in a range of other countries, see: https://vidensportal.dk/temaer/udadreagerende-adfaerd/indsatser/de-utrolige-ar-foraeldreprogrammet-basic-forskole

frontline workers by not focusing on 'problematic' cases like alcohol and drug abuse, unemployment or rehabilitation but on the entire population of parents, children, and adolescents. Since only 1% of new parents decline the visits (Dansk Sygeplejeråd 2010, 10), this is a set of professionals with whom most citizens of Denmark interact at some point in their life. By focusing on the profession of visiting children's nurses, this study contributes to the field of frontline workers and citizen-state encounters, which is otherwise dominated by studies of state encounters with migrants and other socially vulnerable groups. In this paper, I am curious about the relationship between citizens (parents) and state workers (nurses) and how they influence each other. In studies of these encounters, the focus is often on the discretionary power of the state workers and how they deploy it to make claimants comply with certain behavioural criteria to be eligible for financial benefits (cf. Järvinen and Mik-Meyer 2003; Dubois 2010; 2014). Studies on how citizens and state actors mutually influence and shape each other are scarcer (see Thelen, Vetters, and von Benda-Beckmann's (2014) call for a more relational approach to studying the state). With this paper, I add a focus on the how state worker and citizen mutually influence and constitute each other as the ones in need of validation and confirmation and the redeemers.

New conceptions of 'care' and ambivalent effects of care work

In reviewing the literature on care, Tatjana Thelen (2015) documents a tendency to conceptualise care as something inherently positive, pointing out, for example, how early feminist studies of care have tended to focus on its positive outcomes. Instead of perceiving care as fundamentally good, Thelen proposes to understand it as a dimension of social security and 'a process aimed to satisfy socially recognized needs' (Thelen 2015, 509). Similarly, Lisa Stevenson (2014) urges us to add nuance to the discourse on care. In her work on the Government suicide prevention work among Inuit in Arctic Canada, Stevenson also discusses how care is not just actions born out of good intentions or with positive outcomes. Like Thelen, Stevenson wishes to extend the discourse on care "so that both the ambivalence of our desires and the messiness of our attempts to care can come into view" (Stevenson 2014, 3). She shows how the Government of Canada's way of *caring* for Inuit limits and harms them, as caregiving during a suicide epidemic focuses entirely on preserving life, not on the question of what life they live. While constant surveillance does reduce the risk of individual Inuit committing suicide, it simultaneously reduces their possibilities for living the life they want (ibid, 79).

The limiting effects of care and care work have also been pointed out in disability studies. By shifting the focus from caregivers to the care receivers, disability studies show how otherwise good intentions can be perceived and received in various, not necessarily positive ways, at the receiving end. In her study of paid and unpaid care for disabled people, Rose Galvin (2004) describes how receivers of unpaid care by relatives experience an expectation of gratefulness and "good behaviour" (Galvin 2004, 146). These expectations of gratitude can feel like a "bitter payment" and a "soul-destroying obligation", Galvin states (2004, 144, 146). Similarly, Zhiying Ma's (2020) study of mental health care in China shows how receiving care can be experienced as restricting and demeaning. While Danish visiting nurses rarely restrict parents' autonomy directly, I will show that the nurses' caring practices indirectly limit it by making the parents dependent on their guidance and expert claims. The nurses render it very hard for parents to be self-reliant and still live up to moral expectations of relying on parenting experts in order to secure their children's future success.

Patrick McKearney sums up the complexity of care relationships and care as a concept by stating that "whether or not an action comes to be evaluated as "care" […] is dependent on more than intentions, rules, and local understandings of the good. It relies, also, on the interactional contingencies of the caring relationship itself." (2020, 229). The disability literature thus shows that help and care are not inherently positive and that the perception of 'care' can be received and understood by the care-receiver completely differently from and independent of the caregiver's intentions: for example, because of the moral expectations of thankfulness that are often implicit in care relations. Examining the nurses' work – their guidance, advice and support to the families – from this point of view of care as not something inherently positive allows me to shed light on how the nurses come to find themselves affecting the families in ways contrary to their claimed intentions. Through their care work, the nurses come to make the parents dependent on and in need of the nurses' assistance, help and validations to 'learn to be a parent'.

Before diving into the nurses' work with new families, I will introduce the Danish institution of visiting children's nurses on a more general level and add a few remarks about the original study that this paper builds on.

Introduction to the institution of visiting nurses and the parents I visited

When parents in Denmark have a child, they are offered a course of visits from a public children's nurse (*sundhedsplejerske*), during which the nurse checks and discusses the health and development of the child and the well-being of the parents. These nurses have specialised training in the health and care of infants and young children. They are employed by the municipalities and work under guidelines issued by the DHA. They visit new parents in their homes to help them ensure the good health and well-being of their child and advise them on infant care. Their job is mainly to guide and support parents and children to ensure 'good' and 'proper' ways of parenting and child development. By providing their biopolitical care (Foucault 2008; Stevenson 2014); directing and supporting a specific 'right' optimisation of the children, the nurses contribute to the formation of ideas of 'proper parenting'.

Thus, childrearing and parenting are indeed matters of public concern in Denmark. Significantly, this has been the case for almost a century and started with the introduction of a strong universal welfare state that included the visiting children's nurses and an increasing institutionalisation of childhood and adolescence in Denmark in the form of public kindergartens and schools as well as day and after school care. This development accustomed Danish citizens being involved with and cared for by public institutions (Jöhncke 2011; Jenkins 2014). As Richard Jenkins (2014, 156) pointed out a decade ago, the way private lives and the state are intermeshed through welfare services is both accepted and uncontroversial among Danes. This is also reflected in, for example, the fact that around 99% of parents accept the visits from the public children's nurses (Dansk Sygeplejeråd 2010, 10).

The visiting children's nurses (whom I will now just refer to as 'nurses') were introduced by the Danish state in 1937 as a welfare service for parents of infants in Denmark and in response to the high rates of infant mortality in the country (Buus 2001). The programme is regulated by the Health Care Act (*Sundhedsloven*), which obliges municipalities to provide **"**general preventive and health-promoting services" aimed at all children (Sundhedsministeriet 2019). This state-funded service is free for all and today all families are offered a series of 5-8 visits during the child's first year. During each visit, the nurse examines the baby physically and 'socially' to see whether it responds 'appropriately' (as defined by the DHA) with eye contact, imitation and vocalisations, depending on its age. The nurses work from a set checklist of the baby's physical, mental and social health. However, this is generally not visible to the parents: rather, the visits seem to be structured as 'organically' flowing conversations between the nurse and parents and might appear from outside to be a pleasant informal chat among

family or friends. Today, this service has been expanded to include not only visits to families but also health services at public schools and kindergartens.

During my year of fieldwork, I followed the nurses' work at the schools and kindergartens they are assigned to and accompanied the nurses on approximately one hundred visits to families with newborns and babies. The nurses in Vipperup are a very homogenous group in terms of appearance, gender and socio-economic background. They are all white Danish women in heterosexual relationships and have two to three children. Additionally, they generally expressed middle-class values and, as it repeatedly became evident during my fieldwork, reinforced these normative values through their guidance. Half a year into my fieldwork, I started following and interviewing some of the families. I made sure to spend time with these families before and after visits to gain insight into their experience of each visit and their nurse. The families we visited represented a wide range of nationalities and socio-economic statuses, ranging from impoverished, unemployed, and/or mentally unstable parents to affluent, socially well-placed and healthy families. Notably, I had fewer opportunities to visit families from the lowest socio-economic classes as some of them did not want me present during visits, which was not the case with other groups. Additionally, in certain cases, the nurses chose not to include me in follow-up visits to these families. Therefore, most of my material is about lower- and upper-middle-class families and all the parents discussed in this paper are middle-class white Danish first-time parents. I participated actively in as much of the nurses' work as possible by, for example, assisting them measure the length and weight of the babies. However, COVID-19 measures significantly limited my active involvement: during and after the lockdown, I was no longer allowed to touch the babies and my fieldwork had to rely more heavily on observation and conversation.

From methodological considerations, I now want to turn my attention to the nurses, and their ideas of what is at the heart of their job with new parents.

'A mother instinctively knows what is good and right.'

The nurses emphasised that an important part of their job is encouraging and teaching parents to develop and trust their inner sense of 'right' and 'wrong' parenting. They often stressed the importance of parents following what 'feels right', which they interchangeably referred to as intuition, gut feelings and maternal or paternal instinct.

After a day of visits with one nurse, Ida, I asked her why she had encouraged several parents to 'use their good sense' and what she meant by that. She explained that she encouraged

parents to use their good sense out of the logic of self-efficacy, which she said was widely used in health care. "It's about making the parents believe in their own abilities", she said, continuing that "not everything has to be led by a nurse. They have to trust their own intuition and their own common sense (*sunde fornuft*)". I said that intuition and common sense (*sund fornuft*) seemed like two different – almost opposite – notions to me.[5] Ida answered that they were not opposite for her and stressed that she was not referring to any spiritual guidance but to following their gut feelings. "If it feels wrong, it probably is wrong", she says. "We're born with a care gene that makes us want to take care of others. So, it comes naturally to us to do the right thing."

The nurses assume that everyone who has grown up in a 'normal' caring family instinctively or intuitively know how to care for others. This instinct just needs to be nurtured, as an older nurse, Ellen, told me in the car between two visits. "If they had a healthy and good childhood, they'll instinctively pass it on to their own children if they don't overthink it. They must learn to connect with their instinct and dare to follow their gut feelings – then doing the right thing will come to the parents naturally", she said.

The nurses often told me that their foremost duty is to make themselves superfluous. Teaching the parents to trust their gut feelings was thus part of making the parents confident in their parenting practices and thus independent, the nurses told me: then, they themselves would become superfluous. However, it is not easy for all parents to learn to 'instinctively know' and 'feel' what is right. For example, first-time mother Kamilla had struggled with breastfeeding her son and more than once brought up questions to her nurse about how to 'know' when her son really was full and his needs entirely satisfied – not only in terms of food and nutrition but also in terms of sleep, motoric and social stimulation. We will join Kamilla in one of these conversations to take a closer look at how the nurses, despite complimenting their parenting practices, contributed to instilling confusion in the parents.

[5] In English 'intuition' and 'common *sense'* may not sound like opposites. However, the Danish translation of 'good sense' is 'sund fornuft', which literally means 'healthy reason', why it seems a lot more in opposition to 'intuition' in Danish.

Child-rearing is a 'guessing game' – where the nurses have the answers.

During Kamilla's son's six-month visit, their nurse, Ida, tried to assuage Kamilla's distress about her and her son's sleep and breastfeeding challenges.

Ida: You know, it's important to remember that it's a process. You're in the process of getting to know each other, right? And there are constantly new sides that he shows you, and which you've got to learn and discover. And to accept that sometimes it's just a bit of a guessing game (*gættekonkurrence*).

Kamilla: Yes.

(Ida looks at Kamilla with a little smile)

Ida: But you're still doing it well!

The nurses often told the parents that infant care and rearing was partly a guessing game, linking this uncertainty to the idea that there are as many (right) ways of rearing and caring for children as there are children. One of them, Ellen told me that she thought of her professional self as a '*tilbud*', a proposition, or a service: she puts herself at the family's service rather than telling them what to do when. "There are *so* many ways to do it all. You can raise a child in so many different ways," she said.

Not all parents welcomed the advice to rely on their intuition and instincts. In an interview, first-time mother Hannah discussed her nurse's way of guiding her and her emphasise on maternal instincts.

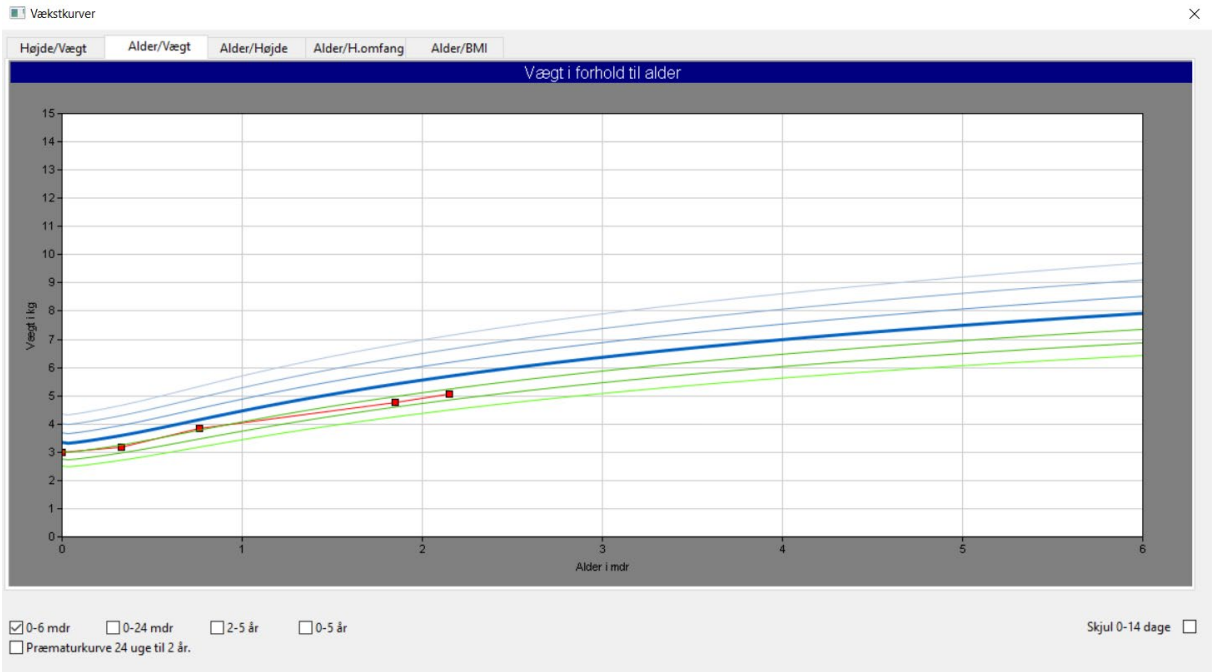
Hannah: I don't know if you've noticed – she [the nurse] might also be saying this to other parents – that you should trust in your maternal instinct. And she tries to do it a bit Socratically. She will not tell you the result, but that you should get there by yourself. That you should trust your maternal instinct. Also, when she says things like, 'there's a lot about infants and how they are which is guesswork'. It's a bit like "Why are you here, if you cannot give me the answer (*facit*) anyway," right?

Hannah was evidently neither happy about being told to listen to her maternal instinct nor content with the statement that a lot of parenting is guesswork. Although other parents did not put it as directly as Hannah, the way they sought validation shows how many of them were looking for direct instructions about which actions were right or wrong. Hannah and many other parents do not feel confident in their abilities to understand their child's signals and discern what they need. Although the nurses might be trying to empower them as parents and grant them authority by stressing that the parents are the experts on their children and, hence, 'know best', the parents sense that they are not the only experts on their children. Otherwise, as Hannah

asks, why are the nurses there, if not to provide the parents with answers about the 'best practices'? Taking a closer look at the nurses' visits can shed some light on this question.

Growth curves and 'phrases': Clear standards of 'the right' development

A central part of the visits consists of weighing and measuring the children. Their height and weight are entered into an electronic journal system, which generates a growth curve for the individual child that the nurse can use as a basis for discussion and guidance. The program that the nurses use to generate the curves automatically compares the individual curves to the 'standard growth curve' for height and weight relative to age and gender published by the World Health Organisation (WHO). (See de Onis et al. 2004; WHO 2009 for how the standards are established). The child's individual curve is thus compared to the 'normal spectrum' defined by the WHO (see picture below). As the nurses enter the latest measurements each child's own curve is displayed superimposed on the standard curve.



Screenshot of a growth curve from a 2-month visit.
The x-axis represents the age (*alder*) of the baby and the x-axis represents its weight (*vægt*).

These numbers are often essential in the nurses' general evaluation of the children and advice to the parents. The weight determines several important matters, such as whether the child is developing as 'it should' according to the growth curves, and whether the mother should

(continue to) breastfeed or switch to feeding by bottle.[6] There is thus a strong metrication of the babies' development and overall well-being. Furthermore, the growth standards clearly establish a 'normal' and consequently preferable or 'right' process of development. Nurses and parents consequently relate to the children's well-being through their weight, through their numbers. Several parents had bought apps for their phones into which they could enter the measurements and create graphs like the ones the nurses showed them. This kind of numerical representation of reality has become a large part of the everyday as the epistemology of biomedical research has seeped into the lives of ordinary people, as the Danish anthropologist Bjarke Oxlund puts it (Oxlund 2012, 116).

The nurses are generally delighted and highly encouraging when the babies gain weight, especially at the 'right' rate. Although it might not be the intention, this communicates to the parents when they have been good and 'done it right'. The growth standard indicates a range of 'normal weights'. The measured weights thus rarely fall exactly on the blue line indicating the centre of this range. However, although the nurses frequently tell the parents that it is fine not to be on the blue line, the amount of positive reinforcement they afford the parents when this is the case often overrides such words.

An episode from one of Kamilla's later visits exemplifies the importance that the nurses place on these metrics. At the first of many visits, Kamilla's son, Felix, had not gained enough weight according to the standardised growth curves, which worried both his mother and the nurse. Later, Ida, Kamilla, and I sat around the dinner table in Kamilla's living room with Felix in his mother's arms. They were discussing how Kamilla had shifted from breastfeeding to bottle and back to breastfeeding again. The original switch had been Ida's suggestion to make Felix gain weight faster, while Kamilla had always wanted to go back to breastfeeding. At this specific visit, Ida (or rather the growth curve) had 'good news'. After weighing and measuring Felix and entering the newest measurements, Ida turned around her laptop so Kamilla could see Felix' growth curves on the screen and said, "I just want to show you this curve. It is so beautiful."

Kamilla: [It's] just like it should be?
Ida: The dots down here, that's where we were, when we had – not a weight loss, but-
Kamilla: A stationary…

[6] This is often critical for the mothers because of the dominant role breastfeeding plays in the ideas about how to be the best possible mother (Schmied and Lupton 2001; Símonardóttir and Gíslason 2018).

Ida: A stationary weight. But if we compare to this weight from last time, then they are like pearls on a string. Right on the average line. It couldn't be more beautiful. It's really good.

Ida praises the new development and comforts Kamilla by letting her know that now things are good. The fact that Ida wanted to show Kamilla the curve and called it beautiful denotes the importance of the growth curves. Ida uses the 'good' weights to complement and validate Kamilla's efforts, thus reinforcing the curves' importance in the parents' understanding of parenthood and evaluation of their 'success' as parents. By introducing the normal weight curve, the nurses introduce the idea of the importance of following that curve.

Later, after the nurse had left, Kamilla told me that during this visit she had hoped to get a "sort of release (*frigivelse*)" after what she called being "put under restrictions" and having to supplement Felix's breastfeeding with formula to make sure he gained enough weight in his first month. it. Because he had not gained weight, it "became the weight which decided what we were and weren't allowed to do regarding breastfeeding and whether he should be fed by bottle", Kamilla said. Later in the conversation, she told me that she hoped that Ida would say that "Now he's getting [the nutrition] he should and we can just go with the flow. That we are no longer a note in her book about something not really working. […] She's the one, after all, who approves (*godkender*) everything as all right." I quote Kamilla at length here because of her interesting choice of words to describe her relationship with Ida. Ida is the one who imposes and removes 'restrictions' and the one who 'approves' when Kamilla and Felix are doing well. Kamilla conveys Ida with a great deal of authority, to decide about how she raises and cares for her son.

Thus, the nurses both challenge and reinforce the idea of 'the normal child' and 'normal development'. They seek to calm the parents by highlighting the great diversity in children and their individual development, but at the same time introduce the range of normality defined by the DHA and WHO. The nurses' enthusiasm about being right on the blue line speaks its own (perhaps more convincing) language and adds to the impression that some ways of developing are, after all, more desirable than others.

Another aspect of the visits that underpins this conviction, is the checklist of 'phrases' (*fraser*), as the nurses call them, that more-or-less determines the structure of the visits. The term 'phrases' refers to the individual tasks – measuring head size, checking the ability to make particular sounds, and so on – that the nurses must perform during each visit. The nurses call them 'phrases' because each item is written as sentences – or phrase – that the nurses can copy

into the child's journals[7] to save time when recording the visit. It is only when something differs from what is considered 'normal' or desirable development that the nurses have to edit these phrases or add new descriptions. As the phrases are essentially the various markers of development, they thus constitute a manual narrating the 'normal' development of babies according to the DHA. These checklists of 'phrases' once again seem at odds with the discourse Hannah reported, that there are 'so many different ways to do it'.

The two positions that 'all children are different and accordingly need different treatment' and that 'all children should fulfil the prescribed phrases' contradict each other. It is thus puzzling how in the same visit a nurse can check that a child is following the DHA's phrases while also telling the parents that child-rearing is "just a bit of a guessing game". When the nurses stressed the 'many ways' approach, they were almost always trying to comfort a worried parent. The nurses seek to support the parents in their journey by 'easing up on' the strict developmental criteria of the DHA and emphasise that "you can raise a child in so many different ways". Nonetheless, being presented with two such different approaches to child-rearing also creates an ambivalent space that can be challenging for the parents to navigate.

By continuously asking for advice and seeking validation of their ideas and practices, the parents react to the statement that "sometimes it is just a bit of a guessing game" and object to the 'all roads lead to Rome' approach. Mothers like Hannah and Kamilla know that not all 'ways' are equally good – for example, their breastfeeding practices at the beginning of their motherhood were not good for them or for the nurses and their growth curves. Although the nurses emphasise that there are many right ways to take care of children, the existence of a state-subsidised institution of visiting children's nurses and of the DHA's guidelines for development are signs that some 'ways' must be better than others according to the state. In this case, the 'right way' is to bring up a baby according to the nurses' advice and guidelines.

While the health authorities and the nurses both represent a 'best' way to care for a child and promote a need for relying on experts, the parents also play an active role in co-constructing themselves as in need of support in parenting by continuously seeking the nurses' advice and validation. In the following section, I will take a closer look at the parents' wishes to conform with a 'right' way to parent and examine their need for expert validation.

[7] The nurses are required by law to keep a journal for each child they visit to record the development of the child and their guidance to the families.

A need for expert advice

> "Well, obviously, your biggest fear both as a mother and as a father is being labelled as a 'bad parent'. Of course, it is not like we're trembling before Maria [nurse] walks in the door, but obviously there is a degree of, you know… Also, just before you have the child, you're like hey, hold on, do we even know how to do this? So, then when she walks in the door, then of course you're eager to know. What can you tell me that will make me a better parent? But surely, you're also a bit, you know, are we doing this well enough and the right way? And are we bad parents if don't breastfeed, or… all those things."
>
> (Tom, first-time father)

Tom's statement highlights the concerns of many new parents. He expresses a desire to be a "better parent" and worry about his abilities as a parent and of doing it 'right'. And, like so many other parents, he reflects an idea that there is 'a right way to parent'. Tom's sentence "your biggest fear … is being labelled as a 'bad parent'" also strongly shows off a parent's concern with being judged by those around them and conforming socially. As nothing about Tom's middle-class lifestyle and engagement with his son would be a red flag to the nurses, it is all the more curious that he brought up that fear. Like several other parents, he pointed to the nurses' authority and duty to report egregious cases to the child welfare authorities, leading to the child being removed from its family. In fact, I met few families who never raised that concern: it might seem unlikely to them, but the thought and fear of the nurses' authority as state actors had nonetheless crossed their minds. I find that this vague yet underlying fear for nurses' reports clearly signifies how the institution of visiting children's nurses in itself – regardless of the nurses' actual practices – asserts that there is a 'right' and thus also a 'wrong' way of parenting and taking care of babies. Because of the nurses' early and continuous presence in the parents' first year of parenthood, these competencies and norms of parenting are often outlined or defined by the nurses based on the DHA's official guidelines for children's health. Through its systems of weightings, measurements and points of development, the 'phrases', the DHA sets standards for the 'normal' child and the pace and right order of the development of children. The 'phrases', which the nurses have to go through in each visit, are, in this sense, essentially a manual for the 'normal' child during its first ten months. The fact that very few families with no history of 'negative' interaction with the state question the nurses' 'right' to visit them and evaluate and guide their parenting practices, reflects how accustomed Danes are to interacting with public institutions and professionals.

The degree to which the nursing institution signals 'a right way to parent' is also illustrated in the following conversation with Tom and his wife Maja. They sought the nurse's

validation, despite having read parenting books, studied the DHA's guidelines and 'read' their child's signals.

> In a conversation with the parents just before a visit by their nurse, I ask if there is anything in particular that they want to talk to the nurse about today.
> "Yes, the transition to solid food", Tom says; "We haven't started yet."
> Maja continues: "We have to hear Maria [nurse] first. We would like to hear what the expert says."
> I laugh: "And why do you want to talk about that now?"
> "She [daughter] eats *so* much", Maja answers, "and then I think she has started to watch us…"
> "Yeah, while we eat, she watches us", Tom continues. "Yes, and then they say that they [babies] start from around the age of four months. I think it says so in the booklet. And from six months, they *have to* start."
> Later in the conversation, Maja says: "It's nice to have Maria to tell us if it's all right. It's kind of her approving the situation. … It gives a certain comfort, feeling of safety, to know that she is checking to make sure we don't do something completely wrong".

From this conversation, Maja and Tom seem knowledgeable about the development of babies' eating habits and needs. Still, they seek validation from their nurse – "the expert", as they call her. This is despite their awareness of their child's changing habits and signals: she watches them while they eat and shows interest in their (solid) food. Moreover, she is now eating a lot herself, as Maja says, which might indicate a larger appetite that demands more substantial meals. Maja and Tom have also consulted the DHA's booklet about food for babies that the nurses distribute to the parents and know at what age the health authorities recommend that babies start eating solid food. According to the DHA, this is around four to six months, and since their daughter was then four months old she was officially able to start eating solid food (Sundhedsstyrelsen et al. 2020). Again, we see how parents seek external approval of their practices and how they accept the premise that nurses should approve and disapprove of how they parent and handle their babies.

This parental search for validation can be read as a middle-class aspiration to achieve perfection. However, I posit instead that the crucial contributors to this phenomenon are the so-called 'expert institutions', including health authorities, government-endorsed parenting courses, and the vast array of self-help literature, parenting websites and TV programmes, all of which collective play a significant role in shaping parental attitudes and behaviours. As knowledge has become increasingly accessible, parents seem increasingly aware of their own ignorance about infants, child-care and child-rearing. Simultaneously, they find themselves consistently reminded of the potential pitfalls in their parenting approach. Sociologist Ellie Lee

(2014) highlights this trend in contemporary parenting support and advice, noting that childcare guidance has become increasingly dominated by warnings. As a result, parents today tend to focus on dangers to their children rather than their well-being. Hence, I propose that parents' tendency to seek expert assistance stems from their acknowledgement of their own knowledge gaps and increased awareness of potential risks. Moreover, state institutions, such as the DHA and municipal authorities, not only actively implement parenting help programmes (like *De Utrolige År*) and expert-run services (like visiting children's nurses) but also promote participation in these services as being in 'the best interest of the child'. Consequently, parents seek to meet these expectations and standards.

As I noted at the beginning, all the parents discussed in this paper are white Danish, middle-class parents. It was generally among them that I observed the wish to be 'told what to do, and how to do it 'right''. In contrast, in some Muslim refugee families I observed an attitude among the mothers more like 'I already know how to parent. I rely on my older family members' advice.' Around lower-class white Danish families, I also observed a more relaxed attitude to parenting. For example, one twenty-four-year-old first-time mother told me that it was "not that difficult to figure out what [a baby] wants. And, otherwise, I just try out different things" when I asked her whether she found parenting difficult. However, some immigrant families and families from lower socio-economic classes did also express direct wishes to meet the nurses' expectations of 'proper' parenting. I read this mainly as expressing a desire to assimilate, an aspiration to belong in Denmark, and a way to avoid further repercussions and interventions in the family.

In line with Oline Pedersen's (2015) findings from her study of Danish visiting children's nurses, the nurses in Vipperup sometimes varied their guidance depending on the parents' class background. Pedersen shows that the nurses are less prescriptive and more open and advisory towards families of their own social class – that is, middle-class. In contrast, the nurses give more concrete and direct instructions when interacting with families of lower social class than themselves (Pedersen 2015, 161–163). I recognise that picture in my own study; however, apart from the manner of their delivery, I generally observed the same normative insistence on their own middle-class values being the 'proper' foundation for childcare in the nurses' interactions with all families. Hence, in line with the literature on classed interventions in parenting, the nurses generally did not recognise families' different abilities to parent 'intensively' (Hays 1996) according to the nurses' (middle-class) standards. "Child-raising practices linked to the currently dominant parenting ideals require financial resources and

immense time and effort, as well as emotional and cultural investment from parents" Alexandra Szőke and Cecília Kovai also point out (2022, 8). Moreover, as Val Gillies highlights, 'middle-class practice' can even be risky for families in contexts "where choice and power are limited" (Gillies 2008, 1093). Such classed differences in terms of 'possibilities' were only rarely discussed by the nurses. Instead, they worked from the premise that all neurotypical parents can *learn* how to parent 'properly'. Given this, the nurses, again, reproduced the idea of parenting being skills one can acquire rather than 'just' a state of being (Faircloth et al. 2013; Lee 2014). Moreover, the nursing institution engenders the idea that parenting consists of skills one *should* acquire and that it is a societal task to help parents with this, which is why all new parents are offered home visits by a specialised nurse.

In the last part of this paper, I want to focus on the paradox between the nurses' stated intentions to help new parents be confident and self-reliant and the parents' continuous wishes for guidance and validation.

When care keeps people stuck in a dependency relationship

In addition to proposing that the parents' need for validation from the nurses partly stems from their own anxieties and wishes to conform, I suggest that it also stems from the way the nurses establish themselves in a role of authority to validate. This authority is based on having (professional health) knowledge, experience, and a mandate from the state to judge individual practices. As the preceding pages show, the nurses do indeed validate and (dis)approve of the parents' practices about their babies – even without being asked. Moreover, the nurses assess not only the babies' health and well-being, but also their toys and other equipment. Often these 'judgements' came as small asides to the main conversation: for example, when one nurse interrupted her own examination of a baby after casting a glance at the baby's activity stand, and said "I'd say that just one dangling toy is enough. She can't focus on more right now; you can add the rest as she gets older." At other times, the 'judgements' came in the form of a raised eyebrow followed by a remark about 'the play area blanket not looking slip resistant'.

Considering this dynamic in the relationship between parents and nurses, it is less surprising that the parents find themselves in positions anticipating validation from the nurses. Both seem drawn into roles that they do not necessarily feel entirely in control of. The parents find themselves in the role of students who must learn from and are graded by the state and health authorities in the form of the nurse. Meanwhile, and because of the parents' expectations, the nurses find themselves placed to teach and judge 'right' and 'wrong'. Hence, the nurses and

parents seem drawn into a self-perpetuating process. As already mentioned, the nurses often told me that their foremost duty is to make themselves superfluous. As we have also seen, they often work towards making the parents confident and independent in their parenting. Yet, their validations – or 'judgements' – and the entire structure of the series of visits – counteract this empowerment. It signals that parents need help and advice during the first ten months after having a child. Thus, the validation seeking and giving sometimes seem to occur in an almost tragic way, which neither nurses nor parents can escape. There is a tension between the nurses' efforts to make the parents self-reliant and the way they continuously make themselves and their guidance available and encourage parents to seek and follow their own and the DHA's advice. As much literature has highlighted, there is an expectation that parents will rely on expert advice in their parenting (Ladd-Taylor and Umansky 1998, 8; Lupton 2011; Lee 2014). This expectation is reinforced by Danish visiting children's nurses. I suggest that this expectation alongside the dynamic of the nurses making themselves available to alleviate the parents' insecurities, in fact, does not allow the parents to be self-reliant in their parenting.

The disability studies literature already introduced demonstrates how an act of care may be received and perceived differently from the care giver's intention (Galvin 2004; McKearney 2020; Thelen 2015, 2021). Considering this ambiguity of care sheds new light on the relationship between nurses and parents. The nurses often expressed that their foremost duty is to render themselves superfluous. While they do indeed work towards making the parents independent and confident in their parenting by teaching them to trust in themselves, at times, their assessments and validations – their 'acts of care' – work against this parental empowerment. They imply that the parents continuously need these validations from experts to be certain that they still parent 'right'. Furthermore, the entire structure of the series of nurse visits pre-supposes that parents will need help and advice during the first eight to ten months after having a child.

I argue that this relational dynamic between nurses and parents should not be credited to the nurses and their institution alone. Thelen (2015) encourages us to recognise care as both processual (Tronto 1993) and interactional (Mol 2008), as this directs "our attention to the connection between persons, instead of turning the spotlight solely on the carer" (Thelen 2015, 509). It makes us attuned to how both parts of a relation are "equal contributors to the construction of need and responsibility" of giving and receiving care (ibid, 502). Perceiving the relationship between nurses and parents as that of caregivers and care receivers illuminates how they co-construct a need for each other. As introduced earlier, disability studies especially have

brought care receivers into focus as actors (ibid). By recognising the parents' agency to act and react to the nurses' service, we see how the construction of a need for care is not only initiated by the nurses: the parents also co-produce and reinforce their need for care by accepting and anticipating the nurses' service.

Conclusion

Validating new parents' thoughts and practices is a big part of Danish visiting children's nurses' jobs. Apart from examining the health of new-borns and toddlers, guiding and comforting worried parents is what the nurses spend the most time on. It is also what the parents most often (more-or-less directly) ask for. The parents worry about whether their child is thriving, and many find that professional validation gives them the most peace of mind. By unpacking the visits that visiting children's nurses pay new parents, I have examined how certain qualities and practices are naturalised as 'proper parenting'. This includes wanting children to develop according to the DHA's models and *phrases*. It includes seeking out and relying on expert advice on parenting, but also working towards being self-reliant and independent as parents. At the heart of these interactions lies a tension between encouraging new parents to be self-confident and independent, while reinforcing a notion that parents need guidance and should rely on state-subsidised experts. On the one hand, the nurses stress that 'there are as many different ways to raise and care for children, as there are children' and they encourage parents to trust themselves and their gut feelings. On the other hand, the nurses introduce standards of development that the babies 'should' follow – and that induce an anxiety among the parents which the nurses must then assuage.

Drawing on the literature on disability (Galvin 2004; Ma 2020; McKearney 2020) and Lisa Stevenson's call to understand 'care' as something other and more than "its frequent associations with either good intentions, positive outcomes, or sentimental responses to suffering" (Stevenson 2014, 3), I have shown the tensions in the nurses' work – how they simultaneously make new parents dependent and independent of expert assistance – has shown how the nurses reproduce a need for their involvement in parenthood that keeps the parents and themselves 'stuck' in a dependency relationship despite their intentions.

I argue that the parents' need for validation is (re)produced and reinforced by the state services of the nursing institution and by the practices of the nurses. Although the nurses want the parents to be independent and self-reliant, they simultaneously induce a need for themselves (and their expert guidance) on the part of the parents. Moreover, the institutionalised

programme and its services – its help, guidance and recommendations – are morally charged offers that the progressive, well-informed, 'good' citizen cannot decline. What parent would not want the best for their child? Consequently, the very nature of the nursing programme reinforces the parents' need for guidance, support and validation by existing as a universal service and hence conveying to the new parents that the new role and life phase they are entering require expert help to handle and navigate it successfully. In this way, the welfare state produces anxieties by offering nurse visits, and the nurses then try to 'reconcile' this parental anxiety. The role of the nurses is thus ambiguous as it both reinforces and modulates the externally produced norms of 'good' family-making.

This paper thus contributes to the strand of literature that concentrates on the influence of state institutions on intimate matters such as family-making and parenting (see for example Thelen and Haukanes 2010) by showing how the norms and practices of 'proper' parenting are shaped by both the face-to-face interactions between welfare officials and parents and the structure of the larger welfare institutions as well as the individual services they provide. Specific to the Danish context is the absence of the critical view of state involvement in children's upbringing that is often dominant in other localities (Thelen 2012, 46). As shown, the parents in my study generally welcomed and desired the involvement of the nurses (and local state actors) in their parenting practices. This is likely a product of the extensive and universal welfare state in Denmark and the population being accustomed to being heavily involved with it, quite literally from cradle to grave (Jöhncke 2011; Gulløv and Højlund 2015). In the Danish anthropologist Steffen Jöhncke's words, the Danish "welfare state is a framework for the daily life of all Danes" (Jöhncke 2011, 41–42). The uncritical use of and interaction with the state services and actors is especially a practice of the middle-class(es) (Merrild and Andersen 2019). However, as Jöhncke states, "The welfare state has developed to become part of the national self-image […] and the Danes are fond and proud of it." (2011, 41–42). Many values, norms and practices, from the most public to the most private matters, are thus produced and negotiated in close dialogue between the welfare state and the Danish citizens.

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Zusammenfassung

In den letzten Jahren sind Praktiken der Elternschaft wieder in den Vordergrund öffentlicher Debatten im Globalen Norden gerückt. Mit der steigenden Zahl von Studien, die die Konsequenzen der ersten Lebensjahre und deren Bedeutung für den späteren ‚Erfolg' hervorheben, steht Elternschaft bei öffentlichen und fachlichen Institutionen verstärkt auf dem Prüfstand. Es setzt sich zunehmend der Standpunkt durch, dass Eltern sich auf den Rat von Expert*innen verlassen sollten. Basierend auf ethnographischer Feldforschung untersucht das vorliegende Arbeitspapier die Dynamiken zwischen Kinderkrankenschwestern (*sundhedsplejersker*) und jungen Eltern in einer dänischen Gemeinde und wie diese den Diskurs bestärken, dass Elternschaft von Expert*innen erlernt werden muss. Allen Eltern in Dänemark wird nach der Geburt der Besuch einer Kinderkrankenschwester angeboten, welche die Entwicklung des Babys überwacht und die Eltern bei der Fürsorge für ihr Kind anleitet. Das Arbeitspapier untersucht die entstehenden Spannungen zwischen dem Wunsch der Kinderkrankenschwestern, die Eltern in ihrer neuen Rolle zu ermächtigen, während sie in der Praxis gleichzeitig deren Abhängigkeit von professioneller Unterstützung bestätigen. Dabei sondiert der Beitrag, wie sich beide Gruppen gegenseitig als *benötigte* Expert*innen bzw. als den Expertenrat *benötigend* (re)produzieren.

Biographical Note

Anne Sophie is a social anthropologist and completed her PhD in Global Studies at Aarhus University (Denmark). Her research interests lie within medical anthropology and the intersection between anthropology of kinship and of the state. In her doctoral dissertation, she examined the work of home visiting children's nurses in Denmark and how they affect not only new parents' parenting practices and but also the parents' sense of belonging to the welfare state.

Biographische Notiz

Anne Sophie ist Sozialanthropologin und hat an der Universität Aarhus (Dänemark) in Global Studies promoviert. Ihre Forschungsinteressen liegen im Bereich der medizinischen Anthropologie und der Überschneidung zwischen der Anthropologie der Verwandtschaft und des Staates. In ihrer Dissertation untersuchte sie die Arbeit ambulanter Kinder-krankenschwestern in Dänemark und wie diese nicht nur die Erziehungspraktiken junger Eltern, sondern auch das Zugehörigkeitsgefühl der Eltern zum Wohlfahrtsstaat beeinflussen.

Anne Sophie Grauslund
Depending on parenting experts. Exploring the ambiguity of care in the relationship between new parents and visiting children's nurses in Denmark
Vienna Working Papers in Ethnography, No. 14, Vienna, 2024
Wiener Arbeitspapiere zur Ethnographie, Nr. 14, Wien, 2024
ksa.univie.ac.at/vwpe14

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