

# Who is a 'good' mother?: Moving beyond individual mothering to examine how mothers are produced historically and socially

## Introduction

Far from being a matter of individual choice, motherhood and mothering are shaped by larger, systemic social and historic forces. In this paper I suggest that maternal child and family health nurses (MCFHNs) can more effectively support women and their families through a recognition and acknowledgement of these forces.

The contemporary liberal feminist focus on birth as a space of self-actualisation and empowerment within the context of an individualised, heteronormative, nuclear family, masks the ways in which maternity has been and continues to be a site of scrutiny and regulation. Institutions and nurses that work within them have been complicit in supporting some groups of people to reproduce (pronatalism) while discouraging or coercing others from doing so (anti-natalism). MCFHNs have a pivotal role to play in the wellbeing of families and communities, but they are also implicated in the state's management of populations. In this article I propose that moving nursing practice away from the individual to instead consider the historical, social and systemic can support MCFHNs to provide more responsive and reflexive care for women and their families. In turn, such a manoeuvre can provide MCFHNs with the tools to better critique their complicity with institutional imperatives and 'victim blaming'.

In the first part of the article I trace the compulsory ontology of being a choosing and informed consumer in maternity, suggesting that milestones in capitalism predate the social and political activism of liberal feminist and consumer movements of the 1970s. These include pronatalist policies in colonial contexts; Victorian ideals of individual mothering; the advent of the family as a target for state intervention and advances in science and industrialisation. In the second part of the article I will bring this potted historical account of maternity into the present and examine how the contemporary ideal maternal subject — one who is active, choosing and informed — and associated modes of thought and practices service particular political, social and economic interests that unevenly benefit particular kinds of mothers.

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## Methodology

Using a historical-conceptual institutionalist analysis such as genealogy (Foucault 1984) presents an opportunity to historicise and politicise the operations of power and knowledge that are present in maternity. Subjecting maternity to a genealogical analysis enables the relationship between the maternal body, discourses, and power to be explored, so that the ways in which contemporary definitions of maternity have been historically constructed in order to meet particular purposes can be ascertained and, in turn, create space for other constructions (Galvin 2002).

## Women as mothers of the nation

Women's roles as biological and cultural reproducers of the nation are fundamental to the production of citizenship in the context of nationhood. The face of the nation is often viewed as maternal, for example, 'Mother India', and countries tend to be denoted by the feminine pronoun and language as the 'mother' tongue. Mothers reproduce the nation biologically through giving birth, and socially by maintaining and transmitting culture within the domestic or private sphere of home and family as keepers of the hearth, home and culture (Yuval-Davis 1993, p. 627). Citizenship brings to mind issues of home, belonging and security, and raises questions about who is entitled to be a part of the home or nation (Chantler 2007). The notion that race can be reproduced is central to the interrelated discourses of racism, nationalism and imperialism. The concept of nation-as-home constructs the inside of the home and family as a refuge, and the outside as unruly and dangerous, a border requiring policing and surveillance (Chantler 2007).

Regulating the reproduction of those considered to be a burden on society has been a way to secure and control the wellbeing of the population, leading to the surveillance and management of women's bodies. A common theme in early 20th century white settler societies such as Australia, New Zealand and the United States were fears of 'race suicide' due to middle-class women not having children while 'other' women (migrant, Indigenous or working-class) were having too many. Reproducing white citizens in the colonies became a patriotic and political duty for white women as it was seen as central to the interests of the nation and the health of the race, superseding involvement in public affairs (Bartlett 2004). Pronatalist and anti-natalist ideologies often occurred concurrently and led to interventions including the removal of children (most notably in 'the Stolen Generation' in Australia) and forced sterilisations without consent (Pateman 1992). Another example is breastfeeding in Nazi Germany, which was obligatory and where women were awarded a medal (called the Mutterkreuz) for rearing four or more children. At the same time extreme anti-natal racial hygiene doctrines were implemented

against 'unfit mothers,' resulting in forced sterilisations and abortions for women with impairments, or women considered "ethnically other" such as Jews, Gypsies and Slavs.

### **Individual mothering and the family as nursery**

Victorian ideas of the home as a woman's sphere and moral standards of good mothering were specific to white, middle-class culture. Before the 19th century women had been primarily associated with "sexuality, cunning and immorality" (Ladd-Taylor & Umansky 1998, p. 7). The pious development of a domestic sensibility gave women a clear role that was linked with more dignity, authority and opportunities for education (Ladd-Taylor & Umansky 1998). The new Anglo-Saxon middle class individualised mothering in contrast with the shared child-rearing that was more common in other societies. This resulted in women from those communities, for example immigrant and Indigenous women, being labelled as bad mothers (Ladd-Taylor & Umansky 1998). Evolutionary theory played a role in demarcating good and bad mothering: Anglo-Saxon and Northern European women were positioned on the top of the hierarchy of the 'races' and were the only women capable of being good mothers, irrespective of what other mothers did (Ladd-Taylor & Umansky 1998). Such women bore the responsibility for ensuring the wellbeing of their families, the future of the nation and the progress of the race. Anglo-Saxon mothers were thus both exalted and pressured.

The high infant mortality rates of the time led to a focus on the management of mothers, rather than the politically challenging public health issues contributing to these rates (Ram & Jolly 1998). Foucault (Foucault & Rabinow 1984) noted that the wellbeing of children in general was seen as a problem of government, and the family provided a link between private good health and general political objectives for the public body (cited in Petersen & Lupton 1996). The family became the nursery of citizenship, with the family milieu acting as an exemplar for broader social relations (Petersen & Lupton 1996). The hygiene of the home became women's work as the emphasis on health implications of the domestic space grew in importance from the late 19th century and early 20th century (Petersen & Lupton 1996). Cleanliness, the orderliness of the home and the bodies inhabiting the home became a duty of citizenship for women. Simultaneously, maternity became defined as caring, altruistic and absorbing and laws were developed in the United Kingdom to punish infanticide, abortion and birth control (Petersen & Lupton 1996). Schemes to address maternal malpractice such as health visitors (whose job it was to survey and educate women) were initiated to ensure that the British, working-class mother was subjected to the imperatives of the infant welfare movement and became a 'responsible' mother. A proliferation of organisations to promote public health and domestic hygiene among the working class thrived, assisted by upper- or middle-class women. Several researchers have noted (Aanerud & Frankenberg 2007; Ram & Jolly 1998) how this class-based maternalism in Europe and North America reflected a race-based maternalism in the colonies, where Europeans challenged and transformed Indigenous mothering in the name of "civilisation, modernity and scientific medicine" (Jolly 1998, p. 1). Similarly, in colonised countries the 'cleaning up' of birth was achieved through both surveillance and improved hygiene and sanitation (Bartlett 2004).

The moral regulation of the population through the governance of the family remains a contemporary parenting practice where women are considered responsible for producing, maintaining and protecting others' health and wellbeing (Ladd-Taylor & Umansky 1998). Neoliberalism has further increased the

responsibilities that are viewed as private and transferred to women when the government retreats (Berger & Guidroz 2010). Therefore, the Foucauldian expansion of the art of government to include maximising the wellbeing of populations has a particular resonance in maternity.

### **Science and industrialisation**

The 'cleaning up' of birth was a colonial and modernist enterprise, involving not only sanitation but also the governance of women's bodies (Bartlett 2005). The discourses of science and government intertwined as techniques of biopower, and came to increasingly engineer maternity. Scientific motherhood evolved as a combination of maternal love and mechanistic scientific knowledge in the late 19th century, and was influenced by two major developments in the 17th century (Dykes 2005). The first saw a shift from the embodied knowledge of women to science as the source of authoritative maternal knowledge. Science's tenets such as dualism, objectivism and reductionism led to the medicalisation of life and a framing of the body as a machine, predicated on the norm of the idealised masculine body (Donner 2003). The second trend was the impact of increased population, industrialisation and urbanisation that occurred with the growth of economies and colonies under Western capitalism. Productivity to boost profits, and monitoring for efficiency and outputs was increasingly emphasised. This made possible "the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes" (Foucault 1977, p. 141). Population, production and profit became drivers for the creation of the major disciplines of hospitals, schools and other "techniques for making useful individuals" (Foucault 1977, p. 211).

In the Victorian era in England, the factory and efficient production reached their peak and the ideologies that made industry productive began to permeate into other spheres of life (Dykes 2005). Factors that enhanced efficiency such as timing, regularity and scheduling were applied to motherhood and parenting, and in turn women's roles were geared towards producing adults for the factory. Submission to the systems and disciplines necessary on a production line became warranted as part of parenting, eventually joined by tenets from early 20th century behavioural psychology such as separation, control, routine and discipline. These Enlightenment tenets remain embedded in contemporary health systems and processes. Dykes draws on Martin (1990) to argue that under medicalisation "[maternal] labour is a production process, the woman is the labourer, her uterus is the machine, her baby is the product and the doctor is the factory supervisor". In a Marxist vein, the labouring woman requires an intermediary who can manage and control the process, thus separating her from her birthing (Dykes 2005). Kirkham (1989, p. 132) extends the metaphor to suggest that the role of the midwife is as a "shop floor worker" who follows the supervisor's "instructions". Dykes (2005, p. 2285) theorises contemporary breastfeeding similarly:

*breastfeeding becomes the production process, the woman is still the labourer and her breasts now replace the uterus as the key functional machines. Now breast milk becomes the product, with her baby assuming the role of consumer. If the breasts (machines) are in "good working order" then they will "produce" the right amount and quality of the "product", breast milk. If the labourer uses them effectively, then they will deliver the "product" efficiently and effectively and in the correct amount to the "consumer", the baby.*

This mechanistic view of breastfeeding and birth has two impacts: the first is that because these processes can go awry, a supervisor is needed (such as a midwife or health professional); secondly, the loss of confidence experienced by women as producers through a mechanistic metaphor. The expert/professional discourses of maternity thus produce particular kinds of maternal subjectivities around these impacts.

### The neoliberal maternal subject

Being healthy is an important responsibility for a citizen and given that health is unstable, it requires work, effort and various practices (Petersen & Lupton 1996). The discourse of the modern individual rational subject has created a particular kind of subjectivity that is termed healthism, requiring the take-up of health-promoting activities as a moral obligation (Roy 2007). Healthist discourse emphasise an enterprising self who takes individual responsibility for health maintenance and enhancement, by engaging in self-discipline and self-surveillance. This ideology of the individual's responsibility to keep healthy is dominant in the media as well as professional health care discourses (Donnelly & McKellin 2007, p. 173):

*... these ideologies and discourses reflect dominant western values for individualism, which, in turn, influence the direction of healthcare practice and the distribution of responsibility and role expectancies between individuals and institutions. Individualism has also influenced how responsibility for health is viewed, and thus how health care is being provided and practiced, and the ways in which people manage pervasive issues of blame and accountability.*

This discrete, self-monitoring subject that invites and acts upon expert advice is a dominant feature of neoliberal public health policies, where it is assumed that access to information will result in effective self-regulation (Stapleton & Keenan 2009). This ideology is reflected in the way in which maternity health care systems position themselves as being the bearers of expert knowledge without acknowledging the credibility and legitimacy of other sources of knowledge such as family and community networks. A 'rational subject' model is assumed where authoritative professionals transmit information to individual women whose embodied, enculturated understandings and experiences are discounted or devalued. Pregnant and postnatal women are represented as autonomous social actors who are fully in control and knowledgeable about their bodies and 'free' to make and justify choices. Individuals and their caregivers are expected to engage in reflexive techniques and/or practices of subjectification, to be accountable for the choices that are made, and to account for their behaviours to those who are tasked with monitoring and validated for monitoring them (Stapleton & Keenan 2009). However, these 'universal' concepts of choice and autonomy are socioculturally constructed, potentially coercive and constrained through the intersections of class, race, ideology and resources (Stapleton & Keenan 2009).

The emphasis on women as primary carers, who bear responsibility for children, parents and partners through cleanliness, remains a dominant theme in contemporary Western societies (Petersen & Lupton 1996). The individualising of motherhood has led to the dominance of foetal rights discourses, where the supposed interests of the foetus are put before the interests of women and

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even other children (Booth 2010). Pregnant women are charged with ever-increasing responsibility over the health of their foetuses, while they themselves are reduced to being a container for their foetuses. This has led to the restriction of women's activities, requiring constant self-surveillance to protect the health of their foetus. This responsibility continues through infancy and adulthood and commits women to maximising the moral, social and psychological development of their children (Schmidt 2008).

This valuing of the individual as a site is privileged in nursing as seen in the concept of individualised care, where the promotion of independence from nursing services through the emphasis on self-care, or the transfer of responsibility for care to informal carers or social care agencies (Gerrish 2001). Nurses have typically believed that patients owned both the origin and the solution to their health problems. Therefore, neoliberalism can be considered to be both an expression of the biopolitics of the state as well and the standard setter for normative citizenship (Ong 1999).

What does this selective history of the idealised contemporary maternal consumer mean for MCFHNs? It helps to identify how contemporary middle- and upper-class mothering standards have been shaped by consumerist, technological, medicalised and professionalised discourses. These discourses exert a normalising pressure which requires mothers to work and be self-disciplined. This intensive and individualised form of mothering is valorised at the expense of other iterations of mothering. MCFHNs assist the state to govern maternity at a distance; therefore, nurses can unwittingly collude with institutional policies that only support a narrow repertoire of mothering styles. For example, the contemporary ideology of intensive mothering requires mothers to devote large amounts of time, energy and money to raise their children and rely on expert advice in child-rearing decisions (Avishai 2007). However, it is classed and raced, advantaging particular groups of people who have the resources to enter the frame of pregnancy and child-rearing as carefully managed projects requiring assessment/research, planning and implementation skills which are supplemented with expert knowledge, professional advice, and consumption (Avishai 2007). The primacy and valuing of intensive motherhood can prevent MCFHNs from being responsive to women whose subjectivities have been formed outside white, middle-class or Western contexts. In place of therapeutic relationships with clients, it is possible to be under-involved or over-involved in a nurse–client relationship (Alberta Association of Registered Nurses — AARN — 1997). More likely the clients that fit into dominant modes of care are labelled 'good' and receive better care whilst those labelled as 'bad' or more typically 'non-compliant' and 'difficult' are avoided or are exposed to greater scrutiny, regulation or neglect.

Nurses need to consider their own roles and values when they deliver care. As culture-bearers, these values demarcate whether we see our clients as deserving of good care or, in turn, lead us to withdraw care or place clients under greater state scrutiny. By recognising the historical, social and structural forces that have shaped our ideas about maternity we can avoid individualising blame for those least in a position to shift things. In the same vein, moving our interventions beyond the individual to consider the broader contexts of maternity means that we can more carefully consider how current practice supports institutions rather than families.

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