MEASURING MOTHERING
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Abstract
As a culture, we have a tendency to measure motherhood in terms of a set of sig-
nal moments that have become the focus of special social attention and anxiety; we interpret these as emblematic summations of women's mothering abilities. Women's performances during these moments can seem to exhaust the story of mothering, and mothers often internalize these measures and evaluate their own mothering in terms of them. "Good" mothers are those who pass a series of tests—they bond properly during their routine ultrasound screening, they do not let a sip of alcohol cross their lips during pregnancy, they give birth vaginally without pain medication, they do not offer their child an artificial nipple during the first six months, they feed their children maximally nutritious meals with every bite, and so on. This reductive understanding of mothering has had counterproductive effects upon health care practice and policy, encouraging measures that penalize mothers who do not live up to cultural norms during signal moments, while failing to promote extended narratives of healthy mothering.

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schedule or feel any pain. These women definitely don't get any respect from me."

ASHLEY, 2006

"Many mothers who have difficult births love their babies. Love is not a contraction. It's the opposite, for me. A very slow opening."

LAUREN, 2004

My mother gave birth to me at the end of 1969, after a difficult pregnancy during which her graduate-student health insurance allowed her only minimal prenatal care. A hippy with degrees in literature, drama, and education, she was an ideal mother for an infant and a preschoo ler. She nourished my every spark of creativity, delighted in my personality quirks, fed me healthy food, and taught me to read by the time I was two. Firm believers that good parenting did not require a hiatus from life and adventure, she and my father became intimately familiar with the playgrounds, zoos, and pony rides of Europe and northern Africa. However, she was a problematic mother of an older child. She was controlling and fearful when I showed signs of independence and derided my desires to fit in with my peer groups. My parents pulled me out of school repeatedly for months at a time and moved me to a new neighborhood and school almost every year, so that they could travel freely without the responsibilities of home ownership. Seeing that I excelled academically despite these disruptions, my mother showed little sensitivity to their effects upon my emotional and social life. Later, once my independence and my failure to accept her vision of life at face value became undeniable, she more or less relinquished responsibility for me, leaving me to support myself from my mid-teens on. Yet she has turned out to be a wonderful mother of an adult child. After we each settled into acceptance of our mutual independence, she became a staunch supporter of my choices and a careful and appreciative audience for my accomplishments, as well as a devoted, playful, creative grandmother. The jury is out on what kind of elderly mother she will become later, after she becomes dependent upon her children in turn.

So was my mother a "good mother"? Aristotle said that a man's happiness could be measured only once he was dead; happiness and unhappiness reside in his life narrative only taken as a whole (1941, Book I, Chapter 10). Similarly, good mothering can be constituted only through an entire parenting narrative. My mother's narrative is not yet complete, nor will it ever be univocal.
Yet as a society we have a tendency to measure motherhood, not in extended narratives, but by a set of signal moments that we interpret as emblematic tests and summations of women's mothering abilities. Women's performances during these moments can seem to exhaust the story of mothering. Mothers often internalize these measures and evaluate their own mothering in terms of them. These "defining moments" tend to come very early in the mothering narrative—indeed, several of them come during pregnancy or even before conception.

Consider how the phrase reproductive ethics has come to refer almost exclusively to ethical analyses of discrete choices faced during pregnancy or even earlier. Key topics in reproductive ethics include abortion, pre-implantation genetic diagnosis, and fertility medicine. This ought to strike us as strange. Reproduction is the process of creating new people and building families and communities. Reproductive ethics ought to refer to the ethics of creating and caring for new generations. This is a process that extends across the life span. If we restrict our understanding of reproduction to the processes of conception and pregnancy, not only will we ignore much of the material and social labor that constitutes the creation and sustenance of new people, but we surely risk distorting the social and ethical meaning of these early stages of reproduction. That is, it would be odd to think that we can understand the ethics or social significance of pregnancy or conception without understanding them as first and foremost the beginnings of longer narratives. Yet mainstream bioethicists consistently lose interest in mothers once the beginning of their narrative is over. We give little or no bioethical attention to the ethics of mothering children after infancy, not to mention older children. I claim that this reductive understanding of mothering has had counterproductive effects upon health care practice and policy, encouraging measures that penalize mothers who do not live up to cultural norms during signal moments while failing to encourage extended narratives of healthy mothering.²

I believe that one of the important tasks for feminist bioethics is to turn the bioethical spotlight upon the fact that reproduction not only happens in women's bodies, but through women's ongoing, richly textured labor—labor that, after all, does not escape a complicated relationship with medical institutions and spaces after pregnancy ends. From pediatrician's offices and late-night emergency rooms to negotiating the increasing medicalization of children's behavior and bodies, women mother in and through their complicated relationships to medical authority, judgment, and possibilities, even when they resist doing so. Whether or not it should be this way, even in our current age of increasingly shared parenting duties, mothers bear a disproportionate responsibil-
ity for managing their children's contact with professional health institutions, maintaining their health at the domestic level (through feeding and hygiene practices and the like), and training them in safety and self-care. Correspondingly, mothers are held disproportionately responsible for their children's physical and mental health imperfections. Just as bioethics misrepresents pregnancy and conception when it severs them from the rest of mothering, likewise accounts of the ethics of family relationships miss a pressing dimension of mothering if they fail to bring the tools of medical ethics to bear.

In the following, I explore three examples of signal moments that we interpret as displays and tests of women's maternal adequacy; I then turn to the larger cultural and ethical impact of measuring mothering in these ways.

**Responding properly to ultrasound images**

Although the rituals and the accompanying rituals vary from country to country (cf., Mitchell and Georges 1997), ultrasound screening for fetal abnormalities during apparently healthy pregnancies has become completely routine in many countries. In Canada and the United States, for instance, it is standard to have such an ultrasound screening around the eighteenth week of pregnancy. The eighteenth-week ultrasound indeed has become so routine that couples often wait until they have had it to announce the pregnancy to friends and family (Mitchell 2001; Weir 1998). The procedure requires no informed consent, is rarely refused by women, and is generally preceded by little or no discussion of the medical purposes of the test, its proven risks or benefits, or the options that will be available if an anomaly is detected. (In fact, there has been no persuasive data showing improved outcomes for individual mothers or babies from routine ultrasound screening, and although an atypical ultrasound may lead to a recommendation for more testing, there are almost no conditions detectable on the ultrasound screen that can be treated or managed in utero. Reported reductions in neonatal morbidity and mortality due to routine ultrasound screening are based on termination rates, and termination can hardly be counted as an option that improves the health of a fetus.)

Although the medical expectations surrounding the test may be vague, the web of normative and social expectations in which it is embedded is not. "Good" mothers are expected not only to have the ultrasound, but to but look forward to it as a key moment on the path to motherhood. The primary purpose of the test, as it is represented in our culture, is not diagnostic but social. Pregnant women
are encouraged to treat the event as a treasured moment during which they will “meet the baby” for the first time. When confronted with the image of their fetus, “good” mothers manifest love and amazement and reaffirm that the test has helped them understand the “reality” of the baby. Good mothers are accompanied to the ultrasound by supportive heterosexual husbands and fathers-to-be. The joint attention of the expectant mother and father, directed to the inscrutable screen as the ultrasound technician rattles off the features and properties of the “baby,” serves to affirm and foreshadow the normative nuclear family unit. At the end of the screening, the couple usually receives a photo to take home with them, which, as medical ethnographer Lisa Mitchell (2001) has shown, serves socially as “baby’s first picture.” Indeed, the medical purposes of the ultrasound have taken a back seat to its social purposes to such an extent that many women find themselves completely unprepared for the emotional impact of problematic ultrasound results (cf., Yaqub 2005).

Lest we remain unconvinced that the primary purpose of the ultrasound is social rather than medical, we need only turn to the commercial ultrasound clinics that have sprung up in malls across the continent in the past decade. For a fee, these clinics will perform an ultrasound and provide a photo of your baby in a cute baby-themed frame. They also sell various other types of merchandise decorated with your ultrasound image. What is significant, for my purposes, is the extent to which these commercial clinics advertise their services through rhetoric that suggests a normative expectation that good mothers will want to preserve their ultrasound experience. “Fetal Moments: An Ultrasound to Remember,” an aptly named clinic in a suburban Atlanta mall, recommends purchasing “custom keepsake jewelry” featuring your baby’s ultrasound photo (see fig. 1). According to their Web site, “Fetal Moments is here to provide you and your family with a wonderful bonding experience through a unique ultrasound that you can treasure for years to come.” While the clinic explicitly declines to offer medical advice or diagnoses, all their packages include a DVD and photos, “gender determination, if requested,” and “room to bring your family and friends.”

The ultrasound ritual serves to put women’s maternal *bona fides* to the test. We can see this most clearly, perhaps, by looking at what happens when women "fail" this test. For example, Lisa Mitchell found that Canadian ultrasound technicians and obstetricians corrected expectant mothers who referred to what they saw on the screen as a fetus instead of a baby. When women did not manifest the “proper” level of emotion or the “proper” form of engagement with the ultrasound image, technicians were suspicious of their fitness to mother and
their commitment to the pregnancy. Technicians also were suspicious of women who showed too much or not enough interest in the health of the fetus or too much or not enough interest in its sex. They were sometimes directly judgmental toward expectant parents who were “too” interested in the sex, telling them that “finding out the sex isn’t important. The most important thing is that the baby is healthy.” Occasionally, in such cases and particularly when the woman was not Caucasian, the technicians would even lie about their ability to detect the sex of the fetus (Mitchell 2001, 381).

Thus the ultrasound test is culturally framed not only as a social ritual during which you meet your baby, but also as an early moment at which an expectant mother’s ability to engage and bond with her baby and to arrange for its proper social reception is measured. One of Mitchell’s interviewees told her the story of how her own ultrasound had gone and then asked, “How did I do?” (ibid., epigraph). On the popular television sitcom Friends, Rachel Greene—one of the main characters, who is already marked as a nonstandard mother when she becomes

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Figure 1. Advertisement for "Fetal Moments" ultrasound studio (www.fetalmoments.com)
pregnant while single after spending a drunken night with her ex-boyfriend—bursts into tears during her ultrasound, wailing "I'm a terrible mother!" because she cannot see the fetus on the screen when the technician points it out. Although the rituals surrounding the ultrasound are culturally variant and relatively recent, our expectations for how women will act and feel during these rituals are already quite rigid and well-entrenched in our folk culture. It is acceptable for a woman to refuse or to seek information about the sex of the baby, for example, but only for the right reasons: she can refuse the information because she wants the sex to be a wonderful surprise, but not because she is just uninterested; she can find out the sex because she wants to start contentedly purchasing gender-coded baby gear, but not because she would greatly prefer a child of one sex (although, interestingly, such preferences seem to be more socially acceptable for fathers). One can refuse the ultrasound altogether on the grounds that one will want to carry the baby to term regardless of any anomalies and "love it the same way no matter what," but not because one is simply uninterested in the test and unconvinced that there is any medical benefit to the procedure.

In the face of the dearth of medical evidence for concrete benefits for ultrasound screening, the standard justification for its routinization has been that it helps women bond with their unborn children (cf., Sedgmen et al. 2006). This is so despite the fact that such an effect is scientifically dubious at best (cf., Lapaire et al. 2007). By implication, a woman who fails to have the normative reactions to the ultrasound event is maternally deficient. Interestingly, why we care whether or not pregnant women bond with their fetuses has gone mostly unquestioned. It is a major empirical assumption—and one for which I have found no scientific evidence whatsoever—that bonding with one's fetus makes one any more likely to bond with one's actual baby. Indeed, we might imagine that bonding with something completely portable that we have met only via an image will make the reality of a spitting, screaming infant that much more of a shock. Most pregnant women are already going to extreme lengths to monitor and discipline their behavior to minimize risk; pregnant women obsessively control their diets, exercise regimes, emotional states, hair care product use, and just about every other aspect of daily life. We hardly need a tool such as the ultrasound to heighten this already excessive phenomenon. Meanwhile, pregnant women who engage in seriously risky behaviors such as drug abuse are unlikely to stop without some intervention more helpful than a suggestive image and a stern warning. It seems to me that our valuation of the maternal–fetal bond stems from our desire to start turning motherhood into a normative affair
as early as possible and likewise to start measuring a woman's maternal adequacy as early as possible.

Birth as a maternal achievement test

Labor and delivery typically take less than a day; some women labor for as long as a few days. Mothering, however, typically lasts for many decades. Within most mothering narratives, birth makes up a tiny speck. Adoptive mothers do not give birth to their children. Yet we have elevated the symbolic importance of birth to the point where it appears to serve as a make-or-break test of a woman's mothering abilities. If she manages her birth "successfully," making proper, risk-adverse, self-sacrificing choices, and maintaining both proper deference to doctors and control over her own body, then she proves her maternal bona fides and initiates a lifetime of proper mothering. If, on the other hand, she fails at these tasks during labor, she reveals herself as selfish or undisciplined and risks deforming her baby's character, health, and emotional well-being, while putting her bond with her child in permanent jeopardy.

According to our cultural mythos, "good" mothers deliver vaginally without pain medication, after advance planning and appropriate prenatal education. Second-best mothers submit regretfully but docilely to whatever medical interventions the doctors recommend to correct and control their unruly bodies. "Bad" mothers make other, "selfish" choices, such as giving birth at home, seeking out an epidural or a cesarean section, or attempting a vaginal birth after a previous c-section. Alternatively, "bad" mothers may just fail to demonstrate sufficient control over their births. They may labor "unproductively" and thereby "fail to progress" or otherwise fail to proceed in a timely fashion toward an uncomplicated birth.7 In some hospitals, women that end up receiving cesarean sections resulting in healthy babies are routinely given unsolicited literature on grieving to help them through their feelings of failure and loss at not having successfully achieved a normative birth.8

When women were first encouraged to draw up birth plans in which they specified their preferences concerning pain medication, who would be allowed in their rooms during labor, and other basic aspects of their care, the laudable idea was to help women become at least partial agents of their own births, rather than passively submitting to medical management. However, over time, formulating a birth plan has moved from an empowering option to a social duty. In the advice column, "Ask Amy," a recent letter-writer was appalled that her pregnant friend was not attending childbirth classes: "She said that she and her
husband were going to "wing it" and that the nurses knew what they were doing. I was a bit stunned that this well-educated woman would have such a casual attitude. . . . This expectant mom also said that they were going to flip a coin to decide whether to have an epidural. I think this is very irresponsible. These procedures do carry a level of risk.⁹ Other North American pregnant women are expected to plan out their births with the elaborate precision and care of a traditional bride planning her wedding day, and they are expected to do it early. One Web site perversely recommends: "In the happy haze of early pregnancy . . . the reality of labor and birth may seem extremely far off—which makes this the perfect time to start planning for the arrival of your baby with a birth plan that details your wishes."¹⁰ One fairly typical "interactive birth plan" that can be downloaded from childbirth.org is a seven-page form that asks mothers to detail their choices in eighteen different categories and several subcategories, covering everything from the lighting in the room, to the specific instruments that may be used in case of complications, to the laboring positions that they will adopt. We can push the analogy between birth planning and wedding planning farther: as women are called upon to plan and design their births, they are invited to think of birth, not primarily as the first day of the rest of their children's lives, but as their "special day," during which their tenure as mothers will be symbolically foreshadowed and put on display, just as weddings are often framed as the bride's special day and as the symbolic moment at which the perfection (or imperfection) of the marriage is performed as a spectacle.

Such elaborate birth plans set up completely unrealistic expectations concerning how much control one can possibly have over the laboring process, thereby setting women up for feelings of failure, lack of confidence, disappointment, and maternal inadequacy when things do not go according to plan, even when mother and baby end up healthy. They also give women the impression that if they do not have strong opinions seven months in advance concerning how they would like their labor room lit and whether they wish to avail themselves of foot pedals during labor, then they are not sufficiently engaged, concerned mothers-to-be. Furthermore, although the entire phenomenon of the "birth plan" is pervaded by the rhetoric of choice and autonomy, all women know that good mothers make some choices but not others. For instance, indicating that one wants pain medication at the earliest medically possible moment is not a socially acceptable choice, even though it is a choice available on the form. Lauren Slater (2004) writes, "Our [prenatal] teacher believed that birth was full of choices. 'You should write a birth plan and give it to the nurses,' she
said, 'You should refuse all pain medication. Refuse a heart monitor. Refuse Pitocin. . .' Our instructor also informed us that birth interrupted by technology equals a mother less able to bond with her baby."

The idea that women had better manage their births successfully or risk failing to bond with their babies—and thereby risk a narrative of motherhood corrupted irreparably from the first moment—is tenacious. Beginning with the attachment parenting movement spearheaded by John Bowlby (1969, 1983, and 1988) and William and Martha Sears (1993) in the 1970s and 1980s, alarmists from both the natural childbirth movement and the traditional medical community have argued, for instance, that mothers who do not breast-feed in the first hour will not bond with their babies, that mothers who are not fully lucid at the moment of birth due to pain medication will not bond with their babies, and so forth. Typically, the nominal concern of those who raise such worries is to protect mothers against losing these opportunities to bond because of overzealous medical interventions. However, in fact, such claims redound against mothers who, for whatever reason, do not manage to orchestrate these first moments correctly, putting their maternal success into question from the start. For example, noted birth anthropologist Brigitte Jordan claims, "A semi-conscious mother who does not hear her baby's first cry and a narcotized infant whose reactions are weak are off to a bad interactional start" (1992, 79). She then tells the story of witnessing a birth in which the mother, purportedly terrorized by too much medical intervention, stopped being "courageous" and instead "gave up" during labor. Her contractions stopped, her labor was artificially restimulated, and her baby was born with the help of forceps. Jordan ends the dramatic tale by commenting "I hope she still loves her baby" (ibid. 112–13). The passage is supposed to be an indictment of medicalized birth practices in the United States, but the normative language of failure aimed at the mother is clear, as is Jordan's belief that this woman's failed performance during the moment of birth—however much it can be blamed on her doctors and the institutionalized rituals of the hospital—portends a lifetime of deficient maternity.

In popular culture, the distaste for mothers who do not behave properly during their births is strong and explicit, as is the implication that this bad behavior reflects upon the entirety of their mothering. Women's choices to have or not to have cesarean sections have particularly mobilized this discourse. Notoriously labeled "too posh to push," mothers who choose elective cesareans for non-medical reasons are vilified by the media and in online discussions. In an article entitled "Too Posh to Push Moms Set Bad Example for Society," the Vancouver Sun editorializes, "Pity poor Sean Preston Spears Federline. . . . His mom couldn't even be
bothered to suffer a little pain for a lot of gain on the day of his celebrated birth. Yes, giving birth the old-fashioned way hurts. *Welcome to motherhood*" (Fralic 2005). Here, Britney Spears's elective c-section—which, given the ways of abdominal surgery, probably did involve more than "a little pain"—is taken as reflecting directly upon her entire relationship to motherhood, whereas proper maternity is associated with self-sacrifice and a willingness to bear pain. Meanwhile, on a babycenter.com bulletin board discussion concerning the ethical acceptability of elective c-sections, typical entries express sentiments similar to Ashley, who writes, "I am totally against elective c-sections. . . . A smart woman who loves her unborn child will avoid having a c-section if at all possible. Only a self-absorbed wimp would choose to put her baby in harm's way so that she doesn't have to alter her schedule or feel any pain. These women definitely don't get any respect from me."

Here again, non-normative choices concerning birth are taken to indicate a global deficiency of maternal love and competence.

Part of what interests me about comments like these is the complete vagueness concerning what sorts of gains and harms are at stake. What exactly would Britney gain by attempting a vaginal birth, and exactly how are mothers who elect c-sections putting their babies "in harm's way"? Of course, this is a complex scientific question, and there is plenty of ongoing research aimed at pinning down the exact advantages and disadvantages for mothers and babies of different modes of delivery. What we do know is that, in comparison with a host of other mundane activities, and in comparison to all previous moments in history, all of the standard options for birth in developed nations (cesarean sections, vaginal births after cesarean, home births, water births) are extremely safe for mother and baby alike. Britney surely takes fewer chances with her baby by scheduling a c-section than does a mother who chooses a preschool that is a car ride rather than a walk away from her home.

In fact, whether we cast cesarean sections or vaginal births as the risky, selfish option varies in accordance with context, not in accordance with the actual risks involved. Not only have some (mostly indigent) women who have resisted medically recommended cesarean sections occasionally been served with court orders (or in the case of Melissa Rowland in Salt Lake City in 2004, with homicide charges), but even women who wish to attempt an elective vaginal birth after a previous cesarean section are increasingly faced with draconian hospital restrictions (Schneider 2005; Grady 2004) and the same charges of selfishness and risk-taking that their peers who seek elective cesarean sections face. The standard justification for preventing women from attempting vaginal
births after a cesarean is based on the risk of catastrophic outcomes due to uterine rupture. Not only is the risk of uterine rupture tiny, but—ironically—this risk turns out to be roughly equivalent to the risk of uterine rupture during primary vaginal delivery (Smith et al. 2002). Meanwhile, repeat cesareans are, of course, no safer than primary cesareans; indeed, quite the opposite. In other words, whether a scheduled cesarean or an attempted vaginal birth is the socially sanctioned, "properly maternal" choice depends on whether or not the mother had a previous cesarean or not. But the fact of a previous cesarean in no way reverses the relative risk of these two options. Therefore, here our social attitudes toward proper maternal choice are cut free of any basis in objective relative risks.14

But in any case, the real risks and their sizes do not seem to be of interest to the lay critics of mothers' birth choices, who appear quite content with hand-waving references to gains and harms. Especially because these critiques are not responsive to any specific, sizable risks, it is hard not to conclude that the main normative standards at play are ideological, not medical: Our cultural insistence that women make "proper" birth choices and maintain control over their birth narratives is not about minimizing real risks; rather, it supports our desire to measure mothering in terms of women's personal choices and of self-discipline exercised during signal moments. What is at stake is not the health of babies but an image of proper motherhood, combined with the idea that birth should function as a symbolic spectacle of such motherhood.

We must remember that mothering is not defined by its first moments. Even the best bond between a mother and her twenty-minute-old baby is a meaningless shadow of a genuine mother–child bond of the sort that sustains good mothering.

You are what your child eats

Providing high-quality early nutrition to children and eating well during pregnancy are undeniably important components of good mothering. Children's nutritional status depends on eating habits that are established over time. However, our culture is replete with images of feeding moments that purportedly corrupt both children and mothers in some permanent way.

The logic of the single corrupting bite shows vividly in a recent article by Jodi Kantor in the New York Times entitled "Memo to Nanny: No Juice Boxes." Kantor writes, apparently without irony, "The current nutritional wisdom says that what children eat may set their tastes in place permanently. In this view, a
hot dog is never just a single tube of meat, because it will lead to thousands of salty, processed, who-knows-what-filled lunches to come." Here the seemingly single hot dog is pictured as extending beyond itself, determining and encapsulating a lifetime of poor eating habits rather than remaining singular. By allowing a hot dog to slip into her child in a moment of weakness, a mother can pervert the child’s tastes and eating practices forever, thereby undoing months or years of devotion to purchasing organic food, avoiding trans fats, and planning and preparing balanced meals for her child out of fresh ingredients.

Ultrasound tests and birth are idiosyncratic events, and I have argued that mothers are measured by their performance during these events. The logic of feeding is slightly different: one must feed one’s child over and over again, and there is no discrete moment at which one can prove one’s proper maternality through feeding. On the other hand, at any moment a mother may prove herself an improper mother through an act of feeding. Hence this is a test that one can never pass but is always at risk of failing. Kantor’s article received hundreds of on-line comments immediately from mothers, many of them arguing in favor of more maternal surveillance and discipline and stricter eating rules. One mother commented, “This article is frightening. How can parents give such discretion to a babysitter?” Commentators described quitting their jobs rather than relying upon nannies and grandparents who couldn’t be trusted to avoid hot dogs, refined flour, or products with traces of peanuts. One mother who admitted in her comments to owning at least one bottle of infant formula was immediately flamed by others.15

Indeed, one can fail the feeding test very early on. Many parenting guides suggest or claim outright that allowing her baby one single suck on an artificial nipple may well destroy a mother’s chances for a successful breast-feeding relationship forever (and in turn, that a baby who is not breast-fed is at high risk for failure to bond with its mother, low IQ, and multiple behavioral and health problems).16 North American breast-feeding promotional materials consistently emphasize exclusive breast-feeding, as opposed to the more productive message that the more breast milk babies receive, the better. “Does one bottle of formula make that much difference? We wish we could say that it doesn’t,” states La Leche League, rather disingenuously, in their breast-feeding guide, “but we can’t” (1997, 90). According to this guide, a single bottle of formula can trigger life-threatening allergies, and any contact with artificial nipples (bottles or pacifiers) can cause nipple confusion, wherein the baby is no longer willing or able to latch onto a breast. In fact, although it is true that a baby who is regularly fed from a bottle may reject the breast or lose
the skill of latching onto it, there is no evidence for nipple confusion resulting from the occasional use of artificial nipples (cf. Fisher and Inch 1996 and Neifert, Lawrence, and Seacat 1995). A 1992 study found no difference in breast-feeding outcomes between newborn infants who were exclusively breast-fed and those who received one bottle daily (Cronenwett, Stukel, and Kearney 1992). The pervasive fear of instant nipple confusion among new mothers, cultivated by the medical establishment, the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF), among others, is itself indicative of the power of the logic of the single corrupting moment.17

Artificial nipples are portrayed as corrupting more than just an infant’s feeding practices; their stain can infect mothering as a whole. In What to Expect: The First Year (the sequel to the ubiquitous and unforgiving queen of guidebooks, What to Expect When You’re Expecting), we find out how, despite a mother’s best intentions, that first offer of an artificial nipple can initiate a process that corrodes nearly all aspects of mothering:

Be aware that pacifier use easily slips into pacifier abuse. What starts out as the baby’s crutch can easily become the mother’s. There is the ever-present temptation to use the pacifier as a convenient substitute for the attention she herself should be providing to her child. The well-meaning mother who offers the pacifier . . . may soon find herself popping in a pacifier the moment [her baby] becomes fussy, instead of trying to determine the reason for the fussing or if there may be other ways of placating him. She may use it to get the baby off to sleep instead of reading him a story, to ensure quiet while she’s on the phone instead of picking him up and consoling him while she’s chatting, to buy his silence while she’s picking out a pair of new shoes instead of involving him in the interaction. The result is often a baby who can only be happy with something in his mouth, and who is unable to comfort himself, entertain himself, or get himself to sleep. (Murkoff, Hathaway, and Eisenberg 2003, 117)

After her initial offer of the pacifier, the mother in this passage is swept passively down a current of bad mothering over which she has little or no control; led into temptation, she soon finds herself substituting the pacifier for her own activities of mothering. She replaces proper mothering activities with markedly gendered, trivial tasks: chatting on the phone and shoe shopping. Although the first suck may be both tempting and fleeting, its consequence is an orally fixated, emotionally crippled child.18
The idea that each feeding moment presents a pivotal choice between risk and maternal responsibility extends backwards into pregnancy. *What to Expect When You’re Expecting* warns, “Every bite counts: Before you close your mouth on a forkful of food, consider, ‘Is this the best bite I can give my baby?’ If it will benefit your baby, chew away. If it’ll only benefit your sweet tooth or appease your appetite, put your fork down” (Murkoff, Eisenberg, and Hathaway 2002, 80). This passage—which regularly incurs the wrath of pregnant women in chat rooms and on bulletin boards—demands that mothers discipline their eating with literally every bite of food, avoiding the corrupting, selfish bite that is not baby-directed. Here, eating simply because one is hungry (“to appease your appetite”) is akin to maternal betrayal.

The risks and benefits that arise from mothers’ ongoing lifestyle, economic security, and access to high-quality foods far outweigh the risks and benefits that attach to any single forkful or suck. Our focus on the importance of feeding moments rather than on long-term eating patterns betrays our entrapment within an ideological picture of normative maternal performance, rather than a reasonable concern with children’s well-being.

**The effects of measuring mothering in moments**

I have described three maternal activities—undergoing a routine ultrasound, giving birth, and feeding one’s baby (or fetus or child)—that I have argued serve as cultural tests during which women’s maternal *bona fides* are measured. In each case, medical institutions, the media, and mothers themselves collude in assessing how mothers perform during heavily, normatively-regulated signal moments. The rhetoric surrounding these moments suggests, on the one hand, that they will determine the success of the future mothering narrative (whether the mother will bond properly with her baby; whether the baby will develop a lifetime of secure relationships and healthy eating habits) and on the other hand, that they reveal the truth about a woman’s fitness to mother (whether she is sufficiently engaged, self-sacrificing, risk-adverse, disciplined, etc.).

Our cultural images of proper maternal behavior during these tests are not politically neutral. Rather, a woman’s ability to perform “properly” with respect to prenatal care, birth, and feeding are marked by socioeconomic status and ethnic identity. Consider:

(1) Lisa Mitchell found that immigrant women in Canada were, not surprisingly, less likely to follow the script during their ultrasounds. Not having been trained on the contingent cultural rituals surrounding the event, often coming
from countries where there is no routine screening during healthy pregnancy, or from countries where the screening is treated as a clinical rather than a social event, they were less inclined to personify the image on the screen, bring along their spouses, expect keepsake photos, and so forth. Accordingly, ultrasound technicians tended to offer these women less medical information than their counterparts who followed ultrasound etiquette, and the technicians socialized less with these fetal images. Later, they reported that the women seemed insufficiently concerned with and excited about their babies (Mitchell 2001, 185).

(2) An unmedicated vaginal birth that goes according to a predetermined birth plan is taken as the maternal gold standard, I argued. But a woman’s chances of having such a birth depend heavily upon her own health, her access to high-quality, continuous health care with a provider who is familiar with her preferences, her ability to articulate her wishes in a way that health professionals will understand, her mastery of English (in an Anglophone hospital or birth center), her ability to hire an advocate such as a doula or midwife, and her level of support from family members and others who can speak for her during the birth. The ability to insist that a birth plan be respected by the hospital staff, even when medically possible, normally requires a high degree of education, confidence, and perceived social authority. Every one of these factors varies by socioeconomic position. Women who manage to have a “natural” birth may feel that they are somehow communing with their mythical pre-industrial sisters, but in fact, they normally draw heavily upon their social privilege and their immediate access to state-of-the-art technological interventions in enacting their birth narratives.

(3) Poor women have less access to high-quality, diverse foods, and less time to prepare meals for themselves and their children. Poor and minority women have lower rates of breast-feeding than financially secure white women.19 We know that this is not because of differences in women’s knowledge of the benefits of breast-feeding (Guttman and Zimmerman 2000). Among other determining factors, poor and minority women are less likely to have jobs that provide enough maternity leave to establish breast-feeding or private spaces in which to nurse. They are more likely to be single parents and to work long hours.20

Thus to the extent that we take “proper” maternal performance during these key moments as a measure of mothering as a whole, we will re-inscribe social privilege. We will read a deficient maternal character into the bodies and actions of underprivileged and socially marginalized women, whereas privileged women with socially normative home and work lives will tend to serve as our models of proper maternal character. Yet it is likely that women pass these mothering tests
less by dint of their inherently maternal character and their responsible commitment to their children than because they have the right kind of education, financial resources, health insurance plans, family structure, and jobs.

Our focus on how mothers perform at signal moments is part of a larger cultural sensibility: in North America and Britain, at least, public ethical discourse tends to focus heavily on personal responsibility and will-power as it is displayed (or fails to be displayed) at discrete choice-points, rather than on the structural conditions that enable or undermine people's ability to make good choices over the long term. It is difficult to turn public attention to the environmental, economic, and social conditions that can make various choices and behaviors difficult or easy; instead we tend to employ a conceptual repertoire—made up of notions such as character, will-power, choice, and responsibility—that inherently isolates individuals as ethical agents and occludes such contextual determinants.

This individualist logic encourages policies and initiatives that focus on influencing the choices that mothers make at particular moments, rather than on creating structural conditions that foster extended narratives of healthy mothering. For example, the public service announcements for the United States Department of Health and Human Services breast-feeding campaign, "Babies were born to be breast-fed," launched in 2005, show pregnant women engaging in absurdly risky one-time activities such as log-rolling and bull-riding, followed by the text, "You wouldn't take risks before your baby's born. Why start after? Breast-feed exclusively for six months." Here, any single departure from exclusive breast-feeding is equated with a dramatically risky, self-indulgent choice. Elsewhere, I have pointed out that this campaign focuses entirely on mothers' choices, using the rhetoric of personal responsibility and blame, without any attempt to advocate for tolerance for breast-feeding among employers, family members, or members of the public, or for structural changes in workplace rules, maternity leave, or urban planning that would make such exclusive breast-feeding viable for more women (Kukla 2006).

Consider also our emphasis on zero-tolerance when it comes to alcohol consumption during pregnancy. Women are repeatedly told that there is "no proven safe level" of alcohol consumption during pregnancy; indeed, in the United States, the official position of the Surgeon General is that any alcohol consumption during pregnancy is unacceptable, and a growing number of other countries are adopting similar positions. Although extensive research has failed to turn up any evidence of negative effects on fetuses from women's light to moderate drinking as part of a healthy lifestyle, the idea that a single drink
SPECIALTY SECTION: Critical Care

One Drink Can Last a Lifetime

Women who consume alcohol during pregnancy put their babies at risk for a multitude of lifelong problems

By Carol Nelke Dunbar, APRN
April 11, 2005

Figure 2. From Nurse Week, April 11, 2005

both reveals maternal irresponsibility and can have a lifelong corrupting influence is pervasive. In a public service announcement produced by the Ad Council,24 a hip young black woman tells her audience, “If you drink alcohol while you’re pregnant, you may be ruining your baby’s chances of ever having a normal life!”25 In figure 2, a headless pregnant belly appears to be gearing up to suck back a giant glass of wine directly into the womb. The article header employs the language of risk and blame (“women . . . put their babies at risk”), while reinforcing the scientifically inaccurate idea that a single drink can undermine an entire mothering narrative (one drink can “last a lifetime”).
Our determination to prevent women from ever drinking during pregnancy, and our demonization of those who do, has come at the cost of educating pregnant women about the difference between healthy and abusive relationships to alcohol and the difference between theoretically and substantially risky behaviors. The public health emphasis upon complete avoidance of alcohol has not been accompanied by substance abuse programs for pregnant women. The implicit assumption would appear to be that good mothers will follow the no-safe-level, zero-tolerance rule, whereas women who violate this rule already have proven themselves to be bad mothers who are beyond saving. Epidemiologically speaking, poverty, social stress, and smoking are much bigger risk factors for having a baby with Fetal Alcohol Syndrome than is occasional drinking (Armstrong 2003), but our focus on moments of maternal choice occludes these social determinants. Scare tactics underscored by the language of choice, maternal character, and personal responsibility pointlessly convince many women who are not at risk for having babies with Fetal Alcohol Syndrome to forgo the pleasure of an occasional glass of wine, while surely inducing little other than guilt in alcoholic women whose babies are at serious risk.

As a culture, then, we privilege early, discrete moments of choice as the measures of mothers, as opposed to ongoing patterns and developing relationships—as if we can bond in a moment, destroy or secure our child’s chances at well-being in a moment, or fail at mothering in a moment. And yet, while there is always the possibility that a poor decision will turn out to have tragic consequences (such as Kate and Gerry McCann’s much-discussed decision to leave three toddlers alone in a hotel room while they went out for dinner—a decision that has been universally cast by the media as Kate’s rather than the couple’s), single events rarely play a large role in determining how a child will turn out, or how healthy and successful a mothering narrative will be. My suggestion is that we need to view mothering as a work in progress until the very end. When it comes to health promotion and policy, we should shift our attention away from mothers’ performances at key moments, and onto providing families with the systematic support that would enable women to engage in ongoing narratives of good mothering. Such support would include food and job security; decent maternity leave; full access to family planning; a cleaner environment; universal access to decent education and health care; workplaces and labor laws that are structured around the assumption that many workers will have substantial parental commitments, including
commitments to breast-feeding and to fathering; accessible interventions for women struggling with addiction, mental illness, or other social stresses; and a safe, competent, junk-food-free public school system for all children.

If we take seriously the idea that reproduction is typically a decades-long social and material labor of love, and never merely a biological event involving eggs, sperm, and wombs; then these are all reproductive rights, and the bioethical consideration of their contours and limits is reproductive ethics. Hence the reorientation of attention that I have been urging would dramatically change the scope and methods of reproductive ethics. In the first instance, reproductive ethics would no longer concern particular medical choices made before conception and during pregnancy. Its primary subject matter would be larger questions of social, economic, and environmental justice, and inevitably—rather than just as an afterthought—gender equity. Contemporary reproductive ethics generally treats mothers as fleeting sources of genetic material and gestational environments, whose ethical role in reproduction is summed up by and confined to a handful of choices made at or before the start of our children’s lives. As feminists, we must insist that bioethicists take mothers to be whole, socially situated people with entire life narratives, typically including several decades of mothering.

Notes

1. Early versions of this paper were presented at the American Society for Bioethics and the Humanities annual meeting in Denver, Colorado in October 2006 and as a keynote address at the "Monitoring Parents: Childrearing in the Age of Intensive Parenting" conference at the University of Kent in June, 2007. For wonderful support and helpful conversations, I am grateful to Sonya Charles, Colleen Fulton, Ellie Lee, Meredith Michaels, Tricia Shivas, an anonymous reviewer, and especially the members of the Obstetrics and Gynecology Risk Research Group: Elizabeth M. Armstrong, Lisa Harris, Miriam Kuppermann, Margaret Little, Anne Drapkin Lyerly, and Lisa Mitchell. This research was supported by a grant from the Social Science and Humanities Research Council of Canada.

2. As an anonymous referee rightly pointed out, I do not make any serious attempt to define good or healthy mothering in this paper. Surely women can be better or worse mothers. However, my interest here is in gaining critical distance from (what I see as) one problematic, hegemonic way of measuring mothering, rather than with forging and defending a specific alternative picture of the ethics of mothering. Mothering is serious moral work, and hence we do need to consider what it takes to mother well; hopefully, however, we can transcend the idea that mothering can be measured in any uniform way.

3. I elaborate and defend the claim that mothers play such a crucial role in the health care system in Kukla 2006.

6. I cannot, in any formal sense, provide empirical evidence that these attitudes are entrenched in our folk culture; it is often in the nature of folk attitudes not to be formally documented or articulated.
7. Several feminist scholars have pointed out how the language of failing and defective women’s bodies pervades our discussions of birth. Cf. Harrison 1982; Davis-Floyd 1994; and Lyerly 2006.
8. This was the practice at Ottawa Civic Hospital, where I gave birth to my perfectly healthy son by cesarean section. I do not know how many hospitals do this, however it is easy to find pamphlets designed for this purpose online. See for instance www.birthrites. org/BookletIndex.html (accessed November 12, 2007). See www.plus-size-pregnancy. org/CSANDVVBAC/csemotionalreco.htm#References (accessed November 12, 2007) for a large clearhouse of literature designed to aid emotional recovery after cesarean section.
11. Bowlby’s program spawned various sympathetic scientific studies (e.g., Kennel, Trause, and Klaus 1975), as well as a scientific backlash attempting to debunk him (including Lozoff 1983).
13. I could not possibly document or compare all the possible risks of routine driving and of being born by scheduled cesarean section. But for purposes of illustration, consider that according to the National Center for Statistics, the 2003 rate of automobile accident-related fatalities in the United States was 8.34/1000 population, whereas the rate of perinatal death associated with scheduled cesarean sections in the United States is 1.3/1000 population (Landon et al. 2004).
14. The argument of this paragraph, differently worded, appeared previously in Lyerly et al. 2007.
16. Cf., e.g., La Leche 1997 and Tamaro 1998, as well as the standard lactation nursing textbook, Lawrence 1994, which recommends giving new mothers this advice.
18. In Kukla 2005, Chapter 5, I document this logic of the corrupting suck, as it appears in popular media, guide books, and scientific journal articles, in quite a bit of detail.


22. Australia and New Zealand are in the process of implementing laws that would require zero-tolerance labels similar to those used in the United States (www.amavic.com.au, accessed November 13, 2007), and New Zealand has recently strengthened its Ministry of Health guidelines, which have gone from recommending avoidance of alcohol during pregnancy to urging “total abstinence” during pregnancy (www.otago.ac.nz/news/news/2006/13-07-06_press_release.html, accessed November 13, 2007). Some Canadian provinces require warnings stating that pregnant women should avoid all alcohol to be posted in licensed establishments. In May 2007, the government of Britain and the Royal College of Obstetricians and Gynecologists “strengthened” their warnings concerning alcohol consumption during pregnancy. Whereas the former official British recommendation was that pregnant women limit their consumption to one to two drinks per week, the new guidelines advise that women should “stop drinking altogether” during pregnancy (Bennett 2007).


24. Inventors of McGruff the Crime Dog, Smokey the Bear, and the “Babies were Born to be Breastfed” campaign, among other social marketing materials.

25. PSA available at www.nofas.org/MediaFiles/PSA/PSA.wmv.

References


