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A paradox of support: the Department of Children and Families and their construction of the "good mother"

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Thesis

**A PARADOX OF SUPPORT:
THE DEPARTMENT OF CHILDREN AND FAMILIES
AND THEIR CONSTRUCTION OF THE “GOOD MOTHER”**

by

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ABSTRACT

Pregnant women with substance use issues are a doubly at-risk group in desperate need of support. Using open-ended interviews, participant-observation, and media analysis, I examine the support provided by the Department of Children and Families (DCF) in Massachusetts for pregnant women who seek treatment at Project Empowerment. Project Empowerment provides prenatal care, maintenance therapy, and other services to expectant mothers who struggle with substance use issues. Drawing upon Foucault’s (1975) notion of surveillance, I explore how pregnant women with substance use issues are surveilled by agencies, and how these surveillance agencies structure their care and policies through their definitions of what it means to be a “good mother.” I argue that through the Department of Children and Families definition of the “good mother,” DCF produces an unintended paradox of support for pregnant women with substance use issues in Massachusetts.

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LIST OF ABBREVIATIONS

- CPSChild Protective Services
- DCF.....Department of Children and Families
- NAS.....Neonatal Abstinence Syndrome
- PE.....Project Empowerment
- TXTreatment

CHAPTER I: INTRODUCTION



Figure 1.1: Baby doe statue on Deer Island (Congi, 2015), the plaque reads:

FOR REASONS WE MAY NEVER KNOW
AN ANGEL CAME TO OUR SHORES
CAUSING US TO SHED A COLLECTIVE TEAR
MAY SHE REST IN PEACE AND
NEVER BE FORGOTTEN

Bella Bond and Others Like Her

In June of 2015, a young girl's body was found on Deer Island, along the coast of Boston. On this island now rests a bronze statue of a baby doe in remembrance of this little girl the country and world came to know as Baby Jane Doe (Figure 1.1). By mere coincidence, the forensic term given to unknown human remains, "Doe," is also the name science has given to a female deer. And, by a second coincidence, she is found on Deer

Island. The aptly made statue of a baby doe for Baby Jane Doe on Deer Island represents a community mourning the loss of the girl whom officials eventually identified as Bella Bond. Even though her name would not be known for over a month, the thought of a girl who was murdered in their own community allowed the public to reflect on this tragic event. The story of Bella Bond continues to find its way across the headlines in Boston and other places, provoking the media to dissect the truth behind her life, and her death.

Recently, Jill Lepore, a journalist from the New York Times, painted a grim picture of stories like Bella Bond's—ones riddled with physical abuse, substance use, and mistakes made by officials (2016). These stories span several decades and Lepore presents several tragedies that occurred in Massachusetts, focusing on the Department of Children and Families (DCF). In 1978, Jennifer Gallison was murdered by her parents; in 2013, Jeremiah Oliver was killed by his father and was found buried off of I-190. Both children were involved with social services during their short lifetimes. Lepore highlights that their deaths could have been prevented if DCF had paid closer attention to the unsafe environments the children were in before their deaths (Lepore, 2016). In contrast to Bella's case, Jennifer and Jeremiah's parents were not identified as drug users. Yet their parents neglected them and eventually were the cause of their death.

These stories represent tragedies for which the media and the public blame the parents, along with DCF. However, what the media does not discuss is the struggle women like Rachelle Bond, Bella's mother, face. Stories like Bella's reflect a multitude of issues facing children, families, and institutions dealing with the struggle of addiction. Addiction, or substance use, is a mental health issue that can be regarded in a number of

ways. I will refer to addiction as “substance use”, rather than “substance abuse”, for two reasons: one being that the term “abuse” carries with it highly negative connotations.

Second, as I discuss in-depth child abuse and neglect, I hope to create a clear divide between “substance use” and “abuse and neglect”. Therefore, I will use the term “abuse” only to discuss child abuse and neglect, rather than addiction.

For substance-using expectant mothers (hereafter I will refer to these women as “mothers”) from Project Empowerment (PE), my research site, maintenance therapy allows them to remain medically stable without going into opiate (or other substance) withdrawal while pregnant. Although the use of maintenance therapy to treat addiction is contested, this method is clinically safe for the unborn baby and their mother (NAPW, 2015).

The fact that mothers with substance use issues have access to prenatal care in conjunction with maintenance therapy at Project Empowerment is a valuable option. Still, these mothers have life stories and social and structural barriers that they face every day, making accessing care difficult. Some of these obstacles are highlighted in the stories providers of Project Empowerment told me about their patients. These stories are tragic and seem surreal, yet they are a harsh reality for many of the mothers at PE.

Stories from Project Empowerment

Stephanie: What's a case that you'll never forget?

Dr. Bare¹: Oh... uh a case that I'll never forget is a woman that I care for and it was her second or third pregnancy and we were talking to her about her history of addiction, sort of how she got started. And she uhh basically started when she was four years old because she would be strapped to a chair and umm by her mom's partner who was also her mother's pimp and also was a drug dealer who would inject her with heroin. And I think that had a profound impact on me because again I think our goal is really helping people understand what addiction is and no one would choose this disease. I think anyone would choose any other disease but this disease and I think when you hear that particular story for that mom, when you're four and you have no choice and the people in your life are there, they're supposed to be umm supporting you and caring for you and this is what you're exposed to, of cour- I would, of course you would turn to drugs as an escape because you've had a really challenging, challenging childhood and that doesn't make you a bad person, it just makes it unfortunate that you've had these experiences... (Interview, 10/12/15).

Stephanie: Can you give me an example of one [mother] that you'll definitely remember?

Shea: Umm I had a patient who overdosed and passed away after she had pregnancy loss umm a few years ago. She was pregnant with twins and she's only nineteen years old [Stephanie: ohh] and she was using heroin and she went - after she lost her twins, she went to a psychiatric hospital and they discharged her with a lot of benzodiazepines [Shea speaks softer] I don't know if it was - I'm pretty sure it was an intentional overdose umm... and she died in a shelter. The shelter that's across the street from here [Stephanie: mmm] So that was very challenging and I feel like I think about - I feel like that kind of changed a lot of how I practice since she passed away. Just that it felt - That was the first patient that I ever had that died and it felt very real that this is a disease that kills people and is killing people and it's very serious. [Stephanie: mmhmm] So I think about her a lot but... Overtime you just kind of - ya' know, you think about someone and then it's okay and you remember, ya' know the good things and it's, it's not so sad (Interview, 07/16/15).

¹ This and all other names are pseudonyms

These stories are among the many that in some sense portray the population, and providers, at Project Empowerment (PE). Shea acts as a social worker for the hospital in which PE takes place and Dr. Bare is an obstetric provider for PE. They, like all their colleagues at PE, are passionate. The population they cater to in Project Empowerment is at times challenging, and devastating, as seen in the passages above. The mothers who seek care at PE receive compassionate care, yet still face many obstacles and daily stressors.

Along with addiction, mothers who struggle with substance use often deal with sexually transmitted infections (STIs), mental health issues, and poverty (Powis et al., 2009). Poverty presents a unique but pervasive struggle to accessing health care, especially when a woman is pregnant (Ostrach & Cheyney 2014). Although Medicaid or insurance covers some of the costs of care, lack of transportation and access to other resources nevertheless provides a stressful situation for low-income pregnant women facing many other social and medical issues (Bridges, 2011). Mothers who struggle with substance use can also lack social support. A mother's social support network, as I refer to it, consists of her friends, family, and/or institutions like hospitals and the providers they employ or government agencies and caseworkers. Social support can provide a mother with emotional, mental, physical, and financial help – helping a pregnant woman seeking health care to overcome other obstacles (Ostrach & Cheyney 2014).

However, the stress a mother faces in seeking and staying in care while struggling with substance use issues is exacerbated if she lacks social support. To the same effect, as I will argue in this thesis, while claiming to provide support, the Department of Children

and Families (DCF) *produces* stress through their definition of what it means to be a “good mother.” This definition, discussed in subsequent chapters, fuels the way DCF structures their surveillance of pregnant women who struggle with substance use. DCF surveillance along with substance use and other issues such a mother faces compounds the stress she experiences.

Pregnant women with substance use issues are in desperate need of support and DCF has the potential to provide institutional access and connection to valuable resources. As an institution that is charged with protecting children and keeping families stable and together, DCF has the chance fulfill their vision while providing support for mothers. The research question, then, is: *Does DCF, through their use of surveillance, provide appropriate support for pregnant women with substance use issues?* In this research I draw on other social science works that focus on mothers and social support, while providing a new and unique ethnographic perspective on the involvement of DCF with substance-using pregnant women in Massachusetts. Interviews with providers and social workers enrich this research with their perceptions of a mother’s experiences with concomitant surveillance and social support networks. Through these narratives, I will show how DCF creates an unintended paradox of support and produces fear and stress for mothers through their use of surveillance.

Chapter Summaries

The background chapter focuses on how social science researchers have discussed pregnancy and addiction, separately and together, within the United States. The history of pregnancy and addiction in this country provides a backdrop for the presentation of

how social science research has examined social support in relation to both. Finally, I present the history of research on, and definitions of, child abuse and neglect in the United States and the creation and implementation of agencies intended to protect children, specifically the Department of Children and Families. In the Methods Chapter I present the original research plan including recruitment plans and the expected number of interviews. This is followed by what actually happened, including a change in direction from looking at fathers as social support, to DCF as social support. I discuss the unfolding of how the research played out during the summer of 2015.

In the three analytical chapters I focus on three separate yet inextricably linked issues pregnant women with substance use issues face that act as obstacles to care. In Chapter Four, I analyze the notion of surveillance from providers, agencies like DCF, and friends and family – a mother’s social support network. I argue that pregnant women with substance use issues, who I refer to as “mothers” throughout (as many of them already have children, or think of themselves as mothers from the time they decide to carry a pregnancy to term), encounter what I call a *multifaceted clinical gaze* within the hospital setting, specifically at Project Empowerment. Finally, I analyze how the ways a “good mother” is defined are intimately tied to how surveillance agencies understand and treat mothers in this country.

In Chapter Five I argue that DCF provides mothers with an “unintended paradox of support.” The Department of Children and Families gives a critical background into understanding how DCF views themselves and enacts their power over children and families in Massachusetts. Their policies are structured around protecting children and as

a result, DCF also constructs a definition of “good mother” that focuses on the health and well-being of children rather than mothers struggling with addiction. I apply all of these factors to how they affect mothers at Project Empowerment who are in need of support.

My narrative in Chapter Six focuses attention on how the media portrays mothers with substance use issues, the providers who treat them, and DCF’s attempts to protect their children. The representations of these mothers include embellished language and often emotion-provoking pictures. I argue that the media gives the public a skewed picture of the struggles mothers’ face, the care providers give, and the results of DCF involvement. In giving the public this skewed picture, they promote demonizing and demoralizing pictures of parents, providers, and DCF that are not necessarily factual. The proceeding chapters thus present a new, and often undiscussed, complex network of social support for pregnant women with substance use issues.

CHAPTER II: BACKGROUND

Child Abuse and Neglect in the United States

When a woman with a substance use issue gets pregnant, her substance use puts the health of her fetus at risk (Smith et. al, 2006). Prenatal substance use does affect the health of the fetus. Due to the “Crack Epidemic” and “Crack Babies” hysteria in the 1980’s², much of the research on prenatal substance use has focused on the effects of cocaine use on an unborn baby. There is limited research on the effects of other illicit substance such as methamphetamine and heroin. Overall, the research has focused on how substance use during pregnancy potentially results in low-birth weights and early developmental issues (Behnke & Smith, 2013).

It also, in the United States, brings her pregnancy into the domain of government initiatives intended to prevent and protect children—including the unborn—from abuse and neglect. In her discussion of child abuse and neglect, Jill E. Korbin states that, “Child abuse and neglect violate some of our most cherished views of human relationships” (2004). Of course, “abuse and neglect” are culturally constructed and historically shaped, leaving these definitions open for interpretation. An epitome of cross-cultural confusion over abuse is seen in *The Spirit Catches You and You Fall Down* (Fadiman, 1997). Anne Fadiman (1997) tells the story of Lia Lee, a Hmong girl who began having seizures in her first year of life. Her parents’ understanding of her seizures lead them to diagnose her with *qaug dab peg*, or “the spirit catches you and you fall down.” For Lia’s parents, their

² These topics will be discussed in Chapter 6.

young daughter's soul kept leaving her body and this made her special, as children who suffered from seizures were chosen to be shamans. As her condition progressed, Lia's parents brought her to Western doctors who saw Lia's epilepsy as a purely neurological disorder and treated it as such. The treatment prescribed for Lia by the doctors was not followed exactly, as the Lees did not entirely understand and did not believe in reliance on medication, noting side effects that led them to think the medications worsened Lia's suffering. As her seizures increased, doctors became concerned and reported the Lees to Child Protective Services (CPS) because they feared for Lia's safety and felt that her parents were not doing their job. This had devastating effects on Lia and her family as she was separated from them.

Georgopoulou (1992) discusses this cross-cultural disconnect: "International data suggests that child maltreatment is the product of a complex interaction of parental characteristics and the social and cultural conditions in which they exist" (p. 81). This confusion between cultural models and understanding of disease was intimately tied to the doctors' and Lia's parents' notion of abuse. Her parents were simply doing what they thought was best for their daughter, yet the doctors saw this as neglect and chose to take action by contacting CPS. As Georgopoulou suggests, "we need not only promote cross-cultural awareness but at the same time, provide competence by incorporating the significance of a cultural dimension into research, theory and practice" (1992, p. 82).

Defining child maltreatment in the United States became a prominent focal point of research in the 1960's and 1970's in order to, "influence case identification and thereby knowledge about child maltreatment" (Korbin, 2004, p. 301). This suggests that

the need to define child abuse led to intervention with and identification of bad parents. The definition of child maltreatment has evolved over the past 40 years and been expanded into four categories: *physical abuse, physical neglect, emotional maltreatment, and child sexual abuse* (2004).

The consequences of child abuse and neglect can be detrimental and have been associated with increased risk of adverse outcomes. These adverse outcomes span across the lifetime: in adolescence, children who have been abused are more likely to have delinquent behavior, and poor social, emotional, and academic development (Tricket & McBride-Chang, 1995; McCord, 1983). The U.S. requires professionals who work with children to be mandatory reporters of suspected child abuse and neglect with the goal of reducing the rates and the risks of adverse outcomes in children (2004). In addition, intervention and prevention programs exist within the U.S. to provide support for children who suffer from abuse and neglect, and for their families. The histories of these programs illustrate the long-standing effort of the United States to protect and support children including through foster care, systems for adoption, family planning initiatives, and programs dedicated to protecting children and their families (Children's Bureau, 2015).

The “Good Parent”

Public social services departments and agencies, such as the U.S. Department of Health and Human Services, were created to protect all people in the United States against injustice and unfair practices. These agencies have evolved and reconfigured how human's roles are defined in society; including parental roles (www.mass.gov, 2015).

Agencies like the Department of Children and Families, which will be discussed later, define a good parent as someone who takes care of their child(ren) by providing them with a home, food, clothing, and ensuring that they have medical care. Parents are given these responsibilities to ensure that their children are safe, healthy, and happy. A “good parent” is able to fulfill these responsibilities and more.

In a scientific analysis of what makes a good parent, Robert Epstein surveyed over 2,000 parents on which parenting skills are most important. Love and affection, and stress management, proved to be significant parental competencies that predict good outcomes for children (Epstein, 2010). However, child maltreatment defies the definition of a good parent in Western culture (Epstein, 2010). When a family unit consists of a single parent, particularly a single mother, the emphasis to be “good,” is placed on her through gender expectations, as her role is also culturally constructed.

The “Good Mother”

The notion of being a good mother can be traced as far back as motherhood itself, one that is defined and shaped by culture and society. In ethnographic literature, Margaret Mead explored gendered norms in the United States and other countries. In *Sex and Temperament in Three Primitive Societies*, one of Mead’s most significant texts, she argues that gender roles are different for each society, hinting towards these roles as culturally constructed (1935). Nancy Scheper-Hughes illustrates this cultural construction of the mother in her work with “motherly love” in the shantytowns of Brazil (1989).

Impoverished, economically exploited, and facing sexism amongst other risks, mothers living in Alto do Cruzeiro give birth to babies that often die within the first year

of life, if not within the first month. The complex ways in which these children die are understood and explained by the women in Alto: natural (caused by diarrhea and communicable diseases) and those resulting from sorcery, the evil eye, or other magical or supernatural afflictions (Scheper-Hughes, 1989, p. 12). A Catholic community, mothers believe that these deaths are part of God's plan. High birth rates in conjunction with high infant death rates show that child death is almost expected, particularly under the conditions in which these women live. Many of their babies are malnourished and if death is seen as inevitable, they will leave the baby alone and let nature take its' course. The mourning process does not occur in Alto as it does in the United States, mothers and the community bury the child and quickly move on, having not shed a tear because that would mean that they did not trust God's will (Scheper-Hughes, 1989).

Although this seems devastating, Scheper-Hughes (1989) asks us then, "What, then, can be said of these women? What emotions, what sentiments motivate them? How are they able to do, what in fact, must be done? What does mother love mean in this inhospitable context?" (p. 13). She answers her question with:

Life in the Alto do Cruzeiro resembles nothing so much as a battlefield or an emergency in an overcrowded inner-city hospital. Consequently, morality is guided by a kind of "lifeboat ethics," the morality of triage. The seemingly studied indifference toward the suffering of some of their infants, conveyed in such sayings as "little critters have no feelings," is understandable in light of these women's obligation to carry on with their reproductive and nurturing lives (Scheper-Hughes, 1989, p. 15).

In doing so, Scheper-Hughes (1989) demonstrates a cross-cultural perspective by asking how motherly love is constructed, if it exists in Alto, and how is it reconstructed because of the conditions these mothers live in. Motherly love, then, is a moral choice and in

example, in order to be a good mother in the United States, pregnant women with substance use issues must seek treatment. This ideal is imposed by the state, as the state intimately shapes the idea of what it means to be a “good mother”. Mothers who struggle with substance use morally choose to love their unborn baby by getting treatment whereas, in Alto, mothers choose not to love their children because of the likelihood of their death.

Being a good mother is one of many gendered roles placed on women, one that Edel & Edel call a moral obligation that includes, “physical and emotional satisfactions for the mother, either innate or capable of being readily cultivated, in caring for her baby” (1968:35). Within the United States, the definition of a good mother is constantly changing. Perhaps one of the most complete efforts to describe the evolution of what it means to a “good mother” was written by Rebecca Jo Plant in her text, *Mom: The Transformation of Modern Motherhood in America (2010)*. Plant begins her timeline with the Victorian era, which placed emphasis on a “moral motherhood”. As she puts it, “Victorians idealized “Mother” because she sacrificed herself for the good of her children” (2010, p. 88). This notion persisted throughout the 19th century but following World War II, the role of motherhood became all encompassing, prescribing much of the responsibility of parenting on to women. Women were at once housewives, cooking and cleaning at home, and mothers taking care of her children. Psychologists and others pathologized the role of motherhood past a certain age of a mother’s children, limiting her role. Plant argues that during these decades, the 1940’s and 1950’s, society “witnessed [the] demise of [Mother love] in mainstream American culture” (2010, p.90).

This change in how motherhood was viewed, Plant claims, was due to psychological and popular literature placing blame on mothers for various role “short comings”. Mothers, as they are now, became responsible for the emotional and mental health of their children. To be a “good mother”, she must teach her children the differences between right and wrong and hope they learn that lesson. These definitions of motherhood came through in literature, in magazines, and through culture. As Edel & Edel point out, society teaches parents how to properly raise a child and therefore, the definition of a good mother is created culturally (1968). Providing lessons on how to be a good mother happens in multiple but often separate spaces including at home from family members and in the medical setting by medical professionals (Field notes, 2015).

For example, in some biomedical systems or social support networks, a prominent feature of a good mother is considered to be her ability to breastfeed in the hospital almost immediately after her baby is born (Flacking et.al, 2007). Flacking et al. explored the role of becoming a mother with mothers whose babies were placed in the Neonatal Unit (NU) for extra care after birth (2007). In existing literature, mothers were separated from their babies and they reported insecure bonds with their newborns. When it came time to breastfeed, they reported not feeling the satisfaction of being able to provide food for their baby. The lesson on how to breastfeed contributed to the definition of a good mother within the space of a hospital but ultimately, by being separated from their babies and not feeling satisfaction from breastfeeding, they felt like they were not fulfilling their role (Flacking et. al, 2009). Mothers just “wanted to do a good job”, and by not being able to consistently breastfeed, they defied one cultural definition of a good mother.

In assessing motherhood in different cultural contexts through ethnography, Barlow and Chapin (2010) explain how anthropology has treated the construction of mothering: “Anthropologists have long recognized mothering as crucial to the transmission of culture, the development of enculturated persons, the constitution of kinship, family, and household, and the reproduction of society” (pg. 324) Although this list is quick to read, it encompasses the many responsibilities bestowed upon mothers in the United States and abroad. Agencies define the good parent but tend to ignore defining the good mother, leaving this open for interpretation and policies to be “reconfigured” to direct efforts towards mothers. (Goldberg, 2015). I am looking at the good mother definition for my own work to better understand how agencies enact power through their definition of this term, examining further these gendered roles/definitions. The “good mother” as it is defined by multiple institutions, will be discussed in further depth in a future chapter.

A recent example of institutions defining what it means to be a “good mother” and enacting power through this notion is the case of Sara Gordon. Sara Gordon was 19 when she became pregnant and as the article describes her, “poor, white, and single” (Miller, 2016). Although Sara describes the father of the baby as a “low-life scumbag,” she lives with her parents and has a strong social support network³. What makes Sara’s case unique is that she has an intellectual disability, or ID, which makes tasks like reading and focusing more challenging. During her hospital stay, after she had given birth, Sara was presented with information she was asked to read on feeding her newborn

³ I will discuss the notion of a social support network on page 28.

and how to breastfeed. A nurse assessed her comprehension and found it to be questionable, and in response reported Sara Gordon to the Massachusetts Department of Children and Families. These instructions dictated what the hospital felt a “good mother” should be able to do. Yet Sara’s inability to fully comprehend them, after having just given birth and being exhausted, made the nurse feel she was incapable of performing the role of “good mother”.

The next day two social workers from the Department of Children and Families arrived in Sara’s hospital room to ask her what her plans were for her newborn baby that she named Dana Gordon. Sara made an attempt to explain her situation: she said that she was capable and her parents would help with Dana and she also tried to show them she could swaddle. In response to Sara fumbling in attempting this task, one of the social workers decided that Dana was not safe in Sara’s custody and removed the child from her care, placing her with a new family. This decision was devastating and confusing to Sara and her parents and they fought, for *three years*, to regain custody. Eventually, through support from women’s advocates and attorneys, Sara and her parents were reunited with Dana. Unfortunately, Sara’s ID and her inability to meet the hospital’s definition of a “good mother” lead to the removal of her baby. Yet Sara is doing just fine now, and when asked what makes a “good mother”, she replied with “Courage. Patience. Not killing your child. Nah — I’m just kidding on that one” (Miller, 2016).

Addiction also defies the definition of a “good mother” in the eyes of DCF when it occurs during pregnancy and/or is experienced by a woman with children, *regardless of if the mother is on maintenance therapy*, which is an approved biomedical treatment for

addiction (Health and Human Services, 2015). The Department of Children and Families lists their definitions of child harm that include: abuse, shaken baby syndrome, neglect, emotional injury, physical injury, and institutional abuse or neglect. The definition of physical injury consists of: “Death; or fracture of a bone, subdural hematoma, burns, impairment of any organ, and any other such nontrivial injury; or soft tissue swelling or skin bruising, depending upon such factors as the child's age, circumstances under which the injury occurred and the number and location of bruises; *or addiction to a drug or drugs at birth*; or failure to thrive” (Department of Children and Families, 110 CMR-20, 2008, emphasis mine).

The history of addiction is important to consider, as it is also treated within the space of the hospital. Although pregnancy is not a disease, pregnancy together with addiction is treated within the same space (Singer, 2014). Addiction is classified as a disease under the DSM, which creates a complex space of treatment for pregnant women with substance use issues. This will be discussed later but the impacts of these co-occurring “conditions” affect the treatment of the patient (Singer, 2014).

Addiction

"H' is for heaven; 'H' is for hell; 'H' is for heroin. In the life of the addict, these three meanings of 'H' seem inextricably intertwined" (Isidor Chein, Donald L. Gerard, Robert S. Lee, Eva Rosenfeld, Daniel M. Wilner, 1964. The road to H: narcotics, delinquency, and social policy).

In juxtaposition to the modern archetype of a disheveled and strung-out addict stands a well-groomed aristocrat sitting on the happiness of opium (Kornetsky, 2014). Wealthy opium addicts in the 19th century gave way to the name "Dope Fiend's Paradise." Men and women of the upper-class used and became addicted to opium as it brought them a feeling they had never felt before. Opium also served as an analgesic and/or tranquilizer because of its calming properties (Kornetsky, 2014). Professionals began to take notice of the addictive properties of opium and attempted to find an alternative for medical procedures. However, many fields did not classify addiction as a disease until the mid-20th century.

In the United States, addictive drugs became a focal point of politics and law enforcement in the 1970's. During his presidency, Richard Nixon signed into law the Comprehensive Drug Abuse Prevention and Control Act of 1970, which sought to define "addict," outline the differences in drugs used for medical purposes from other substances, and make clear which substances were illegal and that importation or the selling of these substances became illegal (fda.gov). Ronald Reagan continued the fight against illegal substances and the people who use them with the "War on Drugs" that targeted substance users, particularly poor addicts (Singer & Page, 2014).

The "War on Drugs" exemplifies Foucault's notion of surveillance through the

Panopticon, an example of a spherical prison where inmates can be monitored from a tower in the center of the circle, constantly under watch (1975). Considered as rubbish, substance users faced surveillance and following the start of the War on Drugs, there were over a million suspected drug offenders arrested annually (Singer & Page, 2014). The public scrutiny of addicts gained traction through the War on Drugs and sentencing time for breaking laws, like possessing illegal substances, increased. As Singer & Page stated,

The demonization of drug users... served not only to enhance state power over the lives of those directly involved with illicit drugs, but, as a result of the social enforcement practices needed to identify, capture, and convict drug-related violators, the communities in which they live as well (2014:21).

Addicts were, and still are, watched from every angle. Law enforcement peers in to the intimate struggles of their daily lives and has the ability to take punitive action. Poor substance users face even more scrutiny over their “bad” decisions (Singer & Page, 2014). The Panopticon is, “at once surveillance and observation, security and knowledge, individualization and totalization, isolation and transparency” (Foucault, 1975). Therefore, the War on Drugs acts as a social Panopticon that surrounds addicts with a visible and unverifiable power.

Law enforcement acts as the central tower that spies upon substance users, surveilling into their often invisible lives (Bourgois & Schonberg, 2009). The Department of Children and Families also acts as surveillance, unverifiable yet ever present, further enforcing law enforcement’s expectations. Substance users act as the inmates caught up in a power situation, constantly observed and forced to hide in plain sight. DCF is

unverifiable because they can become involved at any one moment and have a looming presence over the lives of substance users who have children; potentially surveilling them from any angle in the form of a Panopticon. The origin and effect of surveillance on pregnant women with substance use issues will be discussed in further depth later and demonstrated with original findings from the research I conducted.

The War on Drugs began with the hope that substance use would be pushed aside into prison and the general public would be kept safe from these “bad” individuals (Singer & Page, 2014). However, surveillance contributes to the unintended paradox of support, as an ever-present stressful threat, or reality, in concert with the resources offered by DCF. Substance users face stress not only from surveillance but with the most basic risk factors of addiction including low economic status, housing instability, joblessness, and stigma – each of which may carry their own forms of surveillance, as well (Bourgois & Schonberg, 2009).

Scientific literature speaks about addiction as an adaptation to these stressors (Singer & Page, 2014; Bourgois & Schonberg, 2009). Brown discusses stress as a motivation to adaptive behavior that allows for an individual to adjust to their environment and alleviate the stress they face (1981). Individuals who encounter stressors within their environment can use substances to relieve the stress - being ‘high’ takes the user to another place where no problems can be felt (Brown, 1981). Sinha asserts that stress can act as a motivator to drug use and increases vulnerability to addiction (2008). Long-term stress, or chronic stress, like housing instability, alters neurochemistry and with exposure to illicit substances, rats will self-administer to relieve stress (Sinha, 2008).

Put simply, rats who are exposed to stressors will administer substances like opioids in response to the stress to feel better.

Singer describes drug use as an, “unhealthy selection of a chemical solution to discomforting experiences,” including economic, interpersonal, and health problems (Singer, 2006). Pregnant women with substance use issues typically face multiple stressors that exacerbate their struggle and desire to use throughout their life, including during their pregnancy. It becomes important to here to comprehend how addiction is classified and treated in biomedicine in the United States, as this provides an understanding of treatment options for this population.

Classifying Addiction

The Diagnostic and Statistical Manual of Mental Disorders, or DSM, is a tool used by psychiatric professionals to assess and diagnose mental disorders including addiction. In 2013, addiction went from being separated into two categories: dependence and abuse, into being placed onto a continuum of what is now called, “Substance Use Disorder,” in the fifth edition of the DSM (DSM V, 2013). The definition of Substance Use Disorder changed the way the medical field assessed people with addiction, treating it as a mental health issue rather than a moral failure. As a result of the rethinking of addiction, it is now treated medically with maintenance therapy.

Maintenance therapy is a treatment for addiction that offers an alternative to taking illegal and often dangerous substances. Treatment options primarily consist of two different forms of opioid alternatives: methadone and suboxone, with others currently in various stages of testing and development. Methadone and suboxone are prescribed based

on patient substance use history and tolerance but act in a similar way; staying off physical symptoms of substance withdrawal safely and legally (Walley, 2014). A major difference between maintenance therapy treatments is the way they are administered; patients must come to a clinic to receive their methadone dosage daily, while suboxone gives the patient more freedom as it is in prescription form and patients take it at home until their prescription runs out. Both forms of maintenance therapy can be lifelong treatments (Goldstein & Herrera, 1995).

The road to recovery is a challenging one that is further complicated by internal and external factors (Sinha, 2008). Substance users face environmental stressors and the risk of relapse is high. Substance use is a habit that alters the body and mind of a user and makes users mentally and physically crave drugs (Singer, 2005). These stressors and cravings for drugs make recovery even more challenging (Bourgois & Schonberg, 2009). Maintenance therapy during recovery helps to reduce cravings but does not eliminate an addict's desire to use entirely (Mattick et al., 2009). In addition, substance users in recovery still face surveillance from the Department of Children and Families and law enforcement (Health & Human Services, 2015). Pregnant women with substance use issues face even greater surveillance from the Department of Children and Families and law enforcement and encounter what Chavkin calls a "policy crossroads" (1990).

Policies in place in Massachusetts reach a critical crossroads for pregnant women with substance use issues; first, for their attention to pregnant women pertaining to neglect and second, for their attention to illegal substance use (Chavkin, 1990). The policies clash when illegal substance use endangers the potential life of someone

regarded as having no voice - a fetus (Bell & Harvey-Dodds, 2008). Social science literature is limited in its evaluation of pregnancy and addiction together. Much of the literature surrounding pregnancy together with addiction comes from the medical fields, including perinatology and obstetrics and gynecology, and focuses on appropriate treatment and the role of multidisciplinary provider teams (Goler et al., 2008, Farr et al., 2014). However, the Department of Children and Families views pregnancy and addiction together and attempt to provide support to children and families in need.

Pregnancy in the United States Medical System – The Space of the Hospital

The body of literature surrounding pregnancy often begins with anthropological explorations of culturally shaped beliefs about conception, gestation, experiences of pregnancy, and the process of delivering a baby; which laboring and birthing positions are considered best and by whom, who is allowed to be present, etc. (Jordan, 1993; Sargent & Bascope, 2013). To address the ways in which Western biomedicine treats pregnancy, I refer to critical medical anthropology.

Critical medical anthropology (CMA) has its roots in the concept of political economy and Soheir Morsy's work in the 1970's. Hans Baer and Merrill Singer pioneered several ethnographies on this new approach. CMA gives anthropologists the ability to focus on "structures of power and inequality in healthcare systems" (Singer & Baer, 2012). Singer states that CMA, "pays close attention to the effects of the vertical links connecting the social group under study to larger regional, national, and global social units" (2006: 12). I will use CMA to examine the structures that interact with pregnant women with substance use issues within the clinic and in state bureaucratic

structures, namely DCF, and how these impact the women's experiences of addiction, and of seeking treatment and prenatal care.

In a cross-cultural examination of birth, Jordan (1993) employs a critical approach to examine the power inequalities pregnant women face within the United States' biomedical system. Women's agency over their own bodies during pregnancy is limited in the space of the hospital and the woman's relationship with their care provider is often one that suffers from power inequality (Jordan, 1993). Social pressures such as family members or workers from external agencies also challenge a woman's authoritative knowledge and ability to enact change on her own body (Ellison, 2003). Jordan asserts that, "the high demand for the services of [professional medicine] bears testimony to a widespread discontent with the distribution of power and authority in the conventional patient-doctor relationship, and argues for a more active role in the decision-making process and a greater degree of self-determination for the patient" (Jordan 1993: 140). Biomedicalization is important to consider when discussing a woman's agency because of its' active role in a woman's pregnancy, especially in Western settings (Davis-Floyd, 2014).

Biomedicalization is a useful concept that comes from the work of critical medical anthropologists, especially as it relates to birth (Singer, 2005; Davis-Floyd et al, 1996). The notion of biomedicine contends that, "the human body is, for all intents and purposes, universal and amenable to intervention through standardized approaches to medical management and care" (Lock & Nguyen, 2011). Within the United States, pregnancy and birth is within the biomedical realm; care for most pregnant women

happens within the space of the hospital and the birthing process typically relies on technology and medicine (Davis-Floyd, 1996).

Jordan speaks about childbirth within the United States, emphasizing that it is detrimentally medicalized in Western biomedicine (Jordan, 1993). In talking about the birthing experience, Martin found that women felt fragmented from the process of birth due to the use of technology and monitoring (Martin, 1987). In *Birth in Four Cultures*, Jordan reflects on the birthing process in the Yucatan, observing that there are helpers at every birth, as would have been evolutionarily typical for our species until industrialization (Cheyney, 2011). In contrast in the United States, a woman giving birth in a clinical setting may be limited in the people she can have present in the room, leaving her with a lack of social support during a physically and emotionally demanding process (Jordan, 1993).

Within the space of the hospital, pregnant women are also subject to the clinical gaze. Foucault introduces the concept of the clinical gaze in 1973, defining it as a disembodied gaze upon an objectified body (1973). Power is embodied in the clinical gaze and is inherent in the work of doctors or nurses within the space of the hospital. The recognition of the clinical gaze was part of a movement in science to explore the body as an object, separating mind and body (Bishop, 2011). The doctor-patient relationship is one filled with power dynamics, giving the doctor the utmost power and reducing the power of the patient (Jordan, 1993). With limited power, a pregnant woman is subject to behaving within the culturally defined notion of being a “good mother,” in the space of the hospital.

Khiara Bridges, in her ethnographic work *Reproducing Race*, talks about pregnancy in the space of the hospital, particularly as a site of racialization (2011). Bridges focuses on the role of Medicaid in the lives of pregnant women who need financial assistance at Alpha Hospital in New York City, one of few hospitals in the surrounding area that accepts Medicaid. The pregnant women at Alpha face similar surveillance to pregnant women with substance use issues, yet the surveillance they face – in addition to surveillance from physicians and nurses - is from Medicaid. These pregnant women must adhere to guidelines in order to receive Medicaid throughout their pregnancy, including steps that other women do not have to take in privatized care at another hospital Bridges calls Omega. In addition to the excessive guidelines and surveillance pregnant women face at Alpha, they are produced as “unruly bodies” and if they fail to meet the guidelines, they are denied coverage and cannot receive Medicaid (2011, p. 74).

Khiara Bridges work with pregnant women at Alpha Hospital struggling to meet the demands of Medicaid (2011), in many ways parallels my population; pregnant women with substance use issues who face the surveillance of DCF. I reference her here to set the foundation of her work so I can draw from it in the proceeding chapters. The experience of pregnant women in the space of the hospital in the United States is important to examine, especially as their “unruly bodies” are being produced in my work over 200 miles away.

Pregnancy & Addiction

Pregnancy together with addiction presents healthcare and policy with an immense challenge: to comprehend these conditions and treat them appropriately while keeping both the mother's and unborn child's health in mind. Ethnographic literature addresses the cultural context of pregnancy together with addiction, with a focus on biomedical treatment and clinical interactions. For women at Project Empowerment, they face obstacles to care that are critical to understand when discussing this population and their social support.

Obstacles to Care

Pregnant women with substance use issues are a doubly at-risk group. Pregnant women can face complications during their pregnancy including but not limited to: pre-eclampsia, pre-term birth, or miscarriage (Redman & Sargent, 2005; Meis et.al, 1995). Substance users also face the risks of overdosing, abscesses, and withdrawal (Bourgois & Schonberg, 2009). In addition, greater risks for sexually transmitted infections (STIs) and social factors that include homelessness, poverty, violence, and stigma also make this population at-risk (Powis et al., 2009; Amaro et al., 1990).

Supervision of high risk pregnancy due to social problems in first trimester, Hepatitis C, Anxiety, Tooth pain, Neck abscess, Other genetic screening, Screening examination for pulmonary tuberculosis, Unspecified psychosocial circumstance, Suicidal ideation, Screening for cervical cancer, Opioid use disorder, moderate, in early remission, Fetal hydronephrosis, Injury due to altercation, Pregnancy

Fig. 2.1: De-identified “Problems List” of a patient from Project Empowerment, example of the multi-issue nature of care typically provided.

Scientific literature examines women facing these interactions to better understand their lives and facilitate the creation of programs catered toward this population (Bromberg et al., 2010). Wu et. al (2013) found that methamphetamine-using pregnant women in the United States had significantly higher rates of inadequate prenatal care compared to their non-drug using counterparts. Inadequate prenatal care was also associated with Child Protective Services referral within the United States for pregnant women who used methamphetamine (Wu et. al, 2013). If a pregnant woman is not receiving proper prenatal care, both the developing fetus and the mother’s health can be compromised. The Department of Children and Families is more likely to take action and intervene once the baby is born, viewing the mother’s lack of prenatal care as a failure to

be a good parent (Health & Human Services, 2015).

A similar phenomenon was observed by Bridges at Alpha Hospital, as she explains it: "... the fact of pregnancy alone may not bring a woman within the jurisdiction of the state. Yet, pregnancy combined with the woman's attempted receipt of state aid not only does so, but becomes an opportunity for the state to create a legal subject whose private life is exposed to supervision, surveillance, and regulation" (2011, p. 72). Bridges' population also consists of immigrants and many women of color. As part of her argument that Alpha in conjunction with Medicaid acts as a site of racialization, pregnant women of color are assumed to have little knowledge or previous medical care (2011). This results in nurses and physicians over-explaining and acting out racist behaviors towards patients. In this way, pregnant women with substance use issues are similar: they have little resources (like the women on Medicaid) and are assumed to have had little prenatal care, if any. As a result, they could be subject to DCF intervention, seen as a negative, just as the Alpha population could lose their Medicaid, also a negative.

A substance use issue during pregnancy, like that of using methamphetamine, also creates an obstacle to care that is not always understood by medical professionals. Maguire (2014) argues against what others call a "moral failure" of using substances during the pregnancy, saying that substance use is not a choice but rather a disease. Pregnant women were targeted during the War on Drugs, and shamed for the use; targeted as public symbols of failure because of their substance use (Singer & Page, 2014). However, Maguire advocates for the exchange of explanatory models between

pregnant women and their providers. Explanatory models (EM) convey an individual's understanding and experience of their own illness including etiology, onset of symptoms, and possible or ideal treatment (Kleinman, 1975). EMs serve to allow patients and providers to understand each other's views in order to ideally treat the illness more effectively. Some medical professionals, Maguire asserts, view substance use as a conscious choice rather than a mental health issue (2014). By exchanging explanatory models that make clear the viewpoints of both provider and patient, care has the potential to be improved for this population (Friedl, 1982).

The so-called "moral failure" of substance-using women is also represented in the media. Rather than addressing the health and welfare of the unborn child, the media scolds substance-using women who are pregnant, and shames poor and minority women's behavior and choices during pregnancy (because the media also disproportionately portrays substance-using women as both poor and of color). Springer (2010) analyzed the New York Times to examine race and class privilege of motherhood and found that a disproportionate number of women from lower-income neighborhoods and minority groups were represented in stereotypically negative ways. Women who are pregnant and using substances face discrimination and other obstacles that make it difficult for them to seek appropriate care (Kerker et al., 2004; Stone, 2015). Social support networks help such women in breaking down these obstacles, yet there is a lack of ethnographic studies examining the role of social support in substance-using pregnant women's experiences with combined prenatal care and drug treatment.

My research is one of the first to look at substance-using pregnant women

ethnographically, related to social support. Most extant ethnographic literature on these topics addresses pregnancy and addiction individually, reflecting the complex nature of these interactions. Recently, social scientific literature evaluates the treatment of these co-conditions in terms of epidemiology or public health, arguing that treatment should be provided by multidisciplinary teams that have open communication with one another and their patients (Goler, 2008; Metz, 2012; Winklbaaur, 2008), yet even these studies lack much ethnographic detail. Metz et al. argue that prevention is crucial and that, “careful assessment and screening is necessary to tailor interventions individually to the woman's needs in order to achieve beneficial clinical outcomes for mothers and newborns” (2012). Winklbaaur et al. also make the case for treatment decisions encompassing the full clinical picture (2008).

However, these suggestions are limited in their assessment of social support from friends and family as well as services that cater towards pregnant women and/or addiction treatment. The assessment of support is within the scope of the program clinic and medical issues and does not extend into the everyday life of a woman dealing with both pregnancy and a substance use issue. Social support services play a large role that has previously been neglected in the literature concerning this population.

Social Support Networks, Social Support & Support Networks

A social support network consists of individuals connected to a person who can act as positive support in times of need - especially when an individual's stress level is high. Positive support leads to less stress and has been shown to promote healthcare seeking behavior and to help marginalized populations overcome obstacles to accessing

healthcare (Wethington & Kessler, 1986; Ostrach & Cheyney 2014). In contrast, negative support can cause more stress, and the effect of stress on an individual is heavily documented in many fields including psychology, sociology, and history (Bolger et. Al, 1989; Jackson & Burke, 1965). Negative support is not the same as lack of support; rather, negative support includes members of a woman's social support network that promote and/or participate in risky behavior such as substance use (Edwards, 2001). Negative support in this way can increase stress and affect fetal development during pregnancy and impact the future well-being of the child (Huiznik et al., 2003, Lupien et al., 2009). As a result of negative support, mothers and children suffer from stress when a social support network fails (Kelley, 1998). Pregnant women also report that not having someone in their lives with whom they can talk about dealing with obstacles to health care, or a lack of social support, makes it harder to overcome such obstacles (Ostrach & Cheyney 2014). Women who face a multitude of obstacles to care benefit from a social support network.

In order to create a comprehensive understanding of a social support network, one needs to understand how social support and support networks are defined separately in existing literature. The concepts of social support and support networks are separated based on their definitions within social science literature (Jacobson, 1987). These terms have been used interchangeably but there is a clear distinction between each of them. For the purpose of this research, I will discuss these concepts together as a social support network and then individually as separate concepts.

First, social support can be defined as, "the number of people in one's social

support group” (Reblin & Uchino, 2008) Social support can include friends, family, significant others, and services that provide support including health care (Smith-Oka, 2014). The definition of social support is not limited to the number of connections a person has to others, however; it is much more than that. Uchino et al. take the definition further saying that social support means that, “one is cared for and loved” (1996).

Most importantly for women in his study, Greenfield et al. found that social support is a valuable factor in a woman’s entry to drug treatment (2007). Social support, in the way it is defined here, is valuable and promotes the wellbeing of pregnant women struggling with substance use. However, Jacobson argues that the definition of social support assumes that social relationships are positive yet support networks differ in this way because support is not inherent within the definition of this concept (1987). Social support is inherently positive and promotes healthcare seeking behavior, yet a support network is not inherently positive and can negatively impact a woman’s decisions (Greenfield et. al, 2007).

Wethington and Kessler examined the effects of negative interactions — or lack of support — on individuals facing stressful life events: “we find that negative interactions are as important as, or in some cases more important, than supportive interactions for depressed mood. These results argue that the absence of negative social interactions is as important as social support for emotional functioning” (1986). For pregnant women with substance use issues, negative interactions can include communicating with friends or family that still use, or being faced with repercussions because of their substance use through agencies such as DCF or law enforcement. These

acts of “negative social support” produce stress and can affect a mother’s emotional state.

Second, a “support network” is defined as a, “network of social relationships from which individuals draw support” (Jacobson, 1987). A network does not necessarily provide positive support, however, and can act as a stressor instead, similar to negative social support actors. DCF claims to provide to support to children and families through connecting to resources and protecting and keeping children and their families together. In doing so, DCF can be seen as a social support network.

If DCF is considered a social support network, it becomes pivotal to understand whether the provided support is positive or negative in the eyes of a complex network of individuals including providers, social workers, and pregnant women with substance use issues who encounter DCF. For pregnant women who already face the difficulty of seeking help and remaining in treatment, positive social support will reduce stress and improve overall outcomes, while negative support may produce more barriers and stress.

The History of the Department of Children and Families

In 1912, President Taft created The Children’s Bureau; the first agency of its kind around the globe to center on children and families’ well-being (Carter, 2004). The Children’s Bureau is part of the Administration for Children and Families within the U.S. Department of Health and Human services. The Children’s Bureau is responsible for, “looking at infant mortality, the birth rate, orphanages, juvenile courts, dangerous occupations, accidents and diseases of children, and employment” (Children’s Bureau, 2015). On January 31st 1974, President Nixon signed legislation as part of the Children’s Bureau that would change the way individual states handled cases of abuse or neglect –

this legislation is called the Child Abuse Prevention and Treatment Act, or CAPTA (Children’s Bureau, 2015). CAPTA provides federal assistance to states for prevention, identification, and treatment programs for critical issues that affect children and families. In response to this legislation, the government created the Department of Children and Families (DCF).

Known also as Child Protective Services in other states, DCF is tasked with an enormous job; “to protect children from abuse and neglect and, in partnership with families and communities, ensure children are able to grow and thrive in a safe and nurturing environment” (2015). DCF supports children between the ages of 0–18 and if they have been previously involved with DCF, teenagers 18–21 are also supported (mass.gov). With the vision that, “all children have the right to grow up in a nurturing home, free from abuse and neglect, with access to food, shelter, clothing, healthcare and education”, DCF provides programs and services to children and families across Massachusetts including (mass.gov):

- Adolescent Services
- Adoption/Guardianship
- Domestic Violence
- Foster Care
- Housing Stabilization
- Family Support & Stabilization
- Out of Home Placements

The DCF process of becoming involved with a family or child and providing support is important to lay out in order to understand what mothers in my population can, and often do, face (Kelley, 1998).

The DCF Process

When a potential case is reported to the Department of Children and Families, the initial report is screened. A screening occurs when a social worker speaks with the person who filed the report about the child and can also speak to teachers or doctors that may have more information on the child and their family. If the report is “screened-in”, it will either go through an investigation or assessment response (www.mass.gov, 2015). An investigation response is initiated if the case of neglect is severe and if the case is an emergency. If the case is considered an emergency, DCF has the ability to intervene and potentially remove the child from the family’s custody after a comprehensive assessment. An assessment response is for moderate or low risk allegations and DCF will evaluate the risk of the child and if the child and/or family needs support services (www.mass.gov, 2015).

If a pregnant woman is suspected of having a history of substance use or has used substances during her pregnancy and is reported as having such a history by a doctor or nurse, DCF will not become involved until the baby is born unless she already has children at home. However, once the baby is born, the question then becomes what substance the baby was exposed to in-utero: opiates, cocaine, etc. (www.mass.gov, 2015). A toxicology screen, a test used to determine if an individual has been exposed to a substance, will be done in the clinic on both baby and mother to determine if they have

been exposed (healthline.com, 2015). If the toxicology screen comes back positive, meaning that substances were present, DCF is likely to get involved and/or intervene to protect the future well-being of the child (www.mass.gov, 2015). DCF will also provide support services to the mother and investigate her environment: whether she has support, has other children, if she's in treatment for her substance use issue, and if she is on maintenance therapy and/or goes to group meetings, to ensure the mother has the services she needs (www.mass.gov, 2015).

DCF and Provided Support

Researchers, politicians, social media, and other outlets criticize the support that DCF provides to children and families for being inadequate or inappropriate (Schene, 1998; Camasso, 2013). As stated before, DCF provides support that includes: connection to services, foster care, housing stabilization, etc. (www.mass.gov, 2015). However, their involvement in families can be harmful and is often seen as unnecessary (Schene, 1998). The most common support services employed by DCF workers to assist children and families are: “emergency medical services, domestic violence shelters, substance-abuse evaluation and treatment, emergency housing, mental health evaluation, daytime child care arrangements, diagnostic services for the child, and ongoing counseling by caseworkers” (Schene, 1998). In contradiction to this ideal, federal funding limits DCF's ability to provide these services and assist families, which leaves them even more scrutinized in the public eye.

As Scherz describes it, DCF social workers are caught in a legal and moral bind between erring on the side of child safety or erring on the side of family preservation;

both decisions carry immense weight (2011). For example, when the circumstances that surround a child removal are revealed, the media is quick to ridicule DCF.⁴ Solomon and Asberg found that, “temporarily removing the child from the caregiver [is] associated with increased chances of recidivism” (2012). The literature surrounding DCF focuses on outcomes for children and families and the representation of this department in the media and in politics.

Sandra Morgen, and her work with welfare reform and its’ effects on poor women highlights a similar issue to that of DCF (2003). Welfare in the United States attempts to provide financial support to individuals and families in the same way that DCF provides resources and support to children and their families. Yet Morgen argues: “Welfare reform claims to empower the poor by bringing them into the mainstream of society, i.e., the workforce. But many of those affected by welfare ‘reform’ experience quite the opposite: intensified surveillance, punishment, and ultimately the abrogation of their citizenship rights” (2003, p. 329). Morgen uses poor women, especially of women of color and mothers, to illustrate that welfare form places gendered and racial guidelines on poor women that other women and men do not face (2003).

Morgen (2003) also discusses how, as a result of welfare reform, “race, class, and gender come together in the cultural image of the “bad” mother... whose poverty or noncompliance with welfare policy can be defined by social service personnel as a sign of neglect” (p. 329–330). Women, especially mothers, are expected to be independent *and* working even if they have dependents, including children. Welfare is meant to help

⁴ See: <http://www.cosmopolitan.com/politics/news/a33587/tiffany-langwell-baby/>; etc.

those in financial need yet it asks for poor women to try exceptionally hard to be just a little less poor in order to receive help. Welfare reform acts as a form political oppression by reducing poor women's rights. In a similar effect, the Department of Children and Families pays closer attention to poor women and women with substance use issues. Although DCF provides support, women must adhere to certain guidelines and face intense surveillance.

Pregnant women with substance use issues confront immense stress and obstacles to care. A positive social support network has the ability to reduce stress and provide much needed support to keep mother and baby healthy and to remain in treatment. Although DCF provides support to pregnant women with substance use issues, their decisions are under fire.⁵ An evaluation of the support DCF provides, grounded in the perspectives of those who work most closely with women affected by DCF's policies and practices, thus has the potential to shed light on services that can be reconfigured to improve health outcomes in mothers and babies.

⁵ See: <http://www.thenation.com/article/has-child-protective-services-gone-too-far/>

CHAPTER III: METHODS

Through this qualitative, critical medical anthropology research I explore the role of social support, defined in this research as friends, family, and agencies that provide support, in the lives of patients at Project Empowerment (PE) in order to understand further the impact of social support and its influence on substance-using pregnant women's experiences with recovery and prenatal services. I employed qualitative mixed-methods, using semi-structured interviews and participant-observation with providers in a dual prenatal care/substance use treatment (maintenance therapy) program during clinic hours, including shadowing their interactions with patients enrolled in the program. My research questions explored women's motivations to seek treatment and/or prenatal care (health care seeking behavior), in order to better understand the experiences and needs of this doubly at-risk group.

Through participant-observation and semi-structured interviews, I aimed to: understand why moms chose to join PE, how they found out about the program, and their transportation situation while trying to access treatment and prenatal care. The objective was to explore who was in their social support system, how they supported them, and their involvement in decision-making and pertaining to their healthcare-seeking behavior. In addition, I sought to understand how the "good mother" is defined through varying lenses. I designed the research with the intention of informing existing and new programs to be able to reach out to those who most need the services or who have particular barriers related to differential social support. The study was approved by the Institutional Review Board at Boston University School of Medicine, and formal data

collection took place between June and August of 2015, though participant-observation began earlier that Spring and the IRB approved the inclusion of retroactive fieldnotes as part of the qualitative data.

Original Recruitment Plan and Participant Population

I planned on recruiting between five to fifteen women who were enrolled in the treatment program at Project Empowerment, a maintenance therapy program at the hospital that provides treatment and prenatal care to pregnant women with substance use issues, using purposeful and convenience sampling. I decided on a sample selection of five to fifteen women because they are a population that is constantly in and out of the medical setting and spend very little time there, making it difficult to conduct interviews in this space, likely resulting in a small sample size.

The sample population consisted of women enrolled in PE because of their experience with substance use and being pregnant, as well as their use of treatment and prenatal care. The inclusion criteria for recruitment for women included: pregnant women in combined drug treatment and prenatal care programs at PE, who are between the ages of 19 and 44, and who speak English. All ethnic groups were included in these criteria as well. Exclusion criteria included women under the age of 18, due to increased vulnerability, and over the age of 45, because of changing policies pertaining to pregnant women with substance use issues and/or pregnant women in maintenance therapy. These policies have changed over time and pertain to women and the risk of being arrested due to their medical treatment for substance use issues. Women who did not speak English were also excluded from the sample population due to my lack of skills in other

languages and lack of funding for an interpreter.

In addition, physicians, nurses, social workers, and other health care or social service providers who treat this population (of any age, gender, or ethnic group) were included in the sample population. Healthcare providers presented an alternative and outside perspective on social support systems and their role in the mother's lives.

Revised Recruitment Plan and Participant Population

Despite my earlier research plan having been approved by IRB and in a permission letter from the site, it was later suggested to me by PE providers that my plan to use recruitment flyers would not be appropriate because it would be too difficult. A provider suggested that approaching women during clinic would be easier and more personal, making it more likely that they would say yes to being interviewed. After that suggestion, I had planned on getting moms information if they said they were willing to be interviewed and contacting them about when it was possible to interview them. However, this plan fell through because many moms did not respond to my outreach once they left the clinic.

My plan changed to recruiting women through another research assistant, who would connect me to women she had already spoken with for her own research. This proved to be the most effective form of recruitment. Once I was notified of a new mom being enrolled into PE, I would come into the antenatal unit and knock on the door and see if they were available. If they said yes, I would pull a chair next to their hospital bed and read them the assent form and conduct the interview. However, most women were on titration; a process of determining how much of a substance a woman needs to remain

stable without going into drug withdrawal. These women were exhausted and did not want other visitors in their room aside from the nurses and doctors. Another woman, having already said yes to being interviewed, changed her mind when she heard that I was intending to ask her about past substance use.

Purposive sampling, a technique that selects a population based on their knowledge or experience with the research topic, was what I employed to select provider participants from Project Empowerment. Using convenience sampling I was also able to explore social support through differing perspectives. I was interested in the ways pregnant women with substance use issues navigate and make decisions about their healthcare, with the help of various forms of social support. Although my sample population included a wide range of those with knowledge and experience of my research topic, each participant spoke to larger themes within the research such as social support, healthcare-seeking behavior, and the definition of a good mother.

Field Site

I chose to focus my research on pregnant women with substance use issues and although this population is not limited, I thought I could increase my chances of speaking with mothers if they were receiving care in a familiar and comfortable place. I decided to choose a combined maintenance therapy and prenatal care program at a large northeastern safety net hospital for my field site for this reason. In addition, PE provided a place where this often transient population would be there at set times to receive healthcare, and the providers would have firsthand experience with pregnant women with substance use issues.

I also chose PE as my field site because it is a program run by OB/GYN doctors who were emotionally and professionally invested in pregnant mothers and their unborn children's health and welfare. The program began in an effort to focus attention on this very specific and at-risk group of women who are often faced with discrimination or stigma in a medical setting. PE also employs a social worker and a nurse practitioner-addiction psychiatrist. The team at PE is knowledgeable about this population and aims to treat every patient with respect and patience.

Getting into this particular field site proved to be incredibly difficult first because of the setting in a hospital. Though I had regular access to the hospital facilities where the clinic is located (part of a teaching hospital), my status as a graduate student rather than a standard (bio)medical student made certain roles at PE difficult or impossible, including as a clinical observer. After many months of trial and error requiring diligence, patience, and creativity, I signed up to be a volunteer at PE and went through orientation and other paperwork to get a badge that granted me access through the OB/GYN department and Labor and Delivery within the hospital.

As a volunteer, I went to clinic hours from 8:30 AM to 12:30 PM every Thursday from April to July 2015. During my time in clinic, I would read over the patient list for the day, sit in on the providers' discussions with patients, and talk with other researchers and medical students about their experiences working with the population at PE. During most of my time, I would take notes about what others were saying and what I was observing. I would ask questions about the program and my general curiosities about the population that I had never worked with before until my time at Project Empowerment.

When sitting in on the providers' discussions with patients, I would listen intently and try to make myself as much of a fly on the wall as possible, even though Dr. Bear would introduce me as someone who was shadowing her. The time I spent in the clinic, I was a piece of *a puzzle*, but not the puzzle that the providers and other workers at PE belonged to. I observed patiently and listened closely to take in as much as I could about the inner workings of Project Empowerment.

Original Interview Plan

Mothers

I had several recruitment plans at the start of my research. Initially, I planned to hand out and leave recruitment flyers in the clinic site. Clinic hours at PE only ran three times a week; Monday, Tuesday, and Thursday from 8:30 AM to 1:30 PM and due to my academic commitments by the time I gained access, I was only at the field site on Thursdays. Leaving recruitment flyers with the providers at PE allowed moms to hear about my research and sign up to participate if I was not able to be in the clinic. I also planned to approach women in the clinic and introduce myself and explain my research. If they agreed to talk to me, I would plan a time to conduct the interview with them outside of the clinic hours because moms are seen briefly by multiple healthcare providers and then leave immediately.

One clinic provider suggested that we invite patients to stay after their visit to participate in the interview. I was also put in contact with a research assistant on a project dealing with the moms at PE. The research assistant offered to contact me if there were new admittances to the antenatal unit going through titration who had agreed to become a

part of PE. If a woman was willing to meet me, I would come in and ask if she was interested in being interviewed. If she said yes, I would read her the verbal assent, if she agreed, I would conduct the interview. I used the voice memo app on my iPhone to record each interview. During each interview I would ask about: their experiences with substance use in the past and currently, if they had other children, about who was in their social support network and how they supported them, their transportation, how they heard about PE, and what made them choose to become a part of the program. Unfortunately, many women said yes initially and changed their minds or did not respond when I reached out to follow up and schedule a day for the interview. This led to me only being able to interview one mother who had just entered into treatment at Project Empowerment.

Providers

I approached healthcare providers at PE and asked if they would be willing to be interviewed. Since I had been volunteering there for two months before I began recruiting for interviews, the providers were familiar with my research and were willing to be interviewed and help with my work. I would conduct interviews in the clinic before regular clinic hours because of their busy schedules outside of PE hours. Conducting interviews before clinic hours was also beneficial because during clinic the halls were very busy and loud which would have made the recordings difficult to hear. Although providers were doing work before the clinic, they kindly divided their attention to my interview questions.

Interview Process

Due to the difficulty of getting interviews with mothers, I shifted my focus to interviewing providers and gaining different perspectives, and to reach my sample size goal. The Department of Children and Families (DCF) as a form of social support became my new research focus based on the prevalence of this topic in discussions that I observed at PE. The role of DCF in substance-using pregnant women's treatment experiences appeared to be complex, and one that has not been heavily researched. Providers at PE had insight into DCF because of DCF's frequent involvement with these moms, and they also had strong feelings about DCF. One of the providers had, for example, testified in a court case involving DCF on behalf of a mother from PE, pertaining to her progress in treatment and why she should be able to keep her child.

I planned on using a formal, semi-structured interview guide but my change in focus made this difficult. My initial interview guide was geared toward mothers and as a result, my interviews with providers became mostly informal and open-ended, more of a natural extension of my internship and participant-observation during fieldwork, with most of the data collected based on my field notes and participant-observation. Each participant's scheduled interview was ultimately geared toward their role at PE. I recorded these interviews on my iPhone in voice memos and took notes during the interview to ensure that body language and side conversations were included in my analysis.

The interviews lasted on average 20 minutes and provided different perspectives on social support and the healthcare-seeking behavior of pregnant women with substance

use issues who were on maintenance therapy. Due to the hectic nature of providers' jobs and the form of recruitment for mothers, I was ultimately able to conduct only four formal interviews, though I observed many other interactions during my time in the field. The providers were willing to help with my research as there were many researchers doing work with the population at PE and they were accustomed to researchers. However, provider interviews and participant-observation left gaps in my knowledge about the Department of Children and Families. A colleague connected me with a social worker at DCF who had worked with moms in similar circumstances. The planned interview with the social worker from DCF aimed to fill these gaps and gain another outsider perspective on social support and the definition of a good mother through the lens of DCF. In total, I conducted four interviews with one mother, one doctor and one social worker at PE, and one Department of Children and Families social worker.

Data Analysis

My study design included open-ended questions geared towards the experiences of pregnant women with substance use and their social support systems and for this reason I took a modified grounded theory approach to data analysis. A modified grounded theory approach allowed for me to guide my data collection and analysis. Grounded theory allows for “simultaneous data collection and analysis [that] helps us keep pursuing these emphases as we shape our data collection to inform our emerging analysis” (Charmaz, 2014:34). I transcribed each interview and then hand-coded to create a more accessible and coherent picture of the data.

Process of Analysis

After conducting an initial interview, I began to analyze the data, using field notes to assist in creating codes and making note of recurring themes. I used Harding's *Qualitative Data Analysis from Start to Finish* (2013) to help guide my data analysis through his step-by-step suggestions. Harding discusses the comparative method, which is a form of analysis that compares data from one transcript to another, to identify similarities and differences within a data set. After conducting and transcribing multiple interviews, I used the comparative method to examine the varying perspectives on social support and the definition of the "good mother," among other recurring themes.

From the initial transcriptions, I began to create a codebook that would serve as a reference and guide when coding other transcriptions and attempting to find emerging themes from the data. The codebook was organized thematically and contained defining criteria for each code. Employing both discourse and narrative analysis, I created new codes and redefined ones already in use to create a comprehensive codebook that could be applied to all of my data. In addition, I use the codebook guide to code my field notes, in order to supplement and support my data, and to uncover new themes. My background literature also served as a guide for further analysis, to connect my data with previous theoretical research. Once the codebook was complete, I reviewed the coded transcripts and looked for areas that needed further analysis.

Summary of Results

Prominent themes that emerged from data analysis were the "good mother," the effectiveness of case management by DCF, the responsibilities of DCF, and the role of

social support during pregnancy and treatment, as well as the social support systems' involvement in DCF cases. The good mother pertains to the cultural and social definition of how to be a good mother, and how using substances or being on maintenance therapy defies this definition in the eyes of institutions and within one's social world. DCF's multi-faceted nature encompasses many themes including its role and all former aspects mentioned. The role of DCF is an important theme that greatly impacts the lives of mothers enrolled in Project Empowerment.

The lack of communication between providers at different facilities was also a prominent theme in provider interviews. Patients often have more than one provider for treatment, prenatal care, and other forms of healthcare. By not communicating with other providers, patients can receive multiple prescriptions, which can be dangerous for this particular population. The combination of certain medications can have detrimental effects on patients and can lead to overdosing. Patients' histories can also be limited and by not communicating with past providers, new providers may not know the prescriptions their patients are currently on. Patient engagement with PE is a theme from both the field notes and interviews that can be linked to healthcare-seeking behavior. Patient engagement includes going to appointments, knowing and understanding the prescriptions they are on and the maintenance therapy they are receiving, and being attuned to the baby's needs before and after birth. These prominent themes will be discussed in greater depth, in subsequent chapters.

CHAPTER IV: THE MULTIFACETED CLINICAL GAZE

Introduction

In this chapter, I will argue that mothers encounter what I call a *multifaceted clinical gaze* in the treatment they receive at Project Empowerment (PE). This multifaceted clinical gaze is enforced through surveillance, acted out by providers in and outside of the clinic, law enforcement, and government agencies, specifically the Department of Children and Families. In defying the norm of what it means to be a “good mother” by using substances during their pregnancy, mothers in turn are surrounded by surveillance to ensure that they and their children will be safe. Surveillance entities can also act as support, yet policies in place challenge this role of support, making it difficult for women to fulfill the role of “good mother”.

The Program

The Obstetrics clinic, on the upper floors of the hospital, is surrounded by construction signs and gates. They assert the hospital's impending improvements. People hustle through the maze of hallways foreshadowing the "controlled chaos" of the clinic (Field Notes, 06/16). With my hard-won volunteer badge, I can get into the waiting room and past the moms⁶, walking into Project Empowerment's program office. The astringent smell of disinfectant and subtle aroma of baby powder fills the air. The overhead, fluorescent lighting makes the long, white hallway seem even longer. Doors creak, healthcare workers laugh, and printers print while the moms are counting down the

⁶ The informal voice is intentional here and is discussed further on page 3.

minutes until they can be seen. The OB/GYN doctor, the social worker and nurse practitioner, three medical students, and two researchers grab rolling chairs from patient rooms to sit in the cramped office and go over the patient list for the day. Running every Monday, Tuesday, and Thursday, Project Empowerment⁷, or PE, caters to pregnant women with substance use issues and provides them with prenatal care, behavioral health, maintenance therapy including suboxone and methadone, and connection to other support services.

Project Empowerment includes a team of three main clinicians that provide prenatal care – two obstetrically-trained (Dr. Bear and Dr. Bare), one trained in family medicine and obstetrics (Dr. Cost); a social worker who performs needs assessment and child protective assessments for women who are on methadone or no maintenance (Shea); an addiction psychiatrist/nurse practitioner who works with women who are on subutex (Nurse Deacon); a psychiatrist who provides moms with behavioral health support; and finally a medical assistant and administrative assistant who both work behind the scenes in the clinic. On any given clinic day, each member of the team is present, with the exception that a different main provider runs the clinic every Monday, Tuesday, and Thursday.

Before the program gained its name, moms were treated with just methadone. When one of the main providers of the current program became a resident, she added suboxone as another option for maintenance therapy. With the help of another resident, they created the program as it stands today. Dr. Bare's discussion of the reason for

⁷ Project Empowerment, and all other names, are pseudonyms.

changing the program name speaks to the team's passion for their moms:

We wanted to try to better organize and improve the support services for patients and we wanted to come up with a name. One, hoping that the name would inspire both those people that were providing care for the patients as well as inspire the patients who were seeking care (Interview, 10/12/15).

Programs like Project Empowerment are few and far between which makes the providers' work even more important as they treat women from many surrounding communities.

“Our Moms”

The team, although packed tightly into a room the temperature of a sauna, makes light of a challenging situation. I overhear the social worker talk about a mom, saying she looks exactly like Laverne Cox and laughter ensues, followed by a discussion of how great the Netflix show *“Orange Is the New Black”* is. I don't disagree. On another day, less tightly packed in the office, a medical student returns from a patient interview with an interesting report-back. Apparently a mom is saying that she is having another type of contraction aside from labor contractions and Braxton-Hicks, but the medical providers know there are no other types of contractions. Laughter ensues yet again – a coping mechanism in a field full of tense moments. The team works well together, especially in dealing with a high-risk population. Their commonalities lie in their passion for helping treat and provide support for what they call, “our moms”.

Using the term “mom” instead of mother is prevalent throughout the clinic, as well as the hospital. From my time spent observing, the use of “our moms” conveyed that providers felt a sense of responsibility for the outcomes of the women who come to PE for healthcare. Although the program team mostly provides prenatal care and connection

to other services, PE is one of the few programs in the Northeast that caters to such a population. The use of “our moms” could also express a feeling of pride for the program from the providers, and to creates a sense of familiarity when discussing patients.

“Mom” is said by providers in reference even to women who do not yet have children and are pregnant with their first child. This can create a sense of ownership, for mothers, of their pregnancy and stepping into the role of a mother and all of the responsibilities that come with it. Courtney Everson, in her work with doulas and pregnant teens, discusses the discourse of “mom” as empowering pregnant women (2015). As she highlights, “...doulas assert that recognition as a mom, rather than as a “delinquent teen,” during pregnancy and birth makes a difference for parenting. Sydney said: ‘If they don’t feel empowered as a mom, they inherently enter parenthood from this position of insecurity. I try to help them identify as a mom so they can take ownership of their body, their child, their lives’ (Everson, 2015, p. 103). The providers use the term “our moms” without hesitation, showing their passion and sense of responsibility for their patients. Providers’ responsibility goes further than the care they provide, in their role as advocates.

Providers as Advocates

When recalling a memorable case, Dr. Bear told a detailed story about her involvement in Melissa’s⁸ court case.

One of our patients who was on methadone, who lost custody of her special needs eight-year-old just in the very beginning of this pregnancy, because she relapsed. The child was placed with her aunt and uncle. She came to us, got into care, was doing really well, was doing her recovery, was making her meetings, was coming

⁸ All names are pseudonyms

to her appointments, and she had one other relapse five and a half weeks before she delivered and she was right in this window where we were changing our breastfeeding policy.

That's a whole-nother long ridiculous saga - changing it from preventing women with substance use disorder from breast feeding if they've had a positive urine tox screen in the ten weeks before delivery. We were changing that to four weeks before delivery and she was caught right in the middle. And she was completely devastated by the idea of not being able to breastfeed because she had breastfed her other kids, it was very important to her...

So she delivers on a Wednesday and Friday night I'm coming into work and the pediatrician who runs the service who was part of this whole breastfeeding discussion pages me and says we're doing an emergency removal of her baby because she insists on breastfeeding. [pause] So they remove the baby while both she [the baby] and mom were admitted in the hospital...

Said she could visit and that cascaded down to a court case that you would not – I testified for her twice for three hours each time, wrote an affidavit, tried to discuss with DCF what was going on and she still doesn't have custody...I testified with absolute fervor and conviction for two days for this lady and it did nothing... (Interview, 10/12/15).

Dr. Bear's concerned face and tone while she related this story showed her absolute devastation over her inability to combat the legal system for one of her patients. Her experience with this patient and her vast knowledge as an obstetric provider who caters to this population seems to have carried little weight, yet she persisted to try to keep this baby with her mother. The team of providers are dedicated to ensuring that their moms are doing what is best for their babies and themselves, but also to allow for nuance beyond strict protocols on paper - grounded in their knowledge of "their moms" and their vast experience with the dual fields of substance use and prenatal/perinatal care. This is exemplified in Dr. Bear's case when she reassured the mother about her breastfeeding:

And she said well, is it safe for me to breastfeed if I ya' know used five weeks ago? And I said, ya' know, yeah it's safe. Like that is out of your system. You're back on our program, there's no detriment to you breastfeeding and actually it

will improve the baby's outcomes. It decreases NAS scores⁹, umm it decreases the length of [NICU] stay of babies by like 50%... (Interview, 06/25).

Dr. Bear disagreed with the opinions of other providers and promoted what was, in her professional opinion and experience, a safe, and beneficial practice that was also part of constructing the 'mom' relationship/identity for this patient. Clearly, the relationship between PE providers and the moms is a complicated one.

Provider Responsibility as Mandatory Reporter

The role of a provider as mandatory reporter acts as one of the multiple facets of the clinical gaze. For a brief moment in nearly all of the patient appointments I was able to sit in on, the provider's responsibility as a mandatory reporter invades the space of the patient room. An eager mother awaiting the birth of her baby asks the provider if DCF is going to be involved. "I'm gonna lose my kid," another patient expressed in a panic.

When questioned if patients ask about DCF, Dr. Bare asserts that they ask,

All the time. All the time. They're terrified... That's probably the number one thing people come to us [about], or don't want to come to us - by being in our clinic, it highlights that fact, that they're struggling with addiction and are pregnant" (Interview, 2015).

Mothers fear having their baby taken away by DCF – if they are reported by a provider for any of a variety of reasons, this becomes a real possibility.

In bold lettering on the "Patient Guidelines," the phrase "*we are required to file a*

⁹ NAS, or Neonatal Abstinence Syndrome, occurs when a mother uses a substance or is on maintenance therapy during her pregnancy. When the baby is in-utero they are exposed to that substance but once they are born, they can go into withdrawal because they are no longer being exposed.

51-A¹⁰ when you deliver,” is emblazoned across the page under the “Labor and Delivery” section. While this statement is followed by, “*This does not necessarily mean that a case will be opened with DCF,*” it certainly illustrates the provider's responsibility, and obligation, as a mandatory reporter. A 51-A has potentially severe consequences. Dr.

Bare explains:

Once the baby is born, they're on a controlled substance. So either the methadone or the buprenorphine, so a 51-A gets filed. 51-A is a screening tool to look for safety. Screening doesn't necessarily mean a case is open but if there's something - sometimes DCF will open a case, it doesn't necessarily mean that the patient is doing anything wrong. We try to express that to patients but it's more just a screen to make sure they're doing okay, to make sure that they're safe at home, that they have the resources they need to help with parenting, those kinds of things (Interview, 08/02).

A 51-A form is sent to the Department of Children and Families. Once a 51-A is completed, a DCF social worker examines the case at hand and can take further action, if deemed necessary, towards improving the welfare of the child. When the baby is born, the 51-A is filed by the inpatient social worker. However, healthcare workers in pediatrics, nursing, social work, and any team member of the program are also mandatory reporters. In the case of pregnant women on maintenance therapy, the baby is born exposed to a substance and is in need of attention or investigation. Providers are also mandated to file a 51-A if a mother's urine toxicology screen is positive at the time of birth and/or throughout her pregnancy if she has children at home.

Yet providers are not the only form of surveillance that pervades mothers' lives.

¹⁰ A 51-A is a form that can be filled out by any mandatory reporter, in suspicion of child abuse or neglect, and filed under the section of Public Welfare for the Commonwealth of Massachusetts.

The multifaceted clinical gaze also comes from surveillance entities throughout the hospital and is amplified within the space of the clinic. The clinical gaze provides an opening for the bureaucratic gaze of DCF. In the following sections, I will be making general statements about DCF that are grounded both in a review of policy documents, state websites, and existing literature, to discuss elements of the clinical gaze and surveillance.

The Complicated Relationship

Like the beginning of a confusing game of telephone, moms on occasion show up late or miss their appointments, and providers on occasion do the same. They both balance other things; for moms, it's the struggle of transportation or taking care of other children. For providers, it's getting caught up in an appointment or assisting the medical students and researchers. This complication in the provider-patient relationship can cause tension in the patient room when mothers are angry at having waited or providers become frustrated when patients miss their appointments altogether. However, both patient and provider have a sense of responsibility to one another – but these responsibilities are not limited to just showing up to appointments.

Patient Responsibilities

When a woman joins the program, the providers give her a consent form to ensure that she understands the different available treatments (methadone, subutex, etc.), and that prenatal care appointments are important. Moms also receive a contract of conduct. As one provider said of the contracts:

Basically [saying] that the mom will understand that when they're admitted that,

the very first thing is that we will treat them with respect, number one, and that for their safety and for the safety of kind of everyone that we will ask the public safety officers to come and search their belongings. We have done that because sometimes folks come in with medication they forgot they had in their bags or weapons that they forgot were in there [laughter] ... So the contract says that one, we [also] expect to be treated with calm and respectful language, that their conduct will be reasonable, that they can't leave the floor, and they can't have any visitors just during that titration time (Provider Interview, 06/25).

The hospital public safety officers' routine searches of the mother's belongings as they come into PE also serve as part of the multifaceted clinical gaze. Their surveillance is immediately apparent once a mother enters the clinic and seeks care through Project Empowerment. Other patients that are not a part of PE may be searched if their behavior is seen as suspect, yet they do face such extensive surveillance as the mothers in PE. A mother's ability to remove herself from the surveillance of the public safety officers is near impossible if she wants to receive care. Yet this surveillance is perhaps only a small blip on the radar of the extensive amount of time a mother spends in the clinic. She is also subject to further responsibilities and surveillance through the "Patient Guidelines."

The list of "Patient Guidelines" lays out the mothers' additional responsibilities: being present and observed for urine toxicology screenings, meeting counseling requirements, coming to and being on time for prenatal visits, having two or more specialty ultrasounds¹¹, delivering the baby at the hospital where the program takes place, and calling ahead if they are unable to make an appointment.

In a similar experience, Bridges population of women at Alpha Hospital face similar guidelines because of their use of Medicaid. As Bridges argues, "the course of

¹¹ Specialty Ultrasounds monitor the baby and screens the baby for the risk of Down Syndrome and other genetic disorders, and to check the baby's anatomy and if it is growing properly.

medical treatment required by the New York State Medicaid program produces the pregnant body in a very specific, highly medicalized way” (2011, p. 76). This claim is followed by the list of guidelines pregnant women receiving Medicaid must adhere to, after the initial list Bridges states that “[some guidelines] are not particular to state-subsidized prenatal care; the privately insured undergoing medicalized prenatal care should expect similar treatment. However, the balance of the list differs from the care given to privately insured patients in the following ways...” [to summarize] women on Medicaid are assessed for their ‘psychosocial, nutritional, alcohol and drug treatment needs’, they are referred to WIC, are given more tests especially for sexually transmitted diseases, and are vaccinated for things privately insured pregnant women are not (2011, p. 77–78).

For mothers who are struggling with substance use and multiple other issues, this seems like a daunting list of responsibilities. However, all of this education is ostensibly intended to act as empowerment for these mothers – this includes education about prenatal care, education of maintenance therapy options, and education during appointments for care.

(Project) Empowerment (PE)

The name of the program in its identifiable form is an acronym that represents the goals of Project Empowerment. Overall, the program team hopes to assist and encourage women to make positive changes in their life, for both themselves and their baby’s (Program Website)¹². One letter in the acronym stands out to me, though; the letter “E”,

¹² The source of the program website is excluded for confidentiality.

standing for “empowerment.” In many treatment programs, if a mother's urine screen tests positive, providers take punitive action. This is in stark contrast to Project Empowerment’s program that gives a mother a second chance to stick with her addiction treatment. Iris Marion Young (1993) argues that empowering a patient through providing knowledge and encouraging autonomy, like PE, acts as an alternative to punitive measures (p. 48).

The empowerment approach lets a patient be an expert on her own life and lets their provider be an expert on the illness or disease (Funnell et al., 1991), much like medical anthropology’s privileging of the emic perspective in an explanatory model. However, Young provides two lenses through which empowerment is defined and constructed through service provision, such as treatment. One definition operates within the confessional model of therapeutic talk that, “encourages the client to look into herself and express her inhibitions and resolutions, while others bear witness” (Young, 1993: 49). However, Young (1993) characterizes this approach as too individualistic, relying solely on the mother to use her gained knowledge and apply it to her life and “get on her feet” (p. 49).

Young presents an alternate definition of empowerment, used by social service theorists:

a process in which individual, relatively powerless persons engage in dialogue with each other and thereby come to understand the social sources of their powerlessness and see the possibility of acting collectively to change their social environment (Young, 1993: 49).

However, based on my participant-observation at PE, I accept the value of the first presented definition for this population, as it offers the view,

that a woman's sense of autonomy must be structured not in an effort to separate from others as in many male-oriented concepts of autonomy, but that the autonomous self is established in a context of caring and supportive relationship (Young, 1993).

Project Empowerment thus acts as a caring and supportive relationship that provides knowledge to the patient and lets her be an expert on her own body.

In PE, the mother's expertise is exemplified in the patient room. When asked which maintenance medication they are on, mothers are able to rattle off the name and dosage as well as alternatives to the medication. In response, a provider smiles and says, "You're so *good*" (Field notes, 06/25) – in stark contrast, perhaps, to DCF's rigid expectations of a "good" mother. Patient empowerment in the form of prenatal care and labor knowledge also gives the mother the ability to understand her pregnancy, her baby's growth, and what's to come in the future (e.g., birth) so she can ask questions and feel in control (Fahy, 2002). Empowerment also gives mothers the ability to take control of their body; especially when they are struggling with substance use, these are otherwise issues that they often feel they cannot control.

Using CMA, I argue that this empowerment by providers of patient's authoritative knowledge help mothers navigate their private lives and institutional surveillance.

Providers have extensive knowledge and experience with pregnancy and substance use and assert their power in this way over mothers by giving care. Yet, in acknowledging a mother's experience and knowledge, providers narrow the gap in the power relationship between patient and provider. In this way, providers act as an empowering figure with more power over mothers, yet this power does not act as a detriment to care and pregnant

women are empowered in their knowledge and their role as mothers.

For many of the pregnant individuals who battle addiction in PE, it is not their first time entering a treatment program and being presented with restrictions to their lifestyle. When asked about new patients' experiences with treatment, Dr. Bear discusses her response when a patient comes to the program and has never had treatment:

Yeah, I'm usually shocked when they haven't [had treatment]. We have one patient right now that we are trying to pull back into care who's been using heroin for seven years and has never attempted treatment... This is her first pregnancy and... you would think that sometimes that means the first time they're coming to treatment that their disease has less severity and so it might be easier to treat them but on the flipside, if someone has never experienced the sort of restrictions and expectations of most detox facilities, and treatment care facilities have somewhat of a protocol of expectations so if no one has ever experienced that before that can also be a challenge (Interview, 06/25).

Exemplified by their ability to have a preference over which maintenance therapy they would like, a mother's knowledge and experience with substance use treatment gives her the ability to choose her treatment (Field notes, 06/03). Harris (2015) argues that buprenorphine, in contrast to methadone, "produces self-governing subjects" due to a patient's ability to administer the treatment themselves rather than going to a clinic for treatment. However, allowing a patient to engage in a conversation with their provider about which maintenance treatment they would prefer legitimizes their experiences; a mother's knowledge of her body is used by providers to ensure she receives the most appropriate treatment. This also empowers a mother in her path to getting clean and providing for her baby by letting her be the one to choose, and feel like she has some control, in her treatment.

Empowering mothers gives them a chance to take control over their life with

knowledge and the ability to manage their disease and pregnancy. However, if a mother steps out of the patient guidelines and has a positive urine screen - or when she is not using but is on maintenance therapy and delivers her baby - the provider's responsibility is put into action as a mandatory reporter¹³.

In many ways, the experiences of pregnant women at Project Empowerment parallel those of pregnant women who seek care in Bridges work at Alpha Hospital. For Project Empowerment patients, they are subjected to strict guidelines and must fulfill the role of the “good mother” in order to continue to receive care and avoid the surveillance of the Department of Children and Families. Alpha Hospital patients must also comply to strict guidelines that are dictated by Medicaid in order to receive care with the financial help from insurance. Yet for Alpha patients, they ask for the assistance and help of Medicaid and in fact, often specifically go to this specific hospital because it is one of the few that do accept Medicaid. In contrast, although PE patients actively seek the care from the providers at Project Empowerment, they *do not* want the assistance from DCF.

In addition, a marked difference between these two sets of women is the care they receive from providers. Bridges argues that Alpha Hospital acts as a site of racialization through women’s pregnancies, noting that many of the women who seek care there are of color (2011). For women at Project Empowerment, they are given care by compassionate providers who have experience with and understand the struggles pregnant women with substance use issues face. What makes these separate sets of patients similar is their

¹³ A mandatory reporter is a professional who is required to report any reasonable suspicion of abuse.

active search for care and the surveillance and guidelines that are enacted upon them because of their desire to take care of themselves and their unborn baby.

Using CMA, I argue that women at Project Empowerment and at Alpha Hospital face similar surveillance of their subjugated bodies once they enter the space of the hospital. First and foremost, their pregnancy becomes a lens through which providers explain their bodies. Secondly, women at Alpha Hospital are racialized and women at Project Empowerment (by *some* healthcare workers) are discriminated against because of their substance use. Finally, the involvement of external surveillance by DCF or by Medicaid affects their care by imposing further guidelines to pregnant women in the hospital (2011). The parallels with Bridges' work draws out the space of the hospital as one of micro- and macro- surveillance that subjugates pregnant women's bodies and creates challenges for women seeking care.

Bridges also highlights and makes the argument for surveillance within the hospital, through Medicaid, as a producer of "unruly bodies" (2011, p. 74). She explains this phenomenon as such:

Essentially, the state assumes the poor, pregnant body that presents itself to the obstetrics clinic is one that has not had the benefit of regular (or, even irregular) medical checkups – an assumption especially true for the "undocumented" women who come to Alpha. The battery of tests to which patients must submit themselves might be understood as a corrective to the years of medical inattention that poverty and the absence of health insurance compel. The function of every organ and every system is assessed because class inequality dictates their health would not have been established previously via periodic evaluations – a comfort the insured enjoy (Bridges, 2011, p. 98–99).

I argue that pregnant women with substance use issues who seek treatment at Project Empowerment are also produced as "unruly bodies" using Bridges' work (2011). Yet the

construction is not through their poverty, but through their substance use. Seen as irresponsible, or untrustworthy because of the popular discourse around addiction and provider's experiences, mothers are "unruly" and face surveillance through strict guidelines (Bridges, 2011). Mothers substance use also dictates that their health is not where it should be for the baby or herself. In this way, because of their substance use, women's "unruly bodies" are also produced as "unruly mothers" because they are considered as placing the health of their unborn baby in jeopardy.

Macro- Level Surveillance

In one appointment, a mother faces several people within the clinic including the program team. The patient room becomes a revolving door of probing questions, old and new faces, and a lot of waiting. She receives questions about everything from her not-so-pleasant bodily functions, to the medications she is on, to how swollen her feet are compared to last week. Nothing is off the (exam) table – her body is under the clinical gaze.

This multifaceted clinical gaze comes from many angles. The gaze functions as a complex surveillance network within the space of the clinic, looming over mothers. The epitome of surveillance for mothers in the program happens in the form of a urine toxicology screen. The providers from the program administer screens and they can, and are, also administered by external providers, treatment (Tx) programs, residential programs, law enforcement, and DCF. If the urine toxicology screen is positive for a substance, all of these agencies have the ability to take action and impact mothers' lives.

Tx/Residential Programs

There are several other program options within the city that offer treatment, housing, and group therapy. Homeless shelters provide overnight beds and food through the day but a homeless individual is limited in the number of days they can use the shelter. With the recent closure of shelters just outside the city due to construction, a large number of homeless individuals have had to find new places to eat and sleep (Interview, 06/04). Other homeless shelters within the city have also been shut down due to limited funding. With the exception of passionate, caring shelter employees and volunteers, the homeless are under limited surveillance. Employees do not surveil the homeless once they leave the shelter. The surveillance of homeless pregnant women who may be using substances is left to law enforcement and DCF.

Family shelters offer pregnant women and mothers the ability to stay with their children, something “Trish” was excited about. Trish would have her own room, with her own kitchen – an option homeless shelters do not offer (Interview, 06/04). These shelters also offer substance use treatment, and hope to build children’s and women’s social support networks. However, beds in shelters like these are hard to get. It takes time for women to get placed in a shelter and there is a long waiting list (Field notes, 07/11). The surveillance from these programs comes in the form of urine toxicology screens and general observation of behavior. Ironically, if a woman trying to get sober is perceived as putting others and/or her children in harm’s way, she may be asked to leave the shelter, cutting her off from treatment provided in that setting.

Law Enforcement & Prison

Law enforcement enacts a great deal of surveillance on substance users, as mentioned in chapter two. Police have the ability to arrest women who are actively using and/or are assumed to be abusing their children, removing them from their current lives and potentially placing them into a jail cell. Being pregnant in prison is well-documented in the literature for negatively impacting the health of both mother and unborn baby (Walker et. al, 2014). Pregnant women in prison are more likely to give birth prematurely (Knight & Plugge, 2005). They also face isolation, a lack of personal autonomy, high stress levels, and a persistent worry for their other children outside of prison (Wismont, 2000; Sutherland, 2013). A lack of autonomy is due to the surveillance from correctional officers in prison, officers that women felt “conspired against them,” citing urine tests as a form of invasion of space (Wismont, 2000). Elevated stress levels during pregnancy negatively affect both the mother’s and unborn babies’ health; this is exacerbated if the mother is incarcerated (Fogel, 1995).

One woman I saw during my participant observation became pregnant while she was out on parole. She was then incarcerated for breaking her parole and came to PE for everything the program provides to pregnant women with substance use issues. For each program visit she donned a prison-provided brown jumpsuit and regulation white velcro shoes. The correctional officers escorted her into the patient room and removed the handcuffs connected by chains; each time I saw a tiny picture of the life of an incarcerated pregnant woman seeking outside prenatal care. She rattles off prescription names for maintenance therapy options, asserting that the one she wants is a prescription

that the jail will not provide to her. She calls her baby a “he” and smiles, “Yeah, I’m having a boy,” as we listen to a very active heartbeat during the provider interview. Next in her appointment is a urine screen test and the guards escort her to the bathroom, again asserting law enforcement as a surveillance entity and intensifying the gaze within the clinic (Field notes, 04/19). Unfortunately, when my fieldwork ended, she was close to her due date and still donned the prison-provided jumpsuit. I do not know what the outcomes of her pregnancy and birth were for her or her baby.

The effects of law enforcement surveillance on substance-using mothers is perhaps best reflected in the media, especially lately, and especially in Massachusetts, and in relation to DCF. The prosecution of women who were on maintenance therapy during their pregnancy, unfortunately, is not uncommon (Goldenson & Levy, 2014). The media recently offered examples from across the country where women have been arrested after giving birth; this situation and its effects will be discussed in-depth in a subsequent chapter.

External Providers

Aside from the providers of PE, there are also external providers that operate outside of the clinic, giving care to mothers. If a mother is on other medications aside from maintenance therapy, including those for mental health issues, they will continue to see their primary psychiatrists and these medications will continue to be prescribed by that provider. Mothers are sometimes thought to partake in an activity that providers call “doctor shopping:” seeking a doctor or doctors to prescribe multiple prescriptions to potentially be used inappropriately (Field notes, 06/16). Despite the seemingly innocent

name of this activity, it can have detrimental effects on mothers, including overdosing. As a result of the involvement of external providers, it becomes important that providers, of the PE program or another facility, and mothers, all communicate with each other.

Yet, as Sandra Morgen points out, and as is seen in Bridges work, women who need state assistance are accustomed to state involvement (2003; 2011). Often, poor women are marginalized by the state and placed under surveillance making it difficult to keep up with what the state expects of them in order to receive the assistance they need. In being used to state involvement, women's private lives are no longer private (Bridges, 2011). What they do for work, their entire medical and life histories, how they raise their child(ren), and everything else in between is known by the state and closely monitored all because they lack resources (Morgen, 2003). However, although these women are accustomed to state involvement, it does not make surveillance from entities like DCF any easier or less stressful.

Surveillance in the Clinic

In the clinic, social workers from DCF and hospital social workers, as well as the program and law enforcement officers, all act as surveillance. Their roles as surveillance have been discussed, however according to mothers, the most worrisome surveillance entity in the clinic is DCF. The Department of Children and Families acts outside of the clinic as well, while their place within the clinic is largely invisible yet always felt by mothers.

Communication within the Multifaceted Clinical Gaze

The Department of Children and Families, as a state agency that can provide or withhold services and enforce state laws, acts as surveillance over the mother in a number of ways. DCF becomes involved with a mother and her family if there is a suspicion of abuse, including a mother being on maintenance therapy during her pregnancy. DCF functions as a Panopticon¹⁴, peering into the intimate parts of families' lives, with mothers being "perfectly individualized and constantly visible" (Armstrong, 1983). Mothers are subject to unannounced visits from social workers and can be reported by social workers for further subjection to surveillance for anything from a crying baby at home to a baby's positive urine screen at birth.

Unfortunately, the complex network of surveillance agencies that exist within the clinic do not always communicate with each other. Providers in the program often made remarks about the lack of communication between them and outside providers, or other miscommunications (Field notes, 06/25). Social workers also see only a small glimpse of women's lives. For fear of missing a case, they make quick decisions to become involved in a woman's life to ensure that her children are safe. Removed from one another, it becomes a negotiation between providers, social workers, and mothers to provide and have the best care that is appropriate for mother and child. The lack of communication also leads to missed opportunities for surveillance.

¹⁴ The concept of a Panopticon is mentioned in the Background Chapter.

Missed Opportunities for Surveillance

One of the most powerful moments in the clinic was when Nurse Deacon received a phone call about a previous patient. Her face dropped. She clicked the phone back onto the cradle and let the provider know that her patient had overdosed. She was not notified at the time. No one in the clinic was. Nurse Deacon and the provider were both devastated and a conversation started about patients, where the provider asserted that they “need [a] new policy” about informing each other and other providers about patients’ lives (Field Notes, 06/04). Unfortunately, communication with other care providers, even within the hospital, is a difficult change to initiate and complete. At the time of this writing, Project Empowerment had thus far made no changes in order to facilitate better communication.

Missed opportunities for surveillance impact both children and mothers. In another instance, the program team was discussing a mother, Melissa, who recently delivered, saying they were “shocked she went home with that baby” (Field Notes, 06/11). The mother’s boyfriend, also the father of the baby, is known to be a crack dealer who was using drugs in the postpartum room, and was arrested on site. The mother stays with the father of the baby and sees him in the van he sells drugs out of. The providers all asserted that her life was in no way stable enough for a baby. Surveilling entities within the clinic knew about her situation, but placed the baby into her care, even though this could put the baby in harm’s way. I am not sure what happened to this mother and her baby but cases like this do get missed by surveillance agencies, with potentially grave

consequences¹⁵.

The “Good Mother”

The surveillance entities that invade the space of the clinic convey expectations of how a mother should behave. From others’ work, including Edel & Edel (1968) and Barlow & Chapin (2010), notions of what makes a “good mother” are known to be culturally constructed. As Solinger (2001) discusses it, what makes a good mother is also strongly tied to class and race. In her examination of how mothers felt about trying to raise a child, Solinger mentions how “Americans believed that a welfare mother was an inadequate mother” (2001: 172). In addition, the mothers Solinger spoke with admitted how much *work* it takes to be a mother in poverty (2001: 172). The example of Sara Gordon is also relevant here as she represents a mother, not only with an intellectual disability, but who is also poor. As Sara and her parents discuss, being a mother, especially when facing poverty, is incredibly difficult (Miller, 2016). For Sara, the role of being a mother was especially challenging because of her intellectual disability (Miller, 2016).

The concept of a “good mother” is inherently complex – how do these various clinical entities define “good” behavior, and what are the criteria? In comprehending how an agency defines this concept, one provider cannot speak for the entire clinic and one social worker cannot speak for the Department of Children and Families. However, how a surveillance agency defines a “good mother” fuels the way these entities surveil, treat, and understand women in this population. Department of Children and Families and the

¹⁵ See: <http://projects.statesman.com/news/cps-missed-signs/>

Project Empowerment program providers are the major surveillance entities in these women's lives and provide them with daily support, making their ideas of what it means to be a "good mother" critical.

Defining the "Good Mother"

In contrast to the meager office space used in the clinic, Dr. Bare's own spacious office feels bright as her lengthy pause fills the light air. "I don't think you can define a 'good mother.' I think that brings up a lot of other questions too," she responded as she went on to explain defining anything, such as marriage, is limiting. She asserts that creating definitions place boundaries on the qualities assigned to a person, which is when issues occur (Interview, 10/12). As she explained it, by trying to define a "good mother":

You are putting a round peg in a square hole... we're creating some of the issues that we're trying to address around what is motherhood, what is good parenting, which kids should be left in the custody of their 'parents' and which should be taken away. And I think that because of that, I don't tend to like those definitions. (Interview, 10/12).

Dr. Bare's response highlights how the definition of an individual's role makes performing certain tasks nearly impossible. Especially for this population, each mother's circumstance is different and placing them within the culturally-defined confines of what a "good mother" should be, ignored the other obstacles these women face. Dr. Bare also places the role of parent in figurative quotes challenging the notion of parent in society, usually a biological mother or father. In her experience, a parent is not limited to biology or definition. Rather, like the "good mother," a "parent" is subjective and could be an adoptive parent, a grandparent, a sister or brother, a family friend, or any number of other types of guardian for a child.

However, later in the interview Dr. Bare also says that her population “works so hard to be “good mothers,” insinuating that both she and her patients have assigned qualities and practices to being a “good mother” without explicitly labeling them as such. Her job as a provider assigns her to ensure that mothers are doing what is best, or “good,” for themselves and their unborn baby - enforced by hospital and state regulations. Yet this conflicts with her personal beliefs and experiences that providing limits on what makes a mother good creates more issues than it solves.

Dr. Cost expresses a different perspective and assigns specific responsibilities to a “good mother”:

A good mother is someone who cares for her child and sees and can project the future for this child... I don't think a good mother necessarily needs to provide everything but as long as she knows the resources and can use them and takes from her [own] needs and doesn't always focus on her needs and can provide for the child. Does that mean she can't be her own person? No, but she needs to get above herself... Dressing up your kid is not what makes you a good mother - making sure your kid has diapers, making sure they have a good car seat [is]. (Interview, 10/13).

Dr. Cost's perspective gives a mother the responsibility of learning about, accessing, and using support services, something that is not always feasible for the population she works with. Providing for another human being, especially a newborn, takes time, money, and patience. What happens when mothers do not have time, money, or patience? A possible outcome is the involvement of DCF.

Danielle, the DCF social worker, showed no hesitation when I asked her how DCF defines a “good mother,” saying,

A good mother [is one] who keeps their children up to date medically, their physical health is decent, and is involved with their schooling or developmental

milestones, like babies... doing what they need to do as a parent (Interview, 08/02).

Her definition resembles a checklist, similar to the questions physicians ask during a provider intake, to determine whether mothers are performing their role correctly.

Through the lens of DCF, what makes a “good mother” is defined in largely biomedical terms, by how children are progressing in the clinical setting. The notion of “good care” is reconstructed from that of society’s, in the absence of structural concerns, to assess only a child’s physical health. This definition is also limited in its scope as it ignores the social and economic factors that these women face on a daily basis. For mothers of this population, the spotlight on what makes a “good mother” is on healthcare – and that light shines especially bright on mothers on maintenance therapy. However, similar to Dr. Cost’s perspective, a “good mother” is one who provides for her child – with diapers, a good car seat, and bringing them to doctors’ appointments for check-ups (Interview, 10/13).

The “Good Patient”

The notion of a “good patient” aligns closely with the “good mother” as these definitions are imposed by surveillance agencies. Within the space of the clinic, the women in the program are both patient and mother. Sameena Mulla’s work on the compliant patient (2014) illuminates the view of an imposing surveillance agency that is limiting in its definition and scope of a patient’s experiences.

Mulla’s text *The Violence of Care* (2014) examines the experiences of rape victims within the space of the hospital. She makes the claim that those who are subject

to sexual assault forensic exams (a form of both medical and legal intervention, like some aspects of PE) are both victims and patients. The individual patient-victim must be compliant during their care, resulting in what Mulla calls the “compliant patient” (p. 200). As with the “good mother” in the space of the clinic, the compliant patient must be forthcoming with a provider so proper diagnosis and treatment can occur (p. 214).

At Project Empowerment, the “good mother” expectation operates in several spaces, through how it is defined, including a woman’s home, and upon entering the clinic a patient is treated as not only a mother but also a patient. Within the space of the clinic, mothers from this population are necessarily also seen as addicts, considered socially deviant, which conflicts with their culturally ascribed roles as mothers. Mulla describes this complicated space, requiring intervention, in her own work as “distinct, incongruent, and divergent configurations of space and time [that] mark the nexus of the clinic-courtroom, reshaping the relationship of care to investigation, and healing to justice” (Mulla, 2014: 5).

The ways in which DCF defines the “good mother” constructs the nexus of clinic-home in a similar way. Women are both mother and patient during their time in the clinic, subject to the interventions of the program. A woman’s role as a mother comes into question as DCF examines her ability to fulfill this role due to her addiction, even when she is on maintenance therapy. A woman’s role as a patient comes into question when she is not compliant – when she has a positive urine screen. A woman’s addiction, like a woman who has been sexually assaulted in Mulla’s work, becomes the narrow focus through which providers treat the patient in the clinic. DCF’s surveillance is where the

clinic-home nexus occurs.

DCF examines a woman's life through her addiction and expect her to be a good mother-patient in both spaces. If a mother is not both "good" and "compliant," her ability to perform these roles is questioned. In this way, DCF reshapes the relationship of care in the program to an investigation of a mother's ability to be "good" – with sobriety and stability as prerequisites for a mother's capacity to maintain custody of her children. When a woman does not meet the ideal of a "good mother," surveillance is put into place to reinforce this definition.

Surveillance and Support

When a mother does not meet the ideal standard of motherhood as measured by surveillance entities, her social support network steps in to help – at least that is the hope. Unlike the complex network of surveillance entities, the social support network within the space of the clinic is not a macro- level approach and gives attention to the individual. This network consists of the program team, the Department of Children and Families, and a mother's friends and family. This network provides support in many forms: the program team is a group of passionate healthcare workers who provide prenatal care and connection to other services such as behavioral health. DCF connects women to support services, assesses children's welfare and overall family well-being to prevent and/or put a stop to child abuse and neglect. But friends and family provide a form of support within the clinic different from DCF and providers.

Mothers bring boyfriends, fiancés, husbands, girlfriends, wives, mothers, and friends with them when they come to the clinic. Some stay in the waiting room to provide

the necessary transportation home, others push juice-stained strollers back and forth in the hallway to calm a crying little one. Bottle-full-of-formula toting or not, these people can, and do, act as support for mothers.

One sweaty summer day a mother comes in and waits in the patient room with her fiancé. When Dr. Bear and I come in for the standard patient interview, the mother asks for a pelvic exam to see if she is dilated. Her mother had suggested she do so. Dr. Bear agrees and continues to ask her other questions, noting her intolerably swollen feet. The fiancé laughs and tells us, between her big belly and her swollen feet, he has had to help her put on and take off her flip-flops. He has assisted her in her recovery from substance use throughout the pregnancy. He brings her to prenatal care appointments, he holds her hand wherever they walk, and acts as a concerned father-to-be, ensuring his unborn baby and his fiancée are healthy.

Dr. Bear witnesses support, like the account above, as what she calls a healthy alliance. She explains that “if there’s one person who is really stable and someone who’s not, usually that person – the stable person – can bring the other one up.” Danielle also asserts that support includes “friends that are sober... [ones they] can lean on and be sober with” (08/02). Support in the way Dr. Bear discusses it comes in the form of helping a mother stay sober.

Shea also discusses support in this way saying,

I think the recovery community really can support them. I’m always reassured when I hear that someone’s really active in AA [Alcoholics Anonymous] and has a sponsor and ya’ know, goes to the methadone clinic and can tell me their counselor’s name and, and maybe has a parent that’s in long term recovery or something like that that really shows me that they’re serious and has other - have

other people involved with them that are supporting them through that” (Interview, 07/16).

Regardless of their role in giving care, providers perceive that support for mothers trying to deal with addiction during their pregnancy is the most valuable type of support for their patients. The risks to both mother and unborn baby's health if the mother uses during her pregnancy is a likely reason for this emphasis on support to stay sober, heard from multiple providers. There are also many forms of support available for substance users, including Alcoholics Anonymous & Narcotics Anonymous (AA & NA), many people who go to groups like these, residential treatment programs, and many have friends and family who have gotten clean or who just want what is best for mom and baby.

Friends and Family as Paradoxical Support

Yet friends and family can also hinder a mother's ability to get sober and stay in recovery. Dr. Bear goes on to say that, “if they're both unstable, they're only going in one direction... that's the danger” (Interview, 06/25). When *unhealthy* alliances happen, a mother is at a greater risk for relapsing, putting herself, her pregnancy, and her family in harm's way. For Shea, her experience is with mostly single mothers or mothers whose partners are addicts, providing little positive support to these women (Interview, 07/16). Like in the case of Melissa, whose story I mentioned previously, the partner hindered her ability to remain sober and stable.

Conversely, friends and family can support a mother's health by acting as an intermediary between mother and provider, telling the truth when the mother is keeping

something from the provider or pushing her to tell the truth by herself. Family and friends act much like surveillance in this way, but have less structural power than the ever-looming DCF or law enforcement. Danielle discussed the bluntness of her case experiences with friends and family members:

Fathers will say she's a stupid drug addict or that she's doing everything she needs to be doing. Support system reflects how they're doing. Family will usually reflect that she's in therapy. Families will flat out say that she had a dirty screen in comparison to [what] mom [had said] (Interview, 08/02).

Although friends and family can, and do, support the mother's health, calling her a "stupid drug addict" illustrates a lack of emotional support for the mother. Choosing treatment for addiction then becomes a moral choice in the right direction but continuing to use substances reflects negatively on her ability to make a positive choice for herself and her children. The lack of emotional support from some support network members, like friends and family, highlights their negative feelings about substance use. Intimate support networks can also become frustrated and tired with the ups and downs of addiction and attempts for sobriety, expressed in, "stupid drug addict" or "why don't you answer her question" attitudes. Shea experienced the latter in one of her clinic appointments with a mother:

One of my patients, I remember I was checking in with her and her partner was there. And she was like, yeah it's totally fine that you talk in front of him, he knows what's up.

And I was like how are you doing?

And she was like, I'm doing well.

And I was like, well how are you doing in your recovery?

And she like kind of went on this complete tangent and didn't answer my question (laughter)

And the partner looked at her and was like, 'she asked you a question about your recovery so why don't you give her an answer to that?'

And I was like Yay! It was very helpful (laughing while talking) to have him in the room kind of keeping her honest. So sometimes it can be really helpful. (Interview, 07/16)

Friends and family as a form of support offer an inside perspective that providers and social workers cannot always access. Being a compliant patient can be difficult but supports can help to bridge the gap between other support services. However, DCF and providers also offer a medical perspective to friends and family that mothers cannot always convey.

Danielle explains how friends and family perceive a mother on maintenance therapy:

It happens a lot that family members think that maintenance therapy is a substitute for other drugs. The[ir] goal is always for the mother or client to be off everything. If they need it for life, they need it for life. Stopping them is a serious thing. Sometimes support systems don't get that. (Interview, 08/02)

DCF workers and providers, if trained in addiction, understand how maintenance therapy works and the benefits it provides to mothers trying to stay clean during their pregnancy. However, the mothers on maintenance therapy, along with those actively using, face enormous amounts of stigma¹⁶. It comes from nearly every entity of a mother's social support network and perpetuates an unintended paradox of support.

Conclusion: The Multifaceted Gaze Leads to an Unintended Paradox of Support

The spaces and gazes of the Project Empowerment clinic are perpetuated by macro- level and internal forms of surveillance that pervade the intimate parts of mothers' lives. The multifaceted clinical, legal, and well-meaning social gazes comes

¹⁶ For an expanded discussion of stigma, see chapter six

from providers, law enforcement, treatment and residential programs, friends and family, and DCF. Each surveilling entity defines and constructs what it means to be a good mother, pushing their surveillance further – through support or punitive action, sometimes occurring in parallel fashion. DCF comes with the intention to provide support but through their definition of what it means to be a good mother, they create instead an unintended paradox of support through their role as a surveillance entity.

CHAPTER V: AN UNINTENDED PARADOX OF SUPPORT

In Chapter Four I will analyze how the Department of Children and Families (DCF) represents itself online, and the perceptions of DCF from healthcare workers who work in Project Empowerment. I will argue that many of the claims that DCF makes and the policies they enforce are contradictory. Through how DCF defines a “good mother”, they provide less than appropriate care and in turn produce stress and fear, rather than providing support, for mothers who need it most. In one example, in the quiet and chilly halls of the antenatal floor of the hospital, I was quickly refused an interview by a mother during titration. Her anxiety surrounding DCF filled the room as I told her what I wanted to interview her about. She repeated the word “negative” over and over to refer to her experiences with DCF, even as she politely declined to be formally interviewed. (Fieldnotes, 2015).

Fine Line of Child Removal

If a mother already has children at home and is currently pregnant, as is the case for many Project Empowerment mothers, DCF can become involved at any point. However, for a first-time pregnant mother, DCF may not become involved until the baby is born. Sometimes this involvement happens immediately after birth, when a mandatory reporter contacts DCF and informs them of the mother's self-disclosed past substance use and current maintenance therapy. DCF can do an immediate removal, meaning the baby is removed from the physical care of the mother and placed into another space within the hospital. The mother can still see her baby but she no longer has custody of the baby until

DCF can investigate and determine the safety of the home to which the baby will be brought.

As one can imagine, removing a child upon birth is incredibly stressful for the mother. In this way, DCF amplifies the unintended paradox of support by producing stress while attempting to protect a newborn baby. Dr. Bear expressed her frustration at the apparently unnecessary immediate child removal within the hospital by saying, “What harm is she gonna do where she has nurses coming in and out of the room every ten minutes?” (Interview, 06/25). As discussed in Chapter Two, stress during pregnancy has a negative effect on the health of both unborn baby and mother. Perinatal stress¹⁷, like that which occurs when a baby is removed after birth, also affects both mother and child. Physical touch is an important factor once a baby is born, especially for babies with NAS (Moore, Anderson, & Bergman, 2009). According to one expert I interviewed, as well as existing literature, breastfeeding and physical touch “decreases NAS scores, decreases the length of [NICU] stay...” (Interview, 06/25; McQueen et al., 2011). In this way, by removing the baby immediately postpartum, DCF is potentially creating stress for the mother and affecting immediate postpartum and perinatal health outcomes for the newborn baby.

Removing a newborn baby when a mother has been on maintenance therapy is also not a consistent practice. On occasion, DCF misses a case where a baby’s home is in fact not safe, and the outcomes are tragic¹⁸. On other occasions, DCF reacts quickly and

¹⁷ Perinatal: period of time immediately before and after birth.

¹⁸ Outcomes of DCF involvement will be discussed in chapter six.

does an immediate removal, as in the case of Melissa¹⁹, which they did simply on the grounds of her attempting to breastfeed, even though Dr. Bear, her provider, explicitly suggested and approved this behavior as safe (Interview, 06/25).

The perinatal stress of removing a child from a mother who is struggling with substance use issues also increases the risk of relapse, thus affecting a mom's chances of regaining custody, which is likely to be ultimately beneficial for the infant. As Dr. Bear put it,

The one thing we know that increases postpartum relapse is mom losing custody of her kid. It's guaranteed [relapsing] ya' know, like why [pause]... She did all this work during the pregnancy to try to keep custody of the baby. Why would I- why would she stay clean now? (Interview, 06/25)²⁰.

For Dr. Cost, Dr. Bear, Dr. Bare, and Shea, reporting a mother to DCF is a tough decision. For Danielle, removing a child is “very difficult” especially when she does not agree with the decision. But reporting is mandatory and removing is, to a degree, out of a social worker's or other mandatory reporter's control, under hospital, DCF, and state guidelines. This is the fine line of child removal, one that consists of making a decision based on a multitude of factors but under unvarying and strict protocols. Deciding when to remove the child is a line that social workers toe very carefully.

Necessary and Appropriate

When discussing child removals, DCF is cautious with their word choice. Trying to show the public that child removal is a last resort, they employ words like “necessary”

¹⁹ Mentioned in chapter four.

²⁰ Although there is limited literature to confirm the risk of relapse when a child is removed, sources suggest this occurs within the Project Empowerment population.

and “appropriate” to talk about the decision to remove a child from their home and family (Health and Human Services website, 2015). They emphasize in their vision statement that “safety” and “permanency” are important to a child’s well-being, yet these two conditions may not occur simultaneously. Safety, for DCF, is a child who is safe at home with a mother who is free from using substances. If she is using substances, the home is no longer considered safe and the child can be removed from the “permanency” of their home.

In striking, bold lettering on the website, the information that 85% of children involved with DCF services remain at home promotes DCF’s ideal of “permanency” further. DCF uses the term “necessary” again to talk about placement after removal, saying that “temporary alternative care [is provided] when necessary” (Health and Human Services, 2015). The notion of “temporary” is juxtaposed with “permanency” when a child is no longer in a safe environment and can be removed if “necessary and appropriate.” This juxtaposition presents the reader with opposite ends of the spectrum for the options DCF has for children that are in unsafe environments. By offering both “temporary” and “permanency”, DCF displays their understanding of the situations they find children in and how they intend to keep families together if possible and safe.

By pediatric definition, a child cannot provide informed consent, because they have not yet developed the cognitive capacity to do so. The child therefore can only “assent”, but the final consent must rest in the hands of another party or parties (AMA, 1976). DCF’s focus on making the appropriate and necessary decision for children is important, as children are dependent and legally lack the autonomy to speak for

themselves. In this way, agencies like DCF act as advocates on behalf of children and have the stated intention of, and are entrusted by the state and the public to, ensure their safety.

On the government website where DCF's services are laid out, they assert that removing a child is a "difficult decision," and present the fact that 85% of children under their supervision remain at home as evidence of DCF's careful consideration of reasons for removing children (Health and Human Services, 2015). As Dr. Bare described, DCF's "goal is not to separate families but to try to help provide resources and counseling and education and support to families and to screen for safety" (Interview, 10/12). In this sense, providers are supportive of the goals of DCF. Shea goes further and asserts that, "DCF's decision-making around removing children is very complex and they carry a lot of liability so I understand that they make some more conservative decisions than I probably would" (Interview, 07/16).

DCF is tasked with a tremendous job and their decisions surrounding child removal remain in the public eye²¹. Danielle says that DCF: "must be very cautious, [because they] don't want to make the wrong decision" (Interview, 08/02). Yet their intentions to keep children safe from abuse and neglect is a good one and they try their best to utilize the resources available to do their job. In this sense, DCF is similar to pediatricians who operate as advocates for the child. If pediatricians feel a child is ultimately not safe in their home, they will take actions to protect the child, even if it means challenging the family structure. Children are the major focus of DCF; a mother's

²¹ DCF in the public eye will be discussed in chapter 6.

well-being is not always considered.

Massachusetts Department of Children and Families

Department of Children and Families “serves over 100,000 youth each year while strengthening families” (Health and Human Services website, 2015). With a few swift key strokes and a click on the ‘search’ button, finding information on DCF that the agency wants the public to have, is a simple task. Scrolling down their webpage, a bar graph demonstrates the increase in expenses for Fiscal Year 2015; a picture of a smiling baby mid-wiggle in a crib promotes infant safe sleep; a line graph illustrates an increase in the number children who removed from parents who are placed with other kin. Their website boasts other recent “enhancements” in their system including: “hiring more than 550 new employees in 2014 and distributing nearly 2,400 iPads to help social workers access case information remotely and report information on families more efficiently” (Health and Human Services websites, 2015). All of these public pronouncements seem to advertise an increased awareness of the public scrutiny of DCF in Massachusetts, in the wake of several high-profile cases in which children taken from parents suspected of substance use later died or suffered injury under DCF management. Clearly, the relationship between families, DCF, the state, and various forms of surveillance and care, is known to be contested and publicly monitored.

Technology & the Social Worker-Mother Interaction

In 2015, DCF administrators increased the budget by a substantial \$49,000,000 from 2014 – their use of this money, such as hiring new staff and buying new iPads to make record-keeping electronic, appears to be a point of pride. Their use of the word

“enhancement” speaks to their positive feelings towards improvement, but the increase in technology use has its downsides. Poland et al. (2004) argue that power is exercised through technology. I take this argument further and assert that social workers exercise their power through their use of iPads. The information they type into their devices could bring a family into the realm of DCF surveillance and their child(ren) could be removed. Both the social workers and mothers are consciously aware of this fact.

Drawing from Ihde’s work in *Philosophy of Technology* (1990), Poland et al. (2005) present two types of technology; as either a “transparent mediator” or an “opaque interference... between oneself and the world” (Poland et al., 2005). A transparent mediator is a form of technology, something as simple as a pair of eyeglasses that “enables a smooth engagement of the individual within a world that is made accessible through technology” (Poland et al., 2005). Opaque interference “obfuscate[s] the relationships between the individual, the technology and the world” (Poland et al., 2004). In the context of the clinic or state agency, a social worker’s iPad is an opaque interference, making it unclear to mothers what is happening or being said, and separating the social worker from the mother and family they are working with. By employing iPads in their work, DCF creates a challenging environment that further perpetuates the distrust some mothers have for social workers. For example, one mother I met criticized the introduction of iPads. As she spoke with her hands, true to the New England dialect, she rolled her eyes and complained about a social worker who was more concerned with their iPad than the home visit (Field notes, 2015).

Poland and co-authors’ (2005) initial argument focuses on the way technology

affects an individual's experience. However, they expand on this using a phenomenological approach:

The implications of a phenomenological perspective is to conceive of technology as a medium that remains necessarily at the same time enabling and constraining, reassuring and threatening, empowering and alienating (2004:176).

They present two types of technology within the phenomenological²² approach; “technologies of surveillance” and “technologies of enablement” (Poland et al., 2004). Using iPads in the space of the home act as a technology of surveillance that enables social workers to do their job, but it also has the ability to constrain monitored women by placing their ability to fulfill the role of mother into a confining, state-defined checklist (not unlike the biomedically defined lists discussed in the previous chapter). iPads reassure social workers that they can quickly ‘catch’ everything they need in order to create a full picture of the family, but for women who are being assessed in this rapid way, it may threaten their daily lives as mothers. And finally, iPads empower social workers to complete their assessment in an easy, quick fashion, but alienate mothers by making them feel like their lives are not being accurately represented. In this way, a technology DCF uses to operate reinforces a paradoxical form of support.

Rather than providing support, technology creates a barrier of communication between mothers and the social workers who are there to help. This interruption in communication affects the way cases on mothers are seen and handled because they could be inaccurately reported. Mothers in turn feel that they were not receiving the

²² Phenomenology is the study of phenomena as they appear to the consciousnesses of an individual or a group of people; the study of things as they appear in our lived experiences (Desjarlais, 2011).

appropriate attention from social worker's. This creates a tense relationship between social workers who are supposed to provide support and mothers who may not want the social workers there, but desperately need support.

DCF, a child-centered focus

Danielle admits that it is “absolutely true that looking at the baby doesn’t encompass the whole family” when assessing a case as a DCF social worker (Interview, 08/02). She goes on to say:

That’s definitely a problem. Sometimes we’re not focused on mom, it’s very much about the kid. Do we take the kid into custody to make sure they’re safe, or do we provide support with her and the kid? It’s a full spectrum for sure (Interview, 08/02).

DCF’s focus is almost solely on children because of the issue of autonomy, but ignoring a mother's needs and removing her child(ren) has a powerful and negative effect on a mother’s life. On occasion, the stress of her child being removed can be part of the reason she relapses (Barrow & Lawinski, 2009; Sinha, 2008).

If a mother lacks support at home and in her life, departments like DCF have the opportunity to provide and connect her to services that could relatively improve her life and her ability to care for the child(ren) DCF is concerned about. However, DCF’s main goal is not to support mothers, but rather to keep children safe, even though this can be a false dichotomy. In so doing, DCF sometimes ignores the needs of a struggling mother. Although DCF claims to provide “family support and stabilization,” this is a small fraction of what they aim to do and the lack of attention paid to the family has an impact on mothers and children. This impact highlights the sometimes divergent cultural

emphases placed on motherhood as a gendered social role with specific values and expectations (Dudgeon & Inhorn, 2004).

Defining and Portraying a “Good Mother”

DCF does not explicitly define the “good mother,” but their judgment and provided services speak to how they believe a woman can fail in her role as a mother. As I shared in the previous chapter, Danielle slowly said “hmm...”, pausing before she answered what a “good mother” is through the lens of DCF, but came through with a firm, concise answer:

A good mother is one who keeps their children up to date medically, their [child’s] physical health is decent, [and the child is] involved with their schooling or developmental milestones. They are doing what they need to do as a parent (Interview, 08/02).

Her use of both terms — “mother” and “parent,” in defining the “good mother” implies that a mother takes on the role as parent, or at least that she is obligated to fulfill this role.

Do biological fathers face the same obligation to be a parent? To be a “good father?” Shea feels that the women she works with through Project Empowerment:

[Mothers] have a lot of pressure on them and there’s not a lot of pressure put on dads to make changes. They’re [mothers] typically carrying the major load of the family and if, ya’ know, they’re not fully functioning... I feel like they, it’s just carrying an unfair burden of the family responsibility (Interview, 07/16).

DCF reinforces this gendered expectation of parenting by placing an immense responsibility on mothers who struggle with substance use issues to comply with what they consider a “good mother.” Dudgeon and Inhorn, in their discussion of men’s influences on women’s reproductive health, highlight the differing expectations of men

and women when it comes to fetal health and risk (2004). Referencing Daniels work on a similar topic, they state that, “men and fetal harm in the US is emblematic of broader attitudes toward men’s responsibility for social reproduction. “Crack babies” are the children of “pregnant addicts” and “absent fathers”; these are the terms that frame discussion over fetal harm, such that men are protected from responsibility while women (predominantly African-American women) are criminally prosecuted for fetal abuse and neglect” (Dudgeon & Inhorn, 2004). Dudgeon and Inhorn, pulling from Daniels’ work, highlight the gendered expectations of mothers, demonstrating the negative effects; namely that women face the blame for harm done to the fetus. For DCF, this harm is substance use during pregnancy and fathers face less blame and responsibility.

A mother could be on maintenance therapy trying to stay sober for herself and her family, but for DCF, as long as she is on maintenance therapy she could be jeopardizing her child(ren)’s health. Yet fathers do not face the same expectations if they are involved in the child(ren)s life. In the clinic, fathers are seen as support or lack thereof, rather than responsible for the child. In this way, a mother who is carrying the baby has more social authority over, and thus legal responsibility for, the physical care and health of the baby than the father does²³. Danielle argues that,

If a mother is on maintenance therapy and doing everything she needs to do, then no it’s not a problem [with DCF]. If a mother is doing all of the things that are required of her, then no, DCF looks at it and says she’s a good mom. When she is not doing a therapeutic component, that’s the problem (Interview, 08/02).

²³ Titration is the method or the process of determining the concentration of a dissolved substance in terms of the smallest amount of a reagent of known concentration required to bring about a given effect in reaction with a known volume of the test solution (Merriam Webster, 2016).

Yet this contradicts the reality of DCF practices; DCF investigates mothers even when they are following through with a therapeutic component recommended as *the gold standard to stay sober and be able to care for their child(ren)* (Field notes, 2015). DCF may not screen a mother and her family if they feel she is doing a good job, but the possibility of their surveillance still fills a mother with fear and stress.

Dr. Bear illustrates the contradictory DCF practices surrounding social worker involvement, with what I call a spectrum of recovery:

There's folks that have been in recovery for twelve years who may be on maintenance therapy, methadone or buprenorphine, but who hold a job, have other kids, ya' know, have incredibly stable lives and are probably supporting other people who are struggling. Then there are people at the other end of the spectrum who are really struggling, who have not had any clean time, who really need care and protection for themselves not only for their kids. But DCF, just based on their maintenance therapy, view those two people exactly the same way (tapping on the table) and they say that we have to file a 51A on both of these families... So ya' know, a patient who was on 2mg of buprenorphine - she's a nurse, she's a manager of a dialysis unit, her husband's a pharmacist. She's been in recovery for nine years and they [DCF] opened a case on her, came to her house, went through her daughter's closet, interviewed her nine-year-old daughter by herself about her mom's drug use (Interview, 06/25).

This may be an extreme case. Or it may not be. But mothers who are struggling with substance use issues desperately need support. Dr. Bear's emphatic tapping on the table shows her frustration with the way DCF views all women, regardless of current substance use, in the same way. For Dr. Bear, the stability some mothers have worked hard for qualify them as "good mothers" not in need of intervention. Yet DCF, because of their past substance use, sees every mother on maintenance therapy as potentially needing intervention. Dr. Bear's somewhat disgusted tone in discussing the social worker who went through the daughter's closet illustrates her passion for her patients *and* her

frustration with DCF's excessive surveillance.

By including all mothers on maintenance therapy within the same category of a mother who is actively using illegal substances, or a mother who is "failing" at her job as a parent, DCF produces what I call "an unintended paradox of support." Critically, DCF intends to be a source of support for mothers but produces more barriers such as stress and the fear of losing her child(ren). In so doing, they create the opposite of their stated intent, which is to protect children *and* keep families together.

An Unintended Paradox of Support

Often, at Project Empowerment, mothers will ask if DCF is going to be involved and possibly take away their baby once he or she is born. Danielle asserts that, "If a mother is fearful of losing her child, she won't tell us [DCF] that she's using [substances]" (Interview, 08/02). Many of the mothers in the program, according to Dr. Bare, have also had previous experience with DCF that creates more fear and distrust of this surveilling entity:

I think that unfortunately a lot of them either have personal experience with DCF as they have children that were part of the system or they have personal experience because this is their second or third child and they had DCF involvement with other children. I think unfortunately they hear a lot about DCF from other family members and friends which is unfortunately not very positive and as a result, a lot of their questions stem from around fear and a lot of them want desperately to be good moms and do the right thing and fear that their child, fear that their baby is going to be taken away... And so for them, for some of the patients it instills a lot of fear that they're somehow gonna be targeted, particularly by DCF, and that means that their baby's gonna be taken away (Interview, 10/12).

A mother's past experience with DCF is often indicative of her feelings and mistrust for social workers in the present. Part of the negative experience mothers have with DCF can

be connected to social workers making judgments about a mother's parenting ability, even before meeting her and her family.

A current, former, or recovering substance-using mother's social and institutional support network, which includes PE and/or DCF, creates an unintended paradox of support by producing stressful situations even in relation to entities that are expected to help her succeed. Friends and family stigmatize the use of maintenance therapy for mothers who are pregnant, and providers (as mandatory reporters) invade the space of the patient room. Staff from DCF, who introduce judgement through their definition of a "good mother," produce stress and fear for mothers.

Social Worker Judgment

Involvement from DCF comes with the stated intention to "protect children from abuse and neglect and strengthen families" (Health and Human Services website, 2015). In so doing, however, they gaze into the intimate parts of mothers' lives. Social workers receive information about a mother, her family, and their circumstances before they even meet her, from PE, the hospital, or another surveilling entity. Danielle, a DCF social worker, believes that she tries to be as objective as possible, regardless of a woman's history, when looking at a mother's situation and assessing the safety of the child(ren). Nevertheless, she states that files on mothers "play a role in how we [social workers] make decisions" and admits that sometimes social workers can be more judgmental about how women act as mothers (Interview, 08/02).

Circumstances in which mothers have lost custody of their children prior to DCF intervention or due to substance use in prior pregnancies also affects a mother's case

status and the way they are viewed by DCF, once they are pregnant again. As Danielle elaborated, if a mother has previously lost custody of an older child, social workers are more likely to assume that she cannot fulfill her role as a good mother for a subsequent pregnancy, and surveillance is heightened. A mother's substance use in prior pregnancies exacerbates this assumption, and the judgments social workers place onto mothers. Danielle explained further, saying that, "If a mom had five children exposed to heroin at birth, it changes the view from DCF's perspective and how they [social workers] treat and handle her case" (Interview, 08/02). It is important to discuss here that Danielle views herself as objective, as other social workers also hope to be, yet they may not always achieve this. Bias is difficult to ignore especially when dealing with such a challenging population, as Danielle herself acknowledged during our interview.

When asked if it is difficult to have information on a mother without having met her yet, Danielle said emphatically "Oh absolutely... people on paper are so different than in person" (Interview, 08/02). When working with a family multiple times, Danielle says she looks at them a little differently than a first time case: "I'm more subjective, I know their history, I know what they're capable of. But either way, you have to look at those things to make decisions" (Interview, 08/02). Danielle's objectivity is limited when she deals with a family she is more familiar with, and this certainly influences her choices and the outcomes of her cases.

Danielle's experiences as a social worker cannot be applied to all DCF workers, but her discussion on perspective is intimately tied to judgment from DCF towards mothers. Social workers' personal experiences in and outside of DCF affect how they

perceive, and in turn judge, how well a mother is doing her job. For Danielle, her experience with substance use and working with a family more than once changed her perception of the mothers she worked with – but for many social workers, this is not the case. Shea explains that, “DCF workers are typically master level [sic], bachelor level employees who don’t... have the more specialized clinical background of social workers here in the hospital” (Interview, 07/16). Shea goes on to say that hospital providers or a fellow social worker like herself, “may be working with someone [DCF social worker] who has never dealt directly with mental illness or directly with people who have substance use issues before” and asserts that this can be challenging when trying to advocate and do what’s best for patients. Social workers who have no experience with substance use may not understand that it is a disease rather than a moral failing and may judge mothers for their substance use without meeting them or looking at the whole picture. This judgment is exacerbated in an underfunded agency that does not require training around substance use issues.

Underfunded and Under-trained

There is no doubt that DCF is charged with an impossible task of ensuring the safety of all children between the ages of 0–18 across the entire state. While struggling to protect children, DCF also faces barriers to providing support to children and families. As Dr. Bear states, DCF’s job description is “humanly impossible” (Interview, 06/25). She goes on to say that, “[DCF is] an agency that’s under an incredible amount of pressure with very little resources, less training, and minimal to no understanding of substance use disorder.” These reported feelings towards DCF were also shared by Dr. Bare and Dr.

Cost, the latter calling DCF “vastly underfunded” and stating that DCF does not provide proper training for their social workers (Interview, 10/13). In addition, despite the new state grant mentioned earlier, underfunding is still seen as an issue by providers. This highlights public tensions about what DCF sees as important, namely buying new iPads, rather than allocating the grant money towards required trainings for staff on the issues affecting their clients.

DCF’s lack of funding makes the social worker’s job difficult by giving them little space, few resources, and few employees to carry out the task at hand: ensuring the safety of children. Lack of training for social workers about addiction does not impact DCF directly, but it does impact the way cases are handled when a mother with substance use issues is involved.

Dr. Cost discussed the effects of the state relying on under-trained social workers to screen and make decisions about the safety of children born to substance-using women:

There are people who know nothing about drug addiction, nothing about the medical side of drug addiction, nothing about mental illness, and then they go into these houses and they’re like, well this is not like the house I grew up in and like - shit happens with DCF (Interview, 10/13).

The simplicity of her frustrated answer, that “shit happens,” implies that a string of responses still could not answer what happens when under-trained social workers enter the home of a mother with substance use issues. Her quote also highlights a potential class difference between the social workers and the families they work with. Social workers may have a different upbringing in a home that looked much different from the

ones they see in their work, making it difficult for them to make connections between a space that depicts what they know to be “appropriate” for raising a child and the homes they see.

Dr. Cost went on to say that because DCF is worker-dependent, “it’s what training [social workers] have received, what they’re feeling – like what their own biases are” that determine how they will handle a case. Although Dr. Cost and others did not discuss this in-depth, the fact that under-trained social workers was a reoccurring theme points to a need for required training courses on addiction. Danielle said,

The department is looking into more training, encouraging more training. [They] recently had training on substance exposed newborns but it wasn’t required... Investigators have that training – ten day training. We at least have that for us. A handful of social workers have their master's [but each have] a different set of skills and experiences (Interview, 08/02).

The differing education levels and the fact that social workers are randomly assigned to cases, rather than prioritizing the case workers trained in substances issues to work on cases with substance use involvement, points to the idea that these factors impact the provided support of DCF.

Danielle states that more support is provided for certain cases over others, and she links the amount of support given to the education level of the DCF worker. This further complicates the argument that DCF social workers lack proper training on addiction:

Not everyone’s fully educated about substance abuse and exposure and how that affects mother and kid. They [social workers] only know how to do certain things. It comes down to parents doing what they need to do. We can only do so much. It’s not a judgmental thing. It’s whether they’re safe or not – if they’re still using. It can get heated at times. Saying you shouldn’t have your kid instead of understanding that it’s a disease (Interview, 08/02).

During the interview, Danielle stated that DCF needs to connect mothers to support services more effectively, asserting that DCF can provide support but does not always. However, similar to the excerpt above, she places responsibility on the mother to be “involved in the services” that DCF provides (Interview, 08/02). Danielle’s placement of responsibility, in part, disregards the obstacles to care mothers face such as poverty.

Danielle acknowledges that social workers are limited by their education and knowledge of substance use issues, yet says that parents, specifically mothers, have the power to create change within themselves and their family. In asserting that mothers have this power, DCF is also presupposing a mother’s agency, or her ability to have control over “the social relations in which one [a mother] is enmeshed, which in turn implies the ability to transform those social relations to some degree” (Sewell, 1992).

I call on critical medical anthropology here to discuss the structure of DCF further in relation to how it affects a mother’s experience. In assuming a mother’s ability to “pull herself up by her bootstraps”, DCF ignores the greater structures, including themselves, that creates obstacles for pregnant women with substance use issues. As an institution itself, DCF limits their own social workers by confining them also with this notion of a mother’s agency and ability to operate outside of her social environment. Although mother’s can and do make have agencies in many aspects of their life, DCF not only limits this agency but also imposes this ideal while disregarding their own influence.

Sewell (1992) argues that agents become empowered by structures that provide them with the knowledge of resources. A person’s agency is formed from this knowledge and they have the ability to enact control over her life. Sewell’s argument then, if applied

to mothers, insists that DCF provide the knowledge and resources for mothers, giving them agency and empowering them. Yet when the connection to resources and support ends, it leaves mothers to “step up” or “pull themselves up by their bootstraps,” without help.

Danielle’s comment, that it can “get heated sometimes,” also illustrates the difficult decisions DCF workers face: do they remove the child because of the risk of abuse and neglect or do they understand that addiction is a disease and connect a mother to resources with the hope that she will get sober and keep her child(ren) safe? All three main providers for Project Empowerment (Dr. Bear, Dr. Cost, and Dr. Bare) and the social worker for PE, Shea, concurred with the sentiment that “the idea of DCF is a good one, in principle” (Interview: Dr. Bear, 06/25). Dr. Bare lists the beneficial goals of DCF as providing “resources and counseling and education and support to families and to also screen for safety... but I think it’s complicated” (Interview, 10/12).

Dr. Bare’s list of DCF’s goals implies that they have the potential to help mothers, but her use of the word “but” insinuates that she thinks there is more to their goals and that DCF may not always achieve these goals. These conflicting notions of what DCF sets out to do and what truly happens under their surveillance can be seen in the care that Project Empowerment provides to pregnant women with substance use issues.

The Impact of DCF at Project Empowerment

Project Empowerment patients are under constant surveillance within the program, particularly by DCF, because of their admitted substance use issues. DCF’s job is incredibly complex and their place within the clinic is challenging for both mothers and

providers. Shea described working with social workers who lack knowledge in substance use as “challenging” (Interview, 07/16). As mandatory reporters and advocates for their patients, PE providers also struggle with reporting their patients to DCF and ensuring that DCF takes an appropriate course for a mother in need of support. From the perspective of the PE team, working with DCF is difficult and presents obstacles to providing care.

As Dr. Bear would repeatedly say, decisions like these cannot be erased (Field notes, 2015). She asserts that, “Our moms are always vulnerable of custody issues if one year postpartum they relapse. As they should be. As that can be dangerous...” (Interview, 06/25). Dr. Bear is implying that DCF surveillance is necessary. Shea also discusses the surveillance of DCF over mothers with substance use issues as an impetus for change:

I mean, you have someone who’s evaluating whether or not you can take a child home or whether or not you can keep custody of your children that you already have and they make recommendations that if you don’t follow the [sic], you go to court and see if the judge is gonna remove your kids or not. It lights a fire under people to really make changes (Interview, 07/16).

Dr. Bear, Dr. Cost, and Dr. Bare all presented detailed stories about a case, if not case(s), where DCF’s involvement with a mother went terribly wrong. But it is even in the ways in which DCF carries out their work properly that can have a negative impact on a mother’s life. Dr. Cost gave me an example of a mother whose fear of DCF involvement kept her from staying in treatment:

So we had a mom who established care, I think she was fourteen or fifteen weeks. She came back with a positive urine for opiates.

And so we said okay, you have a positive. We said in the beginning if you have custody of children that we have to report it. And we can’t not report it. And she was like, this isn’t what it’s supposed to be. And we said okay, come back. Come back, do another urine. If it’s negative, then we’ll go from there.

It was positive again so Shea called DCF and she- the patient never came back... But she came back a couple of weeks ago and I think it was only because she was having this bad vaginal infection...

And we diagnosed her again and we reiterated she needed to come to clinic but this was not gonna be a good outcome and that stuff might happen. And she said she's never gonna come back, like I don't want to come back. You guys are gonna call DCF.

And sometimes I think that some of our patients don't always deliver here because they know that we're gonna call (Interview, 10/13).

The mere mention of DCF involvement at PE, even if removal of the child is not imminent, prevented a mother from seeking appropriate care for herself and her growing baby. As support for mothers, this is an unintended consequence of the ostensibly 'supportive' integrated DCF surveillance of children and their families who attend Project Empowerment.

DCF as a Social Support Network

DCF is one of the few surveilling entities that scrutinize every aspect of the mother's lives. A mother's substance use issues, her children and family, her role of motherhood, her pregnancy, and whether she is in treatment or not is all being monitored by DCF. Social workers receive case files that provide them with information about a mother and her family and on behalf of DCF, enter into the intimate space of a mother's home. The clinical and social views of social workers merge when they enter the home. They carry with them ideas about substance use and maintenance therapy, a clinical perspective, and ideas of what makes a good mother and a safe home, a social perspective. In carrying out these roles DCF perpetuates their function as a Panopticon,

surrounding mothers through surveillance within the clinic-home nexus²⁴.

As an institutional support network for mothers, DCF has the potential capacity and power to enact this surveillance *and* provide support simultaneously. Although DCF lacks funding and some of their social workers are not trained in substance use, there are nevertheless positive outcomes that represent their ability to support mothers, when good rapport is established and resources are offered and accepted. Yet conflicting notions of DCF's intentions, through social perception and past experiences, by providers, mothers, and even social workers makes carrying out both aspects challenging. What creates a greater divide between mothers, their social support networks, and DCF is a confusing and convoluted system, or lack thereof, surrounding child removal.

A Negative Perception

The providers of the PE team asserted that much of what society hears about DCF is negative, and this information is not necessarily accurate. Dr Bare stated that, "I think that a lot of times we only hear the most negative parts of DCF" (Interview, 10/12). Dr.

Bear adds to this, saying, "I think that they [DCF] are very easily criticized" (Interview, 06/25). Yet these clinicians seem to support and possibly perpetuate this negative perception by discussing DCF in a similar light. As Dr. Bear discussed:

There's some really bad outcomes... probably worse outcomes that happened because they intervened rather than not. So they put in a new stipulation that any baby that's born with any opioid in its system, DCF is involved. They think of it as a safety net that they're going to screen out those families that don't need DCF involvement. But we really haven't seen that screening out... (Interview, 06/25).

²⁴ The clinic-home nexus is discussed in chapter four.

She argues that DCF may not need to become involved and when they do, the mistakes can be “catastrophic” and the outcomes could be worse.

Dr. Bear appears to also argue against the DCF policies surrounding babies who test positive for opioids when they are born, seeming to place blame on DCF policies for bad outcomes. Yet there are examples of good stories and positive outcomes of mothers who were involved with DCF; these stories are important because they validate some of the great work that DCF does to protect children and help stabilize families.

A Positive Outlook

While admittedly biased, Dr. Cost says that social workers are amazing and that DCF “does a lot of good work and they do a lot of things to keep either families together or getting kids adopted” (Interview, 10/13). Although removing children from their home or babies from their mothers at birth is painted negatively, if they are unsafe at home adoption is seen as a positive outcome. The child will be adopted by a stable family, rather than remain unsafe with their biological one or be bounced from foster home to foster home. Yet, if the home is safe and the mother is following her treatment, keeping the family together is good for both mother and child. For one of Dr. Cost’s patients, DCF is providing her with:

a *huge* amount of support. Provides her with a subsidy... providers her with cribs, with clothing- finds her clothing. They’ve provided her with in-house therapy, provided her with daycare subsidies. Like all this support so she can keep her three children all together... Like that’s a case where I think DCF is working... So when that happens it’s great (Interview, 10/13).

When discussing DCF, Shea argues that:

They can be more positive than what people feel that they are... DCF has the

power to say we're gonna get your kid daycare so that you can go to your intensive outpatient program. Or we can... you're struggling with clothes, let's try to figure out like how we can help you with this, help organize this for you. They do a lot of things in the community that I don't have the capacity to do (Interview, 07/16).

For Shea, DCF's power is important to their ability to provide support and they can do so in a number of ways, similar to Dr. Cost's experiences. Shea also makes the case that DCF surveillance is another level of motivation to get and stay in treatment that other patients, those not monitored by DCF, do not receive (Interview, 07/16).

The notion of DCF as a motivation to stay in treatment contradicts what, on occasion, happens instead; mothers become more stressed and choose to stop treatment in fear of being reported by providers in the clinic (Interview, 10/13). A parallel contradiction can be drawn to drug laws and needle exchange policies that were intended to reduce substance use or increase safe injection practices but produced fear and stress resulting in unsafe drug practices (Singer 2006; Bourgois & Schonberg, 2009). Structures and policies created with good intentions can instead heighten an already struggling population's difficult social environment, producing the opposite effect of beneficial surveillance.

Although the good intentions and hopeful outcomes ostensibly offered by DCF may on the surface be similar, the actions taken create a different effect. Mothers who stop seeking treatment, which often includes prenatal care, in order to avoid the DCF gaze, put themselves and especially their children at risk. With one of DCF's main goals being the protection of children from abuse and neglect, the action of surveillance and possible threat of child removal does just the opposite, undermining the intended support

they claim to offer. In addition, in many ways, support from DCF overlaps with their surveillance and leads into their surveillance. In attempting to provide support, DCF also enacts surveillance for pregnant women with substance use issues and this highlights the “unintended paradox of support” I argue in this chapter. This “unintended paradox of support” is a form of what I argue as negative social support²⁵; rather than reducing stress, it produces and exacerbates it.

The Missing Piece

Unfortunately, I was only able to interview a small number of affected mothers. My experiences and observations are confined to my time spent as a participant-observer and volunteer shadowing in the clinic and stories told to me through few interviews.

Pregnant women struggling with substance use issues need support and their voices would have been incredibly valuable as I discuss the impact DCF has on their lives. Some mothers are so fearful of DCF and their power that seeking health care no longer feels like an option. I’ve had to fill in many gaps with information provided to me by providers and social workers.

There is limited research on pregnant women with substance use issues and the provided support of DCF. Anthropological literature frequently discusses social support networks, including its role in healthcare-seeking behavior, but my research has a much narrower focus on a doubly at-risk population. Throughout my fieldwork, I was told time and again that “someone needs to be talking about this” (Field notes, 2015). My intention

²⁵ Negative social support is discussed in Chapter Two.

is not to speak *for* mothers but to present a well-rounded picture of the perhaps double-edged social and institutional support networks, and forms of surveillance, surrounding these mothers, and to analyze how effective these forms of support are.

Conclusion: In Need of Support

Especially in times of crisis, for mothers struggling with substance use issues, support plays a preventive role in health – including encouraging healthcare-seeking behavior and helping pregnant women overcome obstacles to obtaining needed health coverage, health care, and other services (Ostrach & Cheyney 2014, McElroy & Townsend, 2003). Support can also act as a buffer against stress, like that produced by life circumstances and surveillance agencies (Orth-Gomer, 1994). McElroy & Townsend (2003) argue,

Health care systems play an important role in the woman's wellbeing. Medical and nursing staff can form a support system for the pregnant woman, or they can create barriers to her seeking care" (pg. 230).

I would take this argument one step further and assert that DCF, like medical and nursing staff in public hospitals or Medicaid case workers, form a part of a larger support system for pregnant women with substance use issues, while also unintentionally creating barriers to seeking care. Similarly, Bridges observed how Medicaid can provide financial support for women while also making it near impossible for them to get and keep the financial support (Bridges, 2011). As discussed in Chapter Two, pregnant women in Bridges population at Alpha Hospital face immense paperwork to get Medicaid and then if they fail to meet all of the guidelines while receiving Medicaid, they will be denied coverage. In this way, Medicaid acts as support but also creates barriers to care by

imposing strict guidelines.

When a mother's support from her family and friends is lacking, her reliance is potentially on state agencies. Social workers, through the power and bureaucratic policies of DCF, have the ability to help these mothers (Sun 2000). When agencies like DCF produce stigmatization and stress rather than provide support, this leaves mothers overwhelmed and left on their own to fulfill the "good mother" role with the hope of keeping custody of their child(ren). The judgment mother's face from DCF exacerbates this stress and creates a relationship rife with anxiety and mistrust.

CHAPTER VI: UNVEILING TRAGEDIES ONE MEDIA STORY AT A TIME

Mass media – defined in the conventional sense as the electronic media of radio, television, film, and recorded music, and the print media of newspapers, magazines, and popular literature – are at once artifacts, experiences, practices, and processes. They are economically and politically driven, linked to developments in science and technology, and like most domains of human life, their existence is inextricably bound up with the use of human language. Given these various modalities and spheres of operation, there are numerous angles for approaching mass media anthropologically: as institutions, as workplaces, as communicative practices, as cultural product, as social activities, as aesthetic forms, and as historical developments. (Spitulnik, 1993)

Introduction

The media informs the public of what's happening around the world, of tragic events and feel-good stories. Reporters from news outlets, radio stations, newspapers, and the internet write articles to tell the public exactly what is going on and usually, mere minutes after the instance occurs. They can fabricate, exaggerate, and *tell the whole truth and nothing but the truth*. Yet no matter what, this is where the nation gets their news; the news they talk about over family dinners and weekend board games. Their influence is everywhere, trickling into our peripheral vision, tripping up our stream of intentional thought, and intriguing us to think differently about the world around us (Spitulnik, 1993). Due to this prevalence and omnipresence, I will use examples from the media, in all its forms, as a resource to discuss the complicated portrayal and often tragic stories of mothers, families, doctors, and DCF as many in Massachusetts encounter it.

The media resources I analyzed were accessed through a simple Google search for items that can be found and read by anyone with access to the internet. Using terms like “pregnancy and substance use” or “DCF and pregnancy” to find sources, the articles and

videos come from magazine and newspaper websites, and news channel websites. The sources span from 2013 and on, highlighting the relevance and urgency of this issue. Cheryl Mattingly, in her text *Paradox of Hope* (2010), discusses mass media and how it helps create popular culture, specifically in relation to children. She examines how clinicians and families use Disney stories to create new spaces in which to communicate with children who need care in the hospital. The characters from Disney stories parallel the real-life situations, used by providers to create a sense of hope for children and families. These characters' face challenges and overcome them, and each movie has a happy ending and the happy endings help create resilience in the hospital setting.

By drawing parallels, families are able to try to remain strong and hope for a happy ending, making a difficult time just a little easier. Mattingly explains how the creation and perpetuation of this popular culture assists in the hospital: "Children's popular culture can provide a "key" into the world of a child's imagination, one where the clinician can become an ally rather than an enemy" (2010, p. 179). When children become attached to a character, like a superhero or a prince, they create a new space that a doctor can also play in and connect with the child. Mass media not only shapes the life of children in the hospital, but helps clinicians to improve the experience.

Mattingly's discussion presents Disney's hegemonic messages about positive outcomes and how these inform popular culture; providing parallels and producing hope (2010). The media has similar hegemonic messages that pervade discourse about these topics and the populations that encompass them. These ideas and imagery perpetuate other ideas of what it means to be of color, or from a lower socioeconomic status, or to

embody – or not – your gender, and further inform popular culture. In representing all people of every background, positive or negative, they inform societies ideas about what it means to be those “types” of people.

Yet in the stories to come the media portrays a harsh reality, often perpetuating stereotypes about substance-using mothers and/or negligent DCF workers, providing popular scripts for the general public to openly attack both groups. Mattingly also argues that by creating new spaces to communicate, children and families can resist stigma. Through the representation of women like my participants in the news and popular culture, the media reproduce and reinforce stigma and stress, rather than helping mothers with substance use issues.

Media Matters

Happer and Philo claim that mass media “have effectively been given the privileged status of being authoritative” (2013, p. 322). As this implies, what the media presents to the public is taken as factual, and in some cases as truth (Happer & Philo, 2013). By being authoritative on a multitude of topics, how the media discusses tragedies and policies impacts the public's knowledge and understanding of these stories. In some ways, the media functions as an “ideological state apparatus,” or ISA. Using Althusser's (1971) term, Allison (1991) defines ISAs as:

Institutions which have some overt function other than... political and/or administrative... [e.g.] education, healthcare... ISA exerts power not... through repression but through ideology... Designed and accepted as practices with other purpose(s): to educate (the school system), entertain (film industry), [&] inform (news media), [etc.] (Allison, 1991, p. 196)

As an ideological state apparatus, the media exerts its power through ideology that

consumers seek out and freely consume – educating, entertaining, and informing the public. The media’s accepted authoritative knowledge and ability to perform all three roles attributed to ISAs makes the pervasive nature of their work even more powerful. The public can learn about addiction and how to think about addicts, be entertained by the positive stories and upsetting videos, and be informed about current topics. The way the mass media presents pregnant women with substance use issues and all that comes with this population affects the way the public views these women, reinforcing hegemonic cultural, social, and political messages about my research population in the pretty packaging of entertainment.

Media’s hegemony over cultural notions and ideas are important to discuss and acknowledge when thinking about the discrimination and stigma that pregnant women with substance use issues face every day. In media, one idea, often embellished and negative, dominates and spreads, quite literally, like wildfire. Discussions about addicted mothers extend not only our nation but the rest of the world. I will discuss a report later on in this chapter published by Reuter’s, an international news agency in the United Kingdom. The report focuses on women *in the United States* and places blame, showing not only the U.S., but other countries who have access to the report that systems in place for substance using pregnant women are not helping. Media’s hegemonic power pervades cultural discourse in the United States and elsewhere, making it difficult for mothers to escape discrimination and stigma that the media exacerbates.

Happer and Philo analyze this ideological state apparatus, examining the impact of the presentation of policies relating to disability benefits and fraudulent claims on

public perception, finding that experience with a topic played a role in how individuals interpreted the stories (2013). Direct experience with the issue being discussed was considered a “substantial factor in the negotiation of the media message” (Happer & Philo, 2013). For example, individuals who had experience in dealing with disability benefits, or knew someone who had, often rejected the media’s message of fraudulent claims in regards to those on disability. In contrast, the power of the message was heightened for those with no experience, resulting in competing beliefs about the message they received (Happer & Philo, 2013).

Relating to Mattingly’s work, individuals willingly observe and follow mass media, connecting and interpreting the stories they hear and see. Because people choose to consume and interact with it, media has the illusion of not actively influencing how people think – this is the subtle power of an ISA. Mass media as a space that allows for all to follow along plays a critical role in public perceptions of substance-using pregnant women, and of agencies that surveil them. Within this space, addiction, pregnancy, and parenting are up for discussion. Against Happer & Philo’s claim, and in light of my participant-observation in the settings described in earlier chapters, I argue that individuals with direct experience of pregnancy and parenting will accept, rather than reject, the media’s message of substance use during pregnancy and parenting as not only negative but irredeemable.

The idea of what makes a “good parent” and a “good mother” is culturally constructed – by demonizing, and demoralizing, substance users, the media presents the public with conflicting notions that contribute to that hegemonic cultural construction.

Those who have direct experience with addiction, have been through treatment, or have seen someone do the hard work of getting sober, may reject or at least question the media's complete demonization of mothers with substance use issues. But if the discussion is negative, the message is especially heightened for those who have no experience with addiction. When the media presents mothers whose babies have faced medical problems as a result of their substance use, the public is given the image of a bad mother. With the media's authoritative power, and without the media always describing the social, biological, economic, or political factors in these mothers' and their children's accounts, those with no experience of addiction are left to negotiate what has been given to them.

Bella Bond's Story

On June 25th, the media flooded the public with a story about a young girl's life, taken too soon. Found by a woman walking her dog on Deer Island in the Boston harbor, a black trash bag contained the tiny body of a little girl in the clothes she was wearing before her death; a soft zebra print robe and polka dot pajama pants. The little girl's name, the public eventually learned, was Bella Bond. Her life serves as an example of the complexities of the population I previously discussed, and the involvement and surveillance, of DCF.

Soon after the discover of her body, television stations and newspapers began to burst with headlines about the mystery of an unidentifiable girl who the nation soon knew as Baby Jane Doe. On July 2nd, a sketch artist recreated what they thought she looked like during her life (Figure 6.1). Her imagined soft features, button nose, and wispy

brown hair made Baby Jane Doe and international story that garnered affection, curiosity, and indignation across social media. Police asked the public for information about this little girl so they could put a real name and story to Baby Jane Doe.



Figure 6.1: The above image is of the police sketch of Baby Jane Doe, released to the public (Faragher, 2015).

Throughout the month of July, officials put up billboards and gave the public improved ways to send in tips to investigators. A DNA profile obtained from Baby Jane Doe was run against missing children’s cases but there were no matches. No one had reported that she was gone. A vigil was held on Deer Island for the unidentified toddler. On September 17th, one of the multiple tips panned out for investigators, leading them to Dorchester, a largely working-class part of Boston. On September 18th, “Baby Jane Doe” became Bella Neveah Amoroso Bond, a 2-year-old little girl (Figure 6.2). Her mother, Rachelle Bond, and her mother’s boyfriend (not Bella’s father), Michael McCarthy, were named as the first suspects in what officials now called the murder of Bella Bond

(WCVB, Curran, 09/18) (Figures 6.3 and 6.4). Michael has since been charged with murder and Rachelle has been charged with accessory after the fact, and stealing public assistance (Dumcius, 2015). The trial is ongoing²⁶.



Figure 6.2: Bella Bond at home (Beckham, 2015)

The Media and Bella Bond

It is at once both easy and overwhelming to see the numerous links to online articles about Bella Bond and the story of her life, and of her death. With a simple Google search, the plethora of links that provide pieces of an almost-three-year-old girl's life go on for several pages. Clickbait²⁷ headlines came from every angle, reporting

²⁶ Current defenses from Michael McCarthy's lawyer claim that Michael thought DCF had taken Bella and he was unaware she was missing.

²⁷ (on the Internet) content, especially that of a sensational or provocative nature, whose main purpose is to attract attention and draw visitors to a particular web page. (*Oxford Dictionaries, 2016*).

neglect of Bella by her mother, Rachelle, and her mother’s boyfriend. Reporters used Rachelle and Michael’s previous, and suspected current, substance use and their numerous stints in jail to draw an even grimmer picture of Bella’s brief life. The media made the message simple for the public to consume: ‘Bella had no chance at a good life and Rachelle was unfit as a mother.’ And the media presented what the public was looking for – someone to blame. The lens of deep scrutiny was not aimed at just Rachelle and Michael, but also at the Department of Children and Families.



Figures 6.3–6.4: Michael McCarthy, left, and Rachelle Bond, below left, at an arraignment, images by Pat Greenhouse



The links often display the article's headline, which were provocative such as "Tumultuous Start from the Beginning" (McPhee, 09/27). Many of the articles about Bella's story begin with pictures of her playing with toys or gazing straight into the camera, most likely in an effort to let the readers reflect whether this could have been their neighbor, or daughter, or loved one. Pictures like these are followed by intense examinations of the social and parental failings Rachelle Bond and Michael McCarthy and images of them appearing in court, looking run-down and unkempt; intensifying the negative feelings the public could be expected to have for both of them.

As the investigation into Bella's death continued, the media and officials began to question the involvement of DCF in Bella's life. Mainly, how could they have missed this? As a reporter from the Boston Globe stated, the "lack of scrutiny given to the case was striking" because of the mother's long history of arrest, her 12+ times in prison, her constant struggle with addiction, and her two older children who had been removed by DCF previously (Levenson, 10/28).

The media took their scrutiny even further after Governor Baker asked the State Office of the Child Advocate (OCA) to investigate DCF's involvement in Rachelle Bond's life. The press used this to place DCF under surveillance and inform the public of an agency that failed to protect Bella. DCF had been involved with Rachelle and Bella twice before but saw a happy, well-cared for little girl, yet they discussed that DCF "relied heavily on [Rachelle] Bond's own statements." The OCA also discovered that a social worker had copied information from an old report dating back to 2006 (before Bella's birth) and pasting identical language into assessments done in 2012 and 2013.

The OCA talked with a spokeswoman who they reported as, “welcoming the review,” and she said that, “Ms. Bond was trying to be a good mother... both [family shelter and her probation officer] provided her not only the support and resources she needed to care for Bella, but were able to hold her accountable.” At the end of the OCA report, the office stated that they do not blame the individual social worker. The “lack of sufficient management structure contributed to the poor judgment” and that the “reduction in office staff and overflow of cases” was to blame in the oversight in Bella Bond’s case, rather than placing the blame on the social worker. The media used this report to validate their critiques of DCF and quoted this report exactly, multiple times.

Bella Bond’s case hits home and resonates with surrounding Boston communities. Her story illustrates the way the media portrays the roles of mothers, families, and agencies like DCF. The media coverage of Bella Bond’s short life and sad death resulted in the nation knowing a[nother] story about a troubled mother and a failed agency. Critiques of both addicted mothers and DCF’s lack of oversight is not a new phenomenon, especially within the media. Reports about DCF and Child Protective Services (CPS) missing red-flag cases or mishandling families span the nation. Judgments of substance-using pregnant women permeate social media and public opinion. Stories like those about Bella matter because they surround us and influence us, shaping our view of substance-using mothers and of the agencies that (are supposed to) surveil and support them. The ways in which reporters and journalists discuss difficult topics like these also matter.

Discourse Analysis

Similar to my analysis in previous chapters, I will use discourse analysis to examine how the media talks about DCF and substance-using pregnant women. I employ discourse analysis in this section to evaluate language, picture usage, and placement in story headlines. Story headlines are meant to grab a reader's attention and provoke them to read further on the topic. Pictures act in a similar way, without using words. They speak without being prompted and the reader is allowed the room to reflect on how that image represents what they have read. Readers are also often drawn toward a picture first, pulling them in before even reading the story. In this way, my use of discourse analysis will attempt to capture how the media represents stories like Bella's, why they chose to portray it the way they did, and what impact(s) it has on the public, DCF, and mothers.

From "Crack Babies" to "Oxytots"

It is paramount to understand the convoluted history and the present challenges pregnant women with substance use issues face. As I discussed in Chapter Two, substance use was not always stigmatized, but with the War on Drugs followed by the "Crack Baby Epidemic," women who used substances during their pregnancy were, and still are, under fire. In the 1980's, a study was published about the effects of cocaine use during pregnancy, on unborn babies and on children after they are born (Copeland, 2014). The media took this study and ran with it, using the study to inform the public of the potential dangerous, immediate and long-term effects of substance use during pregnancy (NYT, 1985). This generation of so-called "crack babies" "were predicted to suffer from severe, irreversible damage, including reduced intelligence and social skills" (NIH,

2015). In addition, black and other minority groups were disproportionately portrayed in the media, making the “crack babies” label highly racialized. It later turned out that many of the negative, long-term effects were exaggerated in the media and may be inconclusive – this is still being researched in the medical world (Okie, 2009; NIH, 2015). Yet the fear, stigma, and scrutiny lived on, in real time, as mothers had their children removed or were sent to jail for their substance use during pregnancy.

As Goffman (1963, p. 2) explains stigma:

While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind - in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap.

For mothers represented in the media, the attribute they possess that makes them different is their addiction, and potentially their label as “murderer,” in the case of mothers who accidentally (or not) cause the death of their child. “In the extreme,” mothers are portrayed as “bad” and, what seems to be the media’s intention, a discounted person. The stigmas “discrediting effect” is extensive made possible the far reach of the media. The stigma is also then a failing, a “bad mother.”

Recently, a new term has made itself heard across the nation as mothers continue to face prosecution for their substance use: “Oxytots.” Coined by the notoriously conservative Fox News network, “oxytots” refers to babies who were born “addicted”²⁸ to prescription opioids, such as oxycodone used to manage pain. A video posted to Fox

²⁸ Addicted is in quotes here because of its contested use; Abrahams et al., 2013.

News uses the headline “‘Oxytots’ Victims of Prescription Drug Abuse” and begins with a news anchor prompting a fellow reporter, John Roberts, in Atlanta to discuss the “tragic” events. Their use of the term “victim” is an interesting one that highlights the lack of agency a fetus, or baby, has over their own body. Following the prompt, Roberts begins by comparing “Oxytots” to “Crack Babies” and then shows a video of a baby in withdrawal (NAS) after being born, wiggling in a bed in the Neonatal Intensive Care Unit (NICU). The comparison between the “drug epidemics” that have occurred nearly three decades apart provokes a listener to reflect on addiction. Rather than reporting about progress, the journalist discusses addiction as recurring and seemingly never-ending. The discussion then moves away from babies as ‘victims’ and into prescription medications as the new street drugs, a striking choice as the blame is placed directly onto the substance users, yet without the reporter specifically citing mothers as worthy of criticism.

Substance use during pregnancy has actually shown few long-term effects on the development of children, depending on the substance they were exposed to (Jackson, 1998; Okie, 2009; Behnke & Smith, 2013). Figure 6.5 below by Behnke and Smith (2013) displays the short-term and long-term effects of prenatal drug exposure for different substances. Among “crack babies,” exposed to crack-cocaine prenatally, the long-term effects were reported as minimal. For “oxy tots,” in the midst of the so-called “opioid epidemic,” the longer-term effects are unknown or very minimal. Mothers on maintenance therapy, especially who have been in treatment throughout their entire pregnancy, expose their future children to even less risk.

	Nicotine	Alcohol	Marijuana	Opiates	Cocaine	Methamphetamine
Short-term effects/birth outcome						
Fetal growth	Effect	Strong effect	No effect	Effect	Effect	Effect
Anomalies	No consensus on effect	Strong effect	No effect	No effect	No effect	No effect
Withdrawal	No effect	No effect	No effect	Strong effect	No effect	*
Neurobehavior	Effect	Effect	Effect	Effect	Effect	Effect
Long-term effects						
Growth	No consensus on effect	Strong effect	No effect	No effect	No consensus on effect	*
Behavior	Effect	Strong effect	Effect	Effect	Effect	*
Cognition	Effect	Strong effect	Effect	No consensus on effect	Effect	*
Language	Effect	Effect	No effect	*	Effect	*
Achievement	Effect	Strong effect	Effect	*	No consensus on effect	*

* Limited or no data available.

Figure 6.5: Summary of effects of prenatal drug exposure (Behnke & Smith, 2013)

Yet the media pushes on with blaming mothers, just as DCF continues to surveil them and potentially remove their children even when they are in an active treatment program. As a result, the press exacerbates the stigma of substance use during pregnancy and contributes to racialized and class-based stereotypes of what these mothers look like: poor, and often of color (Miller, 2015). Policies surrounding the mothers whose babies are born with NAS perpetuate these stereotypes by criminalizing substance use during pregnancy. Arrests by law enforcement²⁹ and removal of children by agencies like DCF permeate the public imagination, reinforced through media discourse. The representation of surveillance in the media intensifies the awareness of these entities and compounds the stress related to both for mothers and families (Abrahams et al., 2013). In their representation of surveillance entities, the media also places blame on law enforcement, DCF, and others in a mother's social support network, giving the public conflicting messages.

²⁹ See: <http://www.thenation.com/article/state-where-giving-birth-can-be-criminal/>

Placing Blame

Law enforcement and DCF are intimately tied to this population, especially within the space of the hospital before and after a substance-using pregnant woman gives birth. While state laws differ pertaining to pregnant women who struggle with addiction, the relationship between law enforcement and DCF is complex. Goldensohn and Levy (2014), journalists for *The Nation*, imply that state laws are also inconsistent. When discussing mandatory reporters and the arrests of women in Tennessee, Goldensohn & Levy (2014) explain the discrepancies in their practices:

According to numerous interviews with hospital staff and patients, some hospitals drug-test mothers before birth and others do not. Some test all mothers; others test based on appearance and behavior. Some hospitals in poor neighborhoods test everyone; in rich neighborhoods, not so much, doctors in Nashville said. Sometimes, the DCS and the sheriff will decide to arrest. Other times, the DCS alone will pursue the case (p. 4).

Tennessee is one of three states in the nation that directly makes it a crime to use drugs while pregnant (Miranda, Dixon, & Reyes, 2015). Furthermore, in Tennessee, similar to Massachusetts, women have the ability to use their time in drug treatment as a defense in court, as well as attempting to reduce the involvement of DCF. However, poor women who struggle with addiction cannot easily access treatment³⁰ (Goldensohn & Levy, 2014).

The media has taken what seems like a black & white approach to discussing law enforcement and DCF; exaggerated and stigmatizing or sympathetic and understanding. Ada Calhoun (2014) for NBC News presented a soft, bright story – a young mother

³⁰ For a more in-depth discussion of socioeconomic status and racial/ethnic background related to law enforcement involvement and treatment for mothers with substance use issues, see: Solinger, R. (2001). *Beggars and choosers: How the politics of choice shapes adoption, abortion, and welfare in the United States*. Macmillan.

named Jenessa Moman. Although parts of the story are grim, namely the death of her younger sister and her baby being diagnosed with NAS, Calhoun paints a picture of a mother who felt sorry for contributing to her baby's NAS. As Calhoun presents, "No one wants to hear they've done something to cause their baby suffering," she [Jenessa] says, crying."

Calhoun then discusses Jenessa's experiences with Child Protective Services, as the hospital had to report her because of her baby's NAS diagnosis:

"I understood that they might want to come out and see," Moman says. "But the next day, we got a phone call saying they were taking me to court for abuse."

For five months, Moman says, she received regular, unannounced visits from the department. "It put a lot of stress on our family," she says. "My nine-year-old said, 'Why are these people here? Are they going to take me away?' I'm a good mom. I just had that problem. But during my pregnancy, I was good. I turned my life completely around. Sometimes addicts have to have a reason to get help. What better reason is there than that? Your own children." (Calhoun, 2014)

Child Protective Services (CPS) were quick to act in Jenessa's case, entering into her private life unexpectedly because of Jenessa's past history with substance use. In presenting her story, Calhoun shows a confused mother who is trying her best and CPS as an intrusive, stress-inducing surveillance agency. Jenessa got help for her addiction to be a better mother for her future child yet CPS became involved. The media places the blame on CPS here in order to paint a better picture of mothers. Calhoun continues to demonstrate a sympathetic approach to mothers who that have CPS involvement:

Pregnant opiate users and addicts say they sometimes hear one thing from health professionals, who may recommend they be put on a maintenance program like Subutex or Suboxone, and another thing from law enforcement or child welfare agents, who may say that mothers who use any drug, even Subutex or Suboxone, should be investigated. This puts many women in the Catch-22 of either trying to go off a drug completely while pregnant, knowing it could result in a miscarriage,

or following their doctor's orders and fearing that their baby could be taken away at birth. (Calhoun, 2014)

Similar to the findings of Goldensohn & Reyes (2014), Calhoun presents the story of the stress-inducing and inconsistent practices of law enforcement and child welfare agents. She creates a narrative of a mother struggling to take care of herself and her baby, and the surveillance entities that challenge her ability to do so, drawing a rational, yet negative presentation of these entities.

In contrast, journalists who reported about Bella Bond demonized the social workers and DCF who were involved in her case. The media was speaking to a nation that wanted answers and satisfaction in knowing someone was blamed for her death. They gave the public this and more, yet the depths to which they took their scrutiny – and to which others have – can negatively impact pregnant women, their families, and the public. An example of this scrutiny and wide representation of mothers with substance use issues and their social support network is found in a *Reuters* report in 2015.

“Helpless & Hooked:” A Reuter’s Report

The internet is flooded with articles, reports, photos, and videos about pregnant women with substance use issues, making it critical to present a well-rounded picture of the way the media discusses this population. In 2015, Wilson & Shiffman produced a report through *Reuters* that presented, what I have called in my own research, a woman's social support network within the current “Opioid Epidemic” (Siegel, 2015). Rather than discuss several, brief articles, the single *Reuters* report gives a well-rounded picture and provides a substantial amount of material to consider. This report stands to represent

mothers with substance use issues and their support system in similar ways that the media discusses this population. More importantly, it epitomizes the blame that gets placed on the entire support network, heightening stress and contributing to stigma.

The three-part series is available online and when searched, the reader is presented with a video of a baby uncontrollably shaking from NAS, on repeat, with the striking words “The most vulnerable victims of America’s opioid epidemic.” In larger letters below this, also in white, are the words “Helpless & Hooked,” implying babies’ desperate need for drugs and inability to control their cravings.

Scrolling down, the “investigation” continues with the story of a young mother named Tory from Pennsylvania who gave birth to a boy named Brayden, “born hooked on drugs.” The report claims that his “dependency [was] inherited,” yet the use of “inherited” insinuates a dependency on drugs as a genetic characteristic passed on from his mother. Although there has been substantial research on inherited dispositions towards addictive behavior, there has yet to be research that conclusively identifies addiction as a genetic trait that can be passed onto future generations. Wilson & Shiffman emphasize and reinforce the notion of “bad mother” with their use of “inherit” in another story: “In December 2011, Frazier gave birth to Jacey at a hospital in Charlotte, North Carolina. The baby *inherited* her mother’s blue eyes – and Frazier’s dependency on drugs.” The author’s inaccurate use of this phrase is the first of many times throughout the report that they place blame on individuals and state entities.

Within the same story of Tory and Brayden, they make the claim that: “Brayden Cummings turned 6 weeks old the morning his mother suffocated him” (Wilson &

Shiffman, 2015). Tory had been “high on methamphetamine, Xanax and the methadone” when she fell asleep and rolled on top of Brayden. Police reported that it was Tory’s carelessness who caused her son to asphyxiate, but the way in which Wilson & Shiffman tell her story, Brayden’s accidental death seems deliberate. By placing blame on Tory in this way, they present her as a bad mother, one hooked on drugs and incapable of being a good mother. They support the stereotype that addicted mothers cause the death of their babies by making it seem like a common occurrence:

Like Brayden, more than 40 of the children suffocated. Thirteen died after swallowing toxic doses of methadone, heroin, oxycodone or other opioids. In one case, a baby in Oklahoma died after her mother, high on methamphetamine and opioids, put the 10-day-old girl in a washing machine with a load of dirty laundry.

Drawing upon Mattingly’s work, I argue that the media support for this stereotype is an attempt to “make similar” the experience of parenting and loss (2010). Mattingly writes about a young boy named Willy making Buzz Lightyear his own: he consumed the movie *Toy Story II* and made Buzz’s character similar to himself in that according to his mother, “they both had surgery today.” I use this to frame my example from the media, where Wilson & Shiffman present examples of “bad” mothers, allowing readers to make the stories their own; to allow for mothers to reflect on or react to their own “ability” to do this to their children. Similar to the case of Bella Bond, Wilson & Shiffman also let readers reflect on the potential loss of a child at the hands of their own parents. This example of “making similar” – by imagining the death of their own child, exacerbated in reflection on the cause of death being an accident by the parent’s own hands – draws on the empathy of all readers and provokes them to draw parallels in their own lives.

Wilson & Shiffman also place blame on doctors, specifically for their role as mandatory reporters in some states, including Massachusetts³¹. As part of Tory's story, the report claims that "doctors neglected to take a critical step: they failed to alert child protective services." However, Pennsylvania does not in fact require doctors to report a mother's substance use to child protective services. In this case, the blame being placed is a subjective judgment accusing doctors of failing to intervene, in spite of the state's lack of mandatory reporting policies. If doctors are not required to report cases like these, the choice to intervene is a personal one – therefore rather than "failing to intervene," doctors may choose not to. The report then states that a doctor "must" alert child protective services, seemingly disregarding the state's policies surrounding this issue.

Yet even when the state has mandatory reporting policies in place, like in Massachusetts at Project Empowerment, providers still feel hesitant to report because of the potential outcome of mothers trying to get sober losing their newborns. As I described Dr. Bear telling me in a previous chapter,

I'm very cautious now about what I disclose to DCF. Not 'cause I'm trying, ya' know, to defer the system but umm, the one thing we know that increases postpartum relapse is mom losing custody of her kid... Why would I- why would she stay clean now? (Interview, 06/25).

Dr. Bear is aware of the power that DCF has over her patients, and the ways this power is hegemonic even in her own treatment. The responsibility placed on doctors by state policies, and this role being reinforced by the media, challenges providers by placing

³¹ States where healthcare workers must report substance use during pregnancy include: AK, AZ, IL, IA, LA, MA, MD, MI, MN, MO, ND, OK, RI, UT, VA. For more information on state policies, see: <https://projects.propublica.org/graphics/maternity-drug-policies-by-state>

them in-between what they feel are the appropriate measures to take for their patients' care, and what the state requires of them as doctors, through DCF surveillance and reporting requirements.

Following the placement of responsibility on doctors, Wilson & Shiffman assert that if doctors had alerted child protective services, "social workers [could] ensure the newborn's safety." In saying this, they place responsibility onto social workers. Their use of the word "ensure" also implies a social worker's absolute ability to protect newborns. Yet this assertion is followed by an inherent contradiction: "In [many] of the cases, child protection workers were notified but didn't take protective measures specified in the federal law." By asserting that social workers can ensure the safety of babies, then presenting a situation where they failed to do so, Wilson & Shiffman negate their first statement. Following this, they then place blame on the state and federal policies about mandatory reporting, by quoting a former U.S. Representative who stated:

I would've hoped that the whole system – starting at the federal and state levels, the obstetricians and pediatricians – would've gotten it straight by now. That they haven't is a national disgrace (p. 1).

Wilson & Shiffman mention that variations in state policies is a main reason why "babies go unprotected," acknowledging that some states do not have this policy, to avoid stigmatizing mother's substance use. Here, the article places fair weight on both sides of the argument allowing for the reader to further understand what is happening. However, they place blame on state policies for not protecting all babies – a structural critique, though perhaps an incomplete one. Even when the mandatory reporting policies are in place, the policies can deter doctors from reporting mothers because of the punitive

action that could follow. By presenting all of these details, Wilson & Shiffman paint a fairly nuanced, though not perfect, picture of the convoluted system, from the state and agencies like DCF, to doctors' and mothers' roles.

Nonetheless, Wilson & Shiffman's placement of blame, along with many others within media, was recently countered in an open letter from 51 doctors from around the world. Aptly titled *Open Letter to the Media and Policy Makers Regarding Alarmist and Inaccurate Reporting on Prescription Opioid Use by Pregnant Women*, the letter addresses the way media and policies discuss these mothers and their babies (Advocates for Pregnant Women, 2014). Citing media articles from news shows and newspapers such as *The New York Times*, the authors begin by stating that numerous studies have been conducted over the past few decades about pregnant women using substances and the effects of this on their babies. They further assert that "guidelines have been established for optimal care" within the hospital yet "reporting in the popular media continues to be overwhelmingly inaccurate, alarmist and decidedly harmful to the health and well-being of pregnant women, their children, and their communities." The doctors address the reason behind the letter as: "we are writing to urge that policies addressing prenatal exposure to opioids, and media coverage of this issue, be evidence-based rather than perpetuate and generate misinformation and prejudice."

Following the introduction is a heading: "*No newborn is born addicted.*" As many articles have called babies who are born with NAS "addicted," the letter-signers attempt to combat this statement arguing that the label is "incorrect and highly stigmatizing." They support this claim by stating that NAS is a physical *dependence* on a

substance rather than an “addiction.” The difference is highlighted in the fact that babies have no autonomy, and therefore have no choice over being exposed to a substance. Babies are then physically dependent rather than mentally addicted because of their lack of mental choice over substance exposure. In contrast, mothers face both the physical dependence and mental addiction that comes with substance use, based on their autonomy. The highlighted distinction points to a change in discourse in research surrounding addiction and newborn babies. By distinguishing between “dependence” and “addiction”, and “physical” and “mental”, the doctors who signed the open letter advocate for babies and mothers, pointing to the consequences of confusing the terms and how this can lead to discrimination.

Happer and Philo (2013) discuss the effects of science presented within the media on the public saying that if it is “solidly based,” the public can see that “the potential consequences are real and severe... they [see] more clearly that action has to be taken.” However, the way the media presents NAS provides a “barrier to action” by the “proliferation of [inaccurate] media opinion and arguments” (Happer & Philo, 2013). By providing conflicting information in magazines and newspapers, the public has competing beliefs about what is truly happening.

NAS is also diagnosable and treatable, yet the media has presented these babies as “crack babies” or “oxytots” which the doctors who signed the open letter consider “equally unfounded and pejorative labels... to call them victims rather than babies is unjustified³².” They claim that the representation of babies shaking uncontrollably and in

³² In the *Open Letter*, the doctors also discuss the effect of these labels on children long-term,

pain is a medical mishap, rather than the effects of bad mothering. The doctors also push back against the use of the term “victims” by saying that where there are portrayed victims, there are then presumed to be perpetrators, in this case the mothers. But they argue that mothers should not be characterized as perpetrators; addiction is treatable, and as they stress: “demonizing pregnant women creates an environment where punishment rather than support is the predominant response, and will inevitably serve to discourage women from seeking care” (pg. 3).

The demonizing of mothers, parents, and of DCF, occurred in the Bella Bond case. Yet the circumstances surrounding Bella’s death are different than what is discussed about mothers whose babies have NAS. In Rachelle Bond’s case, the demonization of her character had to do with her daughter’s murder and her failure to, it seems, protect her child from her own romantic partner. But in many articles, the demoralizing focuses on the mother’s “choice” to use substances during her pregnancy that are assumed to affect her baby and the assumption that the mother’s ongoing substance use is implicated in her decision-making. In either circumstance, the media contributes to a stigma surrounding substance use during pregnancy and to a stigma around being a parent with substance use issues, that places obstacles to care.

This was seen in Project Empowerment when one mother sought prenatal care but never came back after her visit because of a fear of punishment, in this case, of being

including stigma and stereotypes placed on “crack babies” and “oxytots” as well as these terms affecting their medical care. To read more, see:
https://opqc.net/sites/bmidrupalpopqc.chmcres.cchmc.org/files/NAS/Resources/NAS%20resource%20letter_3.11.13.pdf

reported to DCF (Field notes, 2015). Unfortunately, I do not know what happened to this mother but her fear is something many other mothers reportedly feel. One mother even declined an interview because of her past negative experiences with DCF. Although DCF can provide support, a mothers' fear that a baby could be removed discourage some from continuing prenatal and substance use care.

In discussing maintenance therapy, Abrahams et al. (2013) mention media reports that claim methadone treatment as "harmful and unethical" for mothers and babies yet a multitude of research says that it is safe, can save babies lives, and helps mothers with their addiction. However, they mention issues that arise when the media presents information on maintenance therapy:

There are, however, enormous financial, regulatory, and cultural barriers to this treatment that are exacerbated by misinformed and inaccurate news reporting. Indeed, we are aware of numerous cases in which judges and child welfare workers have sought to punish as child abuser's pregnant women and mothers who are receiving methadone maintenance treatment (p. 3).

As a population that is in desperate need of support, punishment exacerbates any structural or social issues a mother is already facing, including her struggle with addiction. In Tennessee, the punishment for mothers is being reported and then placed in jail for either substance use *or* maintenance therapy during their pregnancy. In contrast, in Massachusetts, punishment can be considered being reported to DCF, because of their ability to intervene and remove a mother's child(ren).

Conclusion

Regardless of state policies, the media presents discussions of pregnant women who struggle with substance use, typically swaying the reader or viewer one way or the

other. Abrahams et al. (2013: 4) argue that:

Such reporting, judging, and blaming of pregnant women draws attention away from the real problems, including barriers to care, lack of medical school and post-graduate training in addiction medicine, and misguided policies that focus on reporting women to child welfare and law enforcement agencies for a treatable health problem that can and should be addressed through the health care system. It fosters inappropriate, punitive, expensive, and family-disruptive responses by well-meaning but misinformed criminal justice and child protective agencies, creating a reluctance on the part of healthcare professionals to recommend and offer the services that evidence clearly indicates are best for their patients.

As Happer & Philo state, “the sense of not knowing who or what to trust in terms of the most effective course of action, rooted in the proliferation of media opinions and arguments” (p. 2), acts as a significant barrier to action. In “drawing attention away from the real problems”, the media makes it difficult for the public to first comprehend what is truly going on and, second, by presenting multiple and often conflicting ideas, the media creates a “barrier to action” (Happer & Philo, 2013: page 331; Abraham et al., 2013: page 3). In so doing, while placing blame on a mother's social support network, the media reinforces often exaggerated or misinformed ideas about substance use, risk, “good” and “bad” motherhood, and thus compounds the stress that mothers and families already face.

By creating a “barrier to action”, the media makes it difficult for surveillance agencies like DCF and law enforcement to make changes to improve care. In placing blame on a mother's social support network and stigmatizing her, it also becomes challenging for the public to see any policy change that treats addiction as a disease to be a step in the right direction. The media’s pervasive and ideologically reinforcing nature exacerbates the already convoluted system of stigmas and barriers in place, producing and perpetuating stress and fear. The media heightens what structural policies and

systems in place have already done; setting mothers and their social support networks up to fail.

CHAPTER VII: CONCLUSION

Massachusetts: One of Few and One of Many

There is a major difference between federal and state laws: namely, to whom they apply. Federal laws, like those affected by the United States Constitution, apply to every individual throughout the country. State laws apply only to the individuals who reside in each state, and vary across the nation. Article VI, Paragraph 2 of the Constitution acts as an exception to state laws; it is referred to as the Supremacy Clause. The Supremacy Clause “establishes that the federal constitution, and federal law generally, take precedence over state laws, and even state constitutions” (LII, 2015). However, state laws typically hold up in court until they are challenged by individuals who take issue when the law affects them³³, and can access legal resources to go to court over such matters.

One example is the Ferguson v. Charleston case in 2001. The court case pertained to urine tests administered in a public hospital in South Carolina to mothers after they gave birth, if their providers suspected the mother of substance use. Some new mothers were tested for drugs, regardless of consent. However, several women who received care at the public hospital fought back, saying they did not give consent and that the tests were a violation of their Fourth Amendment rights, that protect against unreasonable search and seizure. Judges argued that the tests fell under what they considered “special needs,” in this case, exposing their unborn babies to substances. The main issue in this case was that the tests, administered with or without consent, were reported to law enforcement. In the final ruling, doctors could conduct urine tests for “special needs” regardless of

³³ Ferguson v. Charleston: <https://supreme.justia.com/cases/federal/us/532/67/case.html>

consent as long as the tests were not intended to be given to law enforcement, and therefore would result in punitive action (Ferguson v. Charleston, 2001).

South Carolina is one of three states in the U.S. where state laws define substance use during pregnancy as a crime. Alabama and Tennessee are the only other states that prosecute women for using drugs during pregnancy. These states have received backlash from women's advocates, the Drug Policy Alliance, and some elements of progressive media, for targeting women with substance use issues who often cannot afford treatment (Bassett, 2015). Fortunately, this policy has not been adopted by other states. However, it is critical to understand how individual states handle substance use during pregnancy because each state presents mothers and their social support networks with unique challenges. As these laws are confined by geography and delineated in their ability to take action, I now turn my focus to how Massachusetts deals with this issue.

Massachusetts is one of 45 states that, since 1973, have attempted to prosecute women for substance use during their pregnancy. Put another way, 90% of the country has tried to prosecute women for this reason, which points to a cultural perception, reinforced by state agencies and the media, of these women as "bad mothers." They ostensibly defy the norm of not using substances during their pregnancy and put their children in danger, as the media has stated time and again. Public understanding of this issue, in part informed by the media, is reflected in these states' efforts of surveillance and punitive action.

Nineteen-seventy-three was also a pivotal year for women's rights with the passing of Roe V. Wade (Solinger, 2001). As a result of this case, the U.S. Supreme

Court made it unconstitutional for states to make illegal a woman's ability to have an abortion. This decision came with several caveats pertaining to how far along a woman was in her pregnancy and the reasons behind her decision, including the safety of herself. The most contested issue within the abortion debate, following *Roe v. Wade*, was the protection of human life, namely the fetus (McBride, 2006; Solinger, 2001). The concept of a fetus as being a human life, and therefore having human rights, coincides with states across the nation attempting to prosecute women for substance use during their pregnancy.

As many argued, a baby, unborn or newly arrived, has the right to life and to choose life. Substance use during pregnancy challenged this life and challenged the right to choose, as the unborn baby had no decision in being exposed to substances. Mothers who used during their pregnancies became "bad mothers" and their "moral failing" was brought into the public light because they put their unborn baby's life at risk. Within these contested debates, a pregnancy intended to be carried to term is more closely scrutinized, and a woman who does not terminate her pregnancy is held to a higher standard, as she is assumed to have decided to protect the 'life' of her fetus (Ostrach, 2016).

As discussed in Chapter Six, Massachusetts is one of 15 states that requires health care workers to report if they suspect a mother is using during her pregnancy. In Massachusetts, providers report suspected use, known use, and/or the use of maintenance therapy during pregnancy to DCF rather than law enforcement. The use of maintenance therapy during pregnancy is reported after birth because the urine toxicology screens are

positive due to the substances still found in the new mothers' systems, from treatment. Yet unlike North Dakota, Minnesota, Iowa, and Kentucky, urine tests are not required if substance use is suspected.

By state law, discussed in documents from the Department of Public Health, providers in Massachusetts are intimately tied in their work to the Department of Children and Families. The "mandatory reporter" role for providers, discussed in Chapter Five, plays out in Project Empowerment in complex ways. Critically, Massachusetts is not one of the eighteen states that consider substance use during pregnancy child abuse. Yet the policies in place by DCF, enforced upon Project Empowerment staff, regard maintenance therapy as potential child abuse, despite it being, as one provider called it, a "gold standard" of biomedical treatment for pregnant substance-using women (Interview, 2015). Although mothers can be screened out after being reported, their seeking of substance use treatment, an attempt to *stop* using substances that may place their child at risk, ironically places them under the surveillance of DCF in Massachusetts. Being under this surveillance produces stress and invokes fear in mothers trying to get prenatal care and treatment for their substance use issues.

These circumstances for pregnant women with substance use issues are unique to mothers in Massachusetts. Like the rest of the nation, care is different in each state, posing distinct challenges to mothers, providers, and surveillance agencies. The media, as I discussed in Chapter Six, is implicated in and closely follows how several states understand, deal with, and even criminalize substance use during pregnancy. It is critical to recognize the particular challenges Massachusetts faces, through the research I

conducted at Project Empowerment, to discuss how care and policies can be improved for substance-using women and their children.

Project Empowerment & The Department of Children and Families

Project Empowerment and the Department of Children and Families are intimately connected. Although they operate separately, through mandatory reporting requirements the line between these surveillance agencies is blurred. Providers at PE carry the power to report mothers, even though they have hesitations in doing so. However, DCF carries more power than providers with their ability to remove a mother's child if they see fit. Yet this power of surveillance and potential removal creates tensions within the space of the hospital, where both PE providers and DCF social workers operate, affecting care –

Dr. Cost: So we had a mom who established care... She came back with a positive urine for opiates and so we said okay, you have a positive. We said in the beginning if you have custody of children that we have to report it. And we can't not report it. And she was like this isn't what it's supposed to be. And we said okay, come back. Come back, do another urine. If it's negative, then we'll go from there.

It was positive again so Shea called DCF and she- the patient never came back... and so she came back a couple weeks ago but and I think it was only because she was having this bad vaginal infection... we diagnosed her again and we reiterated she needed to come to clinic but like this was not gonna be a good – outcome and that stuff might happen. And she said she's never gonna come back, like 'I don't want to come back.' You guys are gonna call DCF and sometimes I think that some of our patients don't always deliver here because they know that we're gonna call. (Interview, 10/13)

Massachusetts policy assigning healthcare workers as mandatory reporters presents challenges for Project Empowerment providers. Their role as mandatory reporter invades the space of the clinic and when they disclose this role, mothers fear that their

children will be taken away. As seen in the previous passage from an interview with Dr. Cost, of Project Empowerment, finding out that their substance use and treatment must be reported is frightening for mothers. Lack of treatment and prenatal care for pregnant women with substance use issues produces negative outcomes for both mother and baby. Babies, depending on the substance they were exposed to, can be born with a low birth weight, neurobehavioral issues, and withdrawal (Behnke & Smith, 2013). Without treatment and prenatal care, mothers still face the struggle of addiction and are more likely to have pregnancy complications (Field notes, 2015). These negative outcomes point to the critical need for prenatal care and treatment during pregnancy for women who struggle with substance use. Project Empowerment provides mothers with both.

In Chapter Four I presented profiles and perspectives of PE providers, and their passion for the population they care for. Project Empowerment providers also act as advocates, potentially being a buffer between mothers and other providers in the hospital, or social workers from DCF. Mothers who seek care at PE have compassionate providers who have experience with substance use, and can also reduce the stress and fear that comes from DCF surveillance. Yet mothers throughout Massachusetts who have no such support likely face the fear and stress of DCF without provider advocacy. In addition, few women actually receive care at PE, yet numerous women across the state suffer from substance use issues while pregnant.

The Department of Children and Families can become involved with any mother who they, or others, suspect of child abuse and neglect. Yet women who deal with addiction are under a greater amount of surveillance due to the way DCF defines a “good

mother,” even in the absence of supporting clinical evidence. In essence, substance use during pregnancy, or while being a parent, defies hegemonic cultural notions of what it means to be a “good mother,” in the eyes of DCF. Surveillance is exacerbated within the clinic at Project Empowerment due to Massachusetts state policies. When DCF produces stress, providing an unintended paradox of support for mothers through their use of surveillance, mothers fear remaining in the very treatment that could improve birth and health outcomes for themselves and the babies DCF is so concerned about.

Set Up to Fail

The convoluted and often contradictory system in place in Massachusetts to deal with pregnant women with substance use issues sets up every actor to fail. The social actors in play are made up of what I have called a mother's social support network. Each member of her social support network faces a unique set of challenges that are reinforced by state policy. These policies are enacted through the surveillance of mothers' social support networks. No one is exempt from these challenges and it is critical to acknowledge these obstacles, to discuss how the current system is or is not working.

Department of Children and Families

The agency in Massachusetts charged with protecting children (DCF) often disregards some of the challenges mothers who struggle with substance use encounter every day. DCF claims to provide support for families, yet produces fear and stress instead. Social workers face blame, burn-out, fear of missing a case. They can also “over protect” and screen-in a mother and her family even if the child(ren) are in a safe and

healthy environment (Poulin & Walter, 1992). DCF lacks funding, is over-loaded with cases, and does not require relevant and critical training in substance use, resulting in less than appropriate screening-in of cases. With their lack of resources and excess of cases, DCF frontline workers are seemingly set up to fail in helping protect children and keeping families together, while when the agency is investigated or scrutinized over failures that receive media attention, such as the Bella Bond case, state administrators are all too happy to blame individual case workers rather than point to unrealistic case-loads or funding constraints.

Providers

Providers who care for pregnant women with substance use issues have been assigned the role of mandatory reporter, one that requires them to report substances in a mother's system to DCF. This is a role that discourages mothers from seeking care because of the fear that they could lose their child(ren). Providers who have experience with addiction, like those at Project Empowerment, know the appropriate and safest ways to treat the mothers who come to their clinic. Maintenance therapy has been proven effective as it staves off withdrawal and helps with the cravings that come with addiction (Eder et al., 2005). Yet even if a mother has stayed sober during her pregnancy, the urine screen administered to both her and her baby after birth will be positive if she has been on maintenance therapy. Therefore, providers or a social worker have to report these mothers to DCF even if they know the mother has not used throughout her pregnancy and is doing well at home. This is often a difficult decision for providers who know their patients well and know how hard they are trying to stay sober and in treatment. In

summation of Dr. Bear's feelings surrounding this policy, as discussed in Chapter Five, she thinks carefully about how to report, if at all, mothers who are on maintenance therapy. She knows that reporting them is not always the best decision. In this way, providers are set up to fail in their job at providing appropriate care to mothers because of their role as mandatory reporter – they sometimes must choose between providing the most biomedically appropriate care, risking the mothers' role with their child(ren), or risk not complying with their own role as a mandatory reporter. How providers cope with the resulting occupational stress is an important area for future research.

Mothers

Mothers who seek treatment and prenatal care during their pregnancy may choose to willfully ignore the fear and stress they face as they try to make the “right” decision for themselves and their unborn baby, in order to be able to do what they ‘need’ to do. This “right decision” can be regarded as the actions defined as appropriate, through both biomedicine and DCF, that promote receiving health care during pregnancy, especially if a mother struggles with substance use (Health & Human Services, 2015. Moms know that by seeking care in a hospital, they risk being reported to DCF. If they are reported to DCF and a social worker screens in their case, they could lose their child(ren). Even being on maintenance therapy and trying to fulfill their role of “good mother” brings mothers under the surveillance of DCF. This surveillance exposes mothers to the stress and fear that comes along with DCF. Fortunately, in Massachusetts, substance use during pregnancy is not seen as a crime. Yet it is still *treated* as a crime because of the attempted prosecutions and surveillance of mothers with substance use issues. As seen in their

questioning of providers about reporting to DCF, PE moms know that their enrollment in maintenance therapy may result in their babies being removed by DCF. That these vulnerable moms nevertheless seek both prenatal care and substance use treatment at PE suggests they somehow prioritize their own health and sobriety, and the health of their unborn babies, despite the considerable threats to their family stability and their own mothering role. Future research with these moms, taking into account the considerable challenges in accessing this population, is sorely needed.

The challenges a mother and her social support network attempt to balance, in order to do what is best for mother and baby, are overwhelming. Exacerbating all of these challenges is the lack of communication amongst mothers, providers, and social workers from DCF. Even when doing what is considered the “right” thing through the lens of medicine or the law, each member is set up to fail. Social workers cannot protect children when they are undertrained and underfunded. Providers cannot protect children from being taken away or exposing mothers to fear and stress while simultaneously prescribing beneficial maintenance therapy. Mothers cannot protect their children and themselves with the extensive and stress-inducing surveillance from their social support network that acts as an obstacle to care.

The thread through all of this is surveillance from every actor, in the direction of other actors. As seen in Bridges’ work, mothers are faced with an immense level of surveillance (2011). For the patients at Alpha Hospital, the guidelines that must adhere to are provided by Medicaid and for mothers at Project Empowerment, these guidelines come from both PE and DCF (Bridges, 2011). However, in stark contrast, is that mothers

in Project Empowerment *do not* choose the assistance of DCF. In not choosing this form of support, they unwillingly open their lives up for surveillance as a result of seeking treatment. The media reinforces and exaggerates this surveillance in their well-rounded yet embellished representation of providers, DCF, and mothers. The pervasive nature of surveillance heightens the challenges state policies already present a mother and her social support network. In doing so, all of these actors are truly set-up to fail leaving social workers and providers overwhelmed and leaving mothers without the support they need.

Recommendations

Critical Medical Anthropology (CMA)

I call on CMA to examine the power dynamics of the space of the hospital and all the actors within it. There are several questions that CMA can address about the dynamics between providers in Project Empowerment and other hospital staff. In particular, I presented the story of Melissa in Chapter Four who was trying to breastfeed her newborn baby. Dr. Bear gave her the go ahead, stating that this was in fact a good option because it improves outcomes. Yet nurses in Labor and Delivery ignored this and reported Melissa to the Department of Children and Families because she was on maintenance therapy and the nurses felt that this was cause for suspicion in her attempt to breastfeed. Within the same space of the hospital, how does the knowledge and experience of a PE provider come second to a nurse in a separate wing of the hospital in making decisions about how she wants to, and was told to, care for her baby?

Critical Medical Anthropology can answer a question like this by examining the

power structures in play, including hospital policies. In addition, CMA can suggest recommendations in order to improve care for pregnant mothers with substance use issues, especially when they give birth. As I have previously mentioned, these women have been denied the ability to have an epidural to ease the pain for the birthing process because nurses considered it drug seeking behavior. Again, how does the disconnect between knowledge and experience happen and how does the power relationship between providers and nurses, and different spaces of the hospital operate to heighten the discrimination mothers face. Overall, CMA can examine the health structures on a macro and micro level to suggest policy change and improve care.

A Cultural Shift

Currently, there is a cultural shift occurring in the thinking and understanding of addiction. In the hospital, in DCF, and in the media, addiction is now portrayed and discussed as a brain disorder (Krull, 2016). This cultural shift is slowly replacing the idea that addiction is a moral failing; a choice that an individual chooses to make every day (Maguire, 2014). However, many addiction treatment programs do not reflect this cultural shift where many still do not accept maintenance therapy options and the standard program is Alcoholics Anonymous (AA). Programs like AA are faith based and rely on a sense of community and anonymity to support one another through trying to get and remain sober (Krull, 2016). Unfortunately, these types of programs rely on self-motivation and morality to assist in change, keeping all the pressure on the individual. In this way, it almost makes sense that the Department of Children and Families policies still reflect the idea of personal choice, motivation, and morality over medical treatment.

Yet this cultural shift needs to expand to include a rethinking of how motherhood is defined in the eyes of surveillance entities like DCF, and in Massachusetts state laws and policies. If motherhood is redefined to include the challenges and obstacles to care mothers who struggle with substance use face, the idea of a “good mother” can include a mother who is seeking and staying in treatment. The structures and policies within DCF can reflect the re-defining of what it means to be a “good mother” and in turn provide support rather than produce stress and fear.

In understanding how the policies operate currently, through CMA, policymakers, advocates, and providers can suggest ways that these policies actually come through in action. A conversation must be had to acknowledge the differing views of what it means to be a “good mother” and be part of the conversation when changing policies. Rather than “putting a round peg in a square hole”, as Dr. Bare discussed, the “good mother” and the policies can match up, making it possible for mothers to fulfill this role *while* living up to what DCF considers is adequate mothering.

Re-defining a Good Mother

As providers in a mother's social support network understand, maintenance therapy is beneficial for both mother and unborn baby. This evidence-based understanding needs to be incorporated into the definition of “good mother” for DCF and the media (Abrahams et al., 2013). As I discussed in Chapters Five and Six, seeking treatment is difficult because of the many obstacles to care mothers encounter. If seeking treatment is seen as beneficial by both providers *and* DCF, and mothers find a way to do so, this positive action should be reflected in DCF policies. Therefore, seeking and being

in maintenance therapy should be part of the “good mother” definition for DCF. This could reduce the stress and fear that comes with DCF involvement as mothers will not be reported simply based on their being in treatment. A shift in perspective on maintenance therapy, reflected in policy, could increase the chance of a mother coming to treatment because she will not face the immediate of DCF involvement. In addition, by changing this policy, mothers across the state who are on maintenance therapy can benefit from this; not all mothers have the compassionate care that PE providers give to their patients.

By requiring providers to report maintenance therapy to DCF, this surveillance entity contradicts their own assessment that treatment is part of what makes a good mother. Yet DCF also makes providers unwilling proxies to their policy that requires providers to be mandatory reporters. This policy places providers under DCF surveillance, giving them guidelines and no space to choose what happens with their patients. A provider’s role in care, once a baby is born (if a mother does not already have children at home), is challenged and reporting is not a choice, but rather an obligation.

Mandatory Reporting

In understanding that mothers also fear social workers’ intervention and some even avoid care as a result, DCF should change their policy so that healthcare workers can play a more supportive role in reporting. Rather than reporting every woman who has a positive urine screen, regardless of maintenance therapy, providers should be able to have an open, off-the-record initial conversation with the social workers who complete reports about the mother and her history with substance use. This reporting policy also generalizes care for mothers who face individual challenges. In doing so, the providers

who have experience with substance users can act as advocates for mothers and have a say in the measures they feel are appropriate based on each mother's circumstances. This will also provide an outlet for communication between those who give care to mothers. By having all of a mother's health care workers communicating with one another, her care and treatment plan will be informed and more appropriate for her needs.

This mandatory reporting policy change must take into consideration power dynamics between all of a mother's social support network that enacts their support *and* surveillance within the space of the hospital. Importantly, the question becomes who has the power to decide what is best and what is appropriate? In addition, how do the guidelines DCF imposes on providers through mandatory reporting, and guidelines both DCF and providers impose on patients affect all actors? Employing CMA, I argue that the mandatory reporting policy effects the power relationships within the space of the hospital between those that provide care for mothers. When considering how to adjust this policy, providers should be given more power and more of a voice in decisions like this. In changing their definition for what it means to be a "good mother" to include maintenance therapy, DCF can also acknowledge a provider's voice in mandatory reporting policies.

Substance Use Education

Finally, every social worker and employee of DCF who interacts with families struggling with substance use should be required to have training and education about substance use. As I argued in Chapter Six, the discourse around addicts that pervades popular culture, through media and literature, has an influence on every individual. Social

workers are no exception but their role as a resource and a form of support for mothers that have the potential to remove a child places them in the realm of substance use. In not understanding this issue and how it affects the individual and their family, social workers' preconceived about substance use can dominate how they enact their surveillance and affect their decision making.

Currently, I am enrolled in a Substance Use Policy course for social workers. This class acts as a good model for how to understand and approach substance use, taking a macro look at the social, environmental, financial, and political aspects of addicts lives. In addition, the class focuses on how these structural factors should be considered and accounted for when dealing with families that struggle with substance use. Yet the students enrolled in the course had to *ask and advocate* for this class to be offered, as it had not been for seven years. The only class for social workers that offered a perspective on substance use was a clinical course that offers a biomedical view of substance use, ignoring the structural factors. I found this to be shocking, as the current "Opioid Epidemic" has hit Boston especially hard and social workers are one of the many groups that are charged with combatting this issue.

If courses are not even offered in the training of social workers, how does this affect the way they view substance use when they do enter the field? In addition, if they are not offered during schooling, this points to an additional critical reason that training around substance use needs to be offered in the field for social workers who are tasked with handling families that struggle with it. The Department of Children and Families in Massachusetts should require substance use trainings for all social workers so that social

workers can screen-in or screen-out families based on their knowledge of substance use, rather than their preconceived notions and lack of experience.

Support

There are numerous benefits to positive support such as reducing stress (Wethington & Kessler, 1986). DCF and social workers can and should act as positive social support for a population that desperately needs it. Especially for mothers who have “burned bridges” with their friends and family because of their addiction, institutional support and referrals to community supports can help them seek and stay in treatment, and keep them connected to forms of support while parenting. Currently, DCF social workers can enter into the space of the clinic and the space of the home. This intimate entrance into a mother’s private life has the potential to also open the door for social workers to provide social support. DCF social workers know the most private parts of a mother's life – her substance use history, her friends and family, and her health history – and use this information to assess whether her child(ren) are in a safe, healthy environment. If they employed this relevant information to also provide forms of support that focus on mothers’ needs, rather than solely focusing on the child(ren), DCF social workers could fulfill their claims of support. The stress and fear invoked by DCF involvement can be reduced by opening the door for communication; providing appropriate social support for mothers in desperate need of help.

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CURRICULUM VITAE

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EDUCATION

Boston University School of Medicine, Boston, MA

Master of Science, Medical Anthropology & Cross-Cultural Practices

Thesis Topic: *A Paradox of Support: The Department of Children and Families and Their Construction of the "Good Mother"*

GPA: 3.86

May 2016

Plymouth State University, Plymouth, NH

Bachelor of Arts, Anthropology

Minor, Biology

GPA: 3.8

May 2014

Payap University, Chiang Mai, Thailand

Courses in Political Science and Thai language

Spring 2016

ACADEMIC RESEARCH AND PRESENTATIONS

Undergraduate Research

Plymouth State University Student's Perceptions of International Students from the Middle and Far East. Presented at Seminar Class Presentation, Plymouth State University

Spring 2013

Student Showcase of Excellence

Holmes House: An Analysis of Plymouth's Past. Presented at Annual Student Showcase of Excellence,

Plymouth State University

Spring 2013

Issues of Hand Hygiene Compliance and Sustainability in a Critical Access Hospital: Improving a Culture.

Presented at Annual Student Showcase of Excellence, Plymouth State University

Spring 2014

Honors Capstone

Issues of Hand Hygiene Compliance and Sustainability in a Critical Access Hospital: Improving a Culture

Spring 2014

AWARDS AND DISTINCTIONS

Pi Gamma Mu, International Honor Society of Social Sciences

ON CAMPUS WORK AND INVOLVEMENT

Social Science Department, Plymouth State University

Anthropology/Sociology Club Vice President

Sep 2012 – May 2013

Anthropology/Sociology Club President

Sep 2013 – May 2014

- Schedule meetings and organize events
- Recruit new members

Archaeology Lab, Plymouth State University

Lab Assistant

Sep 2012 – May 2014

- Collect, clean, identify, and bag artifacts from numerous sites
- Organize and sort past artifacts
- Complete paperwork for each site

EXPERIENCE

Boston Medical Center, Boston, MA

Volunteer/Researcher

- Participant Observation of program in OB/GYN clinic

April 2015 – Aug 2015

Boston Healthcare for the Homeless Program, Boston, MA

Volunteer

- Front Desk Assistant
- Server in cafeteria

Dec 2014 – July 2015

Speare Memorial Hospital, Plymouth, NH

Intern/Researcher

- Participant Observation of hand hygiene compliance
- Conducted focus group & survey
- Presented findings to hospital employees

Aug 2013 – Mar 2014

RELEVANT SKILLS

Computer

- Microsoft Office: Word, Excel, PowerPoint
- Google Drive: Docs, Slides

Research

- Institutional Review Board (IRB) Application
- Qualitative Research Methodology & Data Analysis