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Marketing Mothering as 'Crisis': Professions Saving us from the 'Danger' of Becoming Mothers

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Abstract: One of the most efficient routes to profit is using discourse to frighten an entire population, and then selling them the antidote to their fear. Crisis profitability is maximized if crises can be manufactured out of commonplace life events. The medical profession has already discursively recreated childbearing as an epidemic crisis, to be technologically managed to make it 'safe'. Through critical analysis of psycho-social research, a public health screening tool, and research linking PTSD with birth, the author argues that social science is constructing mothering similarly, characterizing becoming a mother as a pathogenic crisis, demanding medical and sociological surveillance and intervention.

Key words: Postpartum, PTSD, maternal psychology, pathologizing

'Crisis' around mothering is a theme in professional medical discourse. Further examination shows that it is being used to generate profit by manipulating public attitude. Having successfully (that is, profitably) constructed childbirth as a 'crisis' requiring expensive professional medicalization, the dominant narrative is now aimed at constructing motherhood similarly. Examples illustrating the embedding of the discourse linking motherhood and 'crisis' will include a thread of research in psycho-social studies, then a hospital screening tool, and thirdly, a critical analysis of some of the literature linking PTSD with birth.

The constructionist re-conceiving of new motherhood can be found in psycho-social academic discourse. A UK government study (Hollway, Phoenix, Elliott, Urwin & Gunaratnam, 2008) illuminated that the way women adjust to new motherhood can be difficult and can be differentiated by class, age, race and more. The study investigated 'vulnerable' groups – working class women, immigrant women, women of visible minorities, very

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young women, and so on, with the unstated assumption being that these groups naturally experience more severe problems. The 'crisis' of the transition to motherhood has been likened to that experienced by men on retirement, which often, statistically speaking, led to their deaths (Hoggett, 2013).

Professional takeover

Becoming a new mother, rather than something difficult but most likely challenging, rewarding and a wonderful part of life for many, is characterized as dangerous and difficult in the medical, psycho-social discourse, so much so that only professional intervention could "save" a young woman from being overwhelmed by her new identity and falling ill, either mentally or physically or both.

Community studies theorist John McKnight (1994) maintains that much of what has become exclusively the territory of professionals used to be part of a distinctly non-institutional sphere he calls "citizen space" (p. 1). Citing the example of a death in the family, he contends that the social glue holding communities together is being eroded by professional interference which turns citizens into clients and often destroys abilities which already exist within the community. Relatives and neighbors used to help with grieving. Now however, if Aunt Tessie comes over to comfort her niece, she might be turned away at the door, because the "bereavement counselor" is due to arrive shortly. Similarly, according to Murfin (2012), all indigenous cultures used to have "a sense of community around the care of a new mother and baby." But now, even if Aunt Tessie has breastfed five children and dealt successfully with many instances of 'caked breast' using only manual expression of milk and bed rest, if Gracie has a breast infection, Aunt Tessie's help is unwelcome because the lactation consultant insists antibiotics are needed to cure this 'dangerous' condition.

In this manner, professions establish "authoritative definitions of need [and] needs are [to] the services sector … what iron ore is to the steel industry … for this new economy to grow, problems [and therefore needs] must proliferate" (McKnight, 1994, p. 3).

Professional medical takeover of what has been a form of community adds considerably to potential income.[6]

Mothers at risk

As long ago as 1956 it was "recognized that the emotional manifestations of pregnancy [and the postpartum period] … parallel … hormonal and general metabolic development" (Caplan, 1956, p. 26). However, with the growing emphasis on postpartum psychology as if it were independent of both normal physiology and social context, expected postpartum adjustments are reduced to "embodied crises" (Reiger & Dempsey, 2006) through a discourse of risk. Female physiology is "faulty" (Walsh, 2010, p. 491) and the "space between [postpartum] physiology and pathology"(Walsh, p. 491), which is as much socially constructed as it is objective (Davis-Floyd, 2003), can be understood to be shrinking, requiring constant monitoring and evaluation. With respect to physiological changes associated with postpartum adjustment, "all that matters" is "an approach to care that … endorses … medical management" (Walsh), one that "streamline[s] and normalize[s]" (Lock, 1998, p. 180) postpartum "into [an] entit[y] wholly (or at least normally) treatable by an available … drug, device or procedure"(Clarke, Shim, Mamo, Fosket & Fishman, 2003, p. 183).

Despite research showing that a simple lying-in period with good social support is an effective way to enhance mental health postpartum (e.g., Abrams & Curran, 2007; Bailham & Joseph, 2003; Lynch, 2003) , new motherhood is being interpreted psycho-sociologically by drawing on psychiatric theorizing on subjectivity, a literature (e.g., Benjamin, 1998; Stern, 1985) bearing a heavy signature of post-Kleinian theorists such as Lacan and Kristeva. This approach assumes upheaval of identity in any major life change, the first when the emergence of an infant's individual consciousness means loss of the mother, later reiterated in events such as becoming a mother. Loss is constructed as an unconscious realization of the fragility and tenuousness of one's selfhood,

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[6] As a matter of record, in the past physicians have succeeded in eliminating competition in this manner. In the Flexner Report of 1910, the American Medical Association launched a campaign to take over community midwifery practice: two of the stated aims were to "drive midwives out of the maternity field and promote obstetric physicians", and to raise obstetrical fees to "attract able men" to the practice (Stewart, 1997, p. 90).

vulnerable to annihilation at any moment; theorists claim it is the source of all psychiatric illness (Mason, 2010). Mothering discourse proceeds in the other direction, fallaciously working from the absurd tacit assumption that life changes produce illness in all individuals; this discourse maintains that because the upset in identity occurring with life changes are precursors to dangerous illness, they must, therefore, be preventatively monitored and treated by professionals to avert the psychiatric disaster of a new mother unsuccessfully "defending against anxiety and handling the threat of loss of cherished aspects of [her]self" (Hollway, 2010, p. 137).

There has been a remarkable shift in the language describing the postpartum period. It has migrated from portraying learning new skills of mothering as something expected to be exciting if somewhat difficult, into the territory of a psychiatric crisis of incompetence requiring a cure. Words like "threat", "trauma", "crisis", "conflict", "loss" , "anxiety", "PTSD", "contradiction", "tension", "competing needs", "struggle" liberally pepper the literature, as if learning *anything* new threatens who one once was, rather than offering challenging new possibilities. One study describes becoming a new mother as "precipitating a biological, social, psychological, emotional and sometimes spiritual crisis that impacts every aspect of a new mother's being," producing, "significant nonpsychotic postpartum depression" for months in up to twenty percent of mothers (Gustave-Bochner, 2008, p. 1).

Some of the research (e.g., Elliot, Gunaratnam, Hollway & Phoenix, 2009) conflates the first few weeks of motherhood with ensuing years, claiming that the "penalties" of "limited career progression, large pay gaps and discrimination" (Elliot, Gunaratnam, Hollway & Phoenix, p. 9) for mothers who later choose to stay home add intolerable pressure on mothers' unconscious subjectivity in the immediate puerperium. Out shopping with the baby two days postpartum, researcher Lisa Baraitser likens the claustrophobic "narrowing of life" (de Marneffe, 2006, p. 248) in "the brutal present tense of motherhood" (Baraitser, 2012, p. 18) to existing in

> a chronic crisis, the endless horror of Groundhog Day? … in the grip of a mute and helpless grief, … chained to this tiny creature …by an invisible thread …restricting the movement of my very being. (Baraitser, 2012, p. 18)

Did this woman expect shopping so soon after birth to feel normal and healthy? Where did she acquire this false expectation?

Baraitser refers to her baby as a "crying, tantruming, questioning, demanding, enigmatic, unpredictable other" (2006, p. 255), whose (normal) behavior activates all the horrific unconscious experiences of hatred for one's mother and from one's mother. Where is her enjoyment of her child? The infant's needs and the mother's needs are being constructed as mutually exclusive, exactly as in the professional and legal rhetoric around pregnancy and birth, as if to satisfy one, damages the other.

When mothers actually report enjoyment, their words may be undercut by researchers claiming to have unconscious intersubjective insight into what their subjects are not saying (e.g., Elliot et al., 2009; Hollway, 2010). This claim is based on psycho-social theorizing which assumes all these defended subjects deliver false self-narratives, and that trained researchers can read between the lines, even when their intuitions contradict directly what has been said (e.g., Hollway & Jefferson, 2000).

Psycho-social writing sets the stage for blaming of all problems on mother by styling successful mother-baby interaction as principally dependent upon a mother coming to terms with a conflict-ridden interior reality – discarding those more obvious conflicts found in the everyday realm of the baby's personality, maternal physiology, social support, and questionable expert advice.[7]

Babies at risk

A similarly insidious discourse alleging incremental maternal incompetence has already crept into the accepted medical construction of pregnancy and birth over the last two generations. In 1981 sociologist Coleman Romalis recounted how birth was being successfully constructed by obstetrical discourse as far too dangerous and difficult for the 'little woman', who should just leave it to the professionals. Barbara Rothman (1981) extended this idea, saying that where medicine cannot prove birth to be dangerous, because of solid evidence to the contrary, the discourse

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[7] Thinking analogously, how credible would the literature for post-operative amputations be if it took no note of straight-forward physiological requirements like rest and good nutrition, but concentrated instead on psychological shifts in amputee identity as being the *most* important source of patients' failure to cope well, requiring a front line *first response* of psychiatric and social worker intervention?

shifts and begins to categorize all birth as either high risk or low risk:

> an inherent emphasis on "riskiness" …define[s] more and more women as high risk. That is, normal births may exist and be only "low risk" but there are many factors which will make any given labor "high risk" … some… built into medical management justify … medical interference. (Rothman, 1981, p. 177)

This same "risk" reductionism is occurring with respect to mothering. Since becoming a mother cannot be declared outright dangerous, the discourse constructs new mothers as either high or low risk.

For example, risk scoring of all new mothers in the first 48 hours postpartum underlies Ontario's automatic screening in its *Healthy Babies Healthy Children* program, a series of assessments offered free to all mothers of children up to the age of six (Ontario Ministry of Health, 2012). Midwives, or nurses "who have barely spent any time with the mothers," "are responsible for scoring details of the new mothers' lives" (Mason, 1999, p. 6), assessing whether the woman will need professional help postpartum. If a mother declines screening, she is automatically scored higher risk than if she submissively acquiesces. Prenatally, more and more mothers are considered high risk, because they belong to groups universally assumed to reflect greater risk – being young, having less than a college education, having opted not to take prenatal classes – even groups which medical management itself creates: having had a previous high risk birth (one in three women, since currently one in three 'need' cesareans) or having *ever* had any psychiatric or psychological treatment before.[8]

By glossing over these unjustified presuppositions and confounds, the screening tool replicates the "cultural conspiracy – [the] one that reinforce[s] … class ideology" (Romalis, S., 1981, p. 81) which medicine, as a profession, is set up to reproduce, an ideology constructing as 'deviant' those groups seen both as 'more deserving' of care and at 'higher risk.'

After giving birth, mothers fill out self-report forms which they are told "gathers information about what supports are

[8] There is a disturbing confound here. What if a teenager received counseling when her parent entered drug rehab? Or if a woman's husband lost his job, and she sought help for anxiety at the time? What if she is getting help for being sexually harassed at work? The reality of her situation is discarded, and her total responsibility for it is assumed; does this imply that it would have been better if she hadn't sought help?

already in place", whereas "in actual fact, it lists and scores the mother's problems" (Mason, 1999, p. 3). It is supposed to predict child abuse, depression or "couple dysfunction" (Ontario Ministry of Health, 2012, p. 54) – in other words, who is likely to become a 'bad' mother.

Sanity at risk

Being "lost in the current highly [standardized] approaches to childbirth is any notion of trust that a [new mother] might be able to find her own personal ways of coping, finding comfort and expressing personal meaning" (Mains, 2001, p. 52).

Further evidence of Mains' concern may be found in the rapidly expanding literature linking birth with Post Traumatic Stress Disorder (PTSD). PTSD "is a type of anxiety disorder … [in which] people re-experience traumatic events" ("Trauma," 2012, para. 3). In 1980 the American Psychiatric Association (APA) created PTSD to describe war survivors' symptoms. By 1992 a psychometric inventory was recommended to assess the presence and severity of PTSD. In 1994 the APA definition was broadened to include "direct personal experience of an event" beyond the normal range of human experience "that involves actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (APA, 1994, p. 424). This qualified childbirth as a triggering event (Paul, 2008). By 1996 the literature was debating the validity of a Perinatal PTSD Questionnaire (PPQ). Subsequently, researchers began searching for predictive prenatal stressors. By 2003 there were reviews of the emerging literature on PTSD and childbirth, and in 2006 the PPQ was revised to "enhance" clinical utility, that is, dramatically increase the number of sufferers by accepting a diagnosis of "partial" PTSD (Callahan, Borja & Hynan, 2006)[9]. Currently, the UK Birth Trauma Association (2011) states 10,000 new mothers develop PTSD annually, and up to 200,000 more may develop symptoms.

In September 2012, Global TV presented "new research" claiming 30% of mothers exhibit symptoms of PTSD. The show

[9] Compared to the severity and persistence of complete PTSD, "partial" PTSD may lack one or two symptoms. "Symptomatic" sufferers of PTSD may not suffer for the minimum month's duration, or experience functional impairment, or they may exhibit only one or two symptoms with mild impairment.

cited a single piece of Israeli research sampling less than 100 women (Polachek, Harari, Baum & Strous, 2012) where symptoms of PTSD were found, two days (five days post-section) and one month postpartum. In contrast to other studies linking PTSD with operative delivery (Maggioni, Davide & Filippi, 2006), this study associated PTSD with unmedicated childbirth. Global TV concluded their program by saying, " PTSD can be treated with medication and therapy, enabling women to move past the trauma and onto the joys of being a mom" ("Trauma," 2012, para. 7). This optimistic finding is contradicted by a recent study examining PTSD in U.S. military veterans, which claims that PTSD is notoriously difficult to treat because no reliable cure has yet been found (Chamberlin, 2012). If new mothers and veterans are suffering the same disorder, why are postpartum women so easily treated? One must wonder whether misdiagnosis is responsible for this puzzle.

Studies (e.g., Paul, 2008) cluster symptoms around 3 constructs: hyperarousal, avoidance and unwanted intrusions. When we unravel the *meaning* of these constructs, there appears a re-interpretation of absolutely normal postpartum adjustment as symptomatic of severe mental illness:

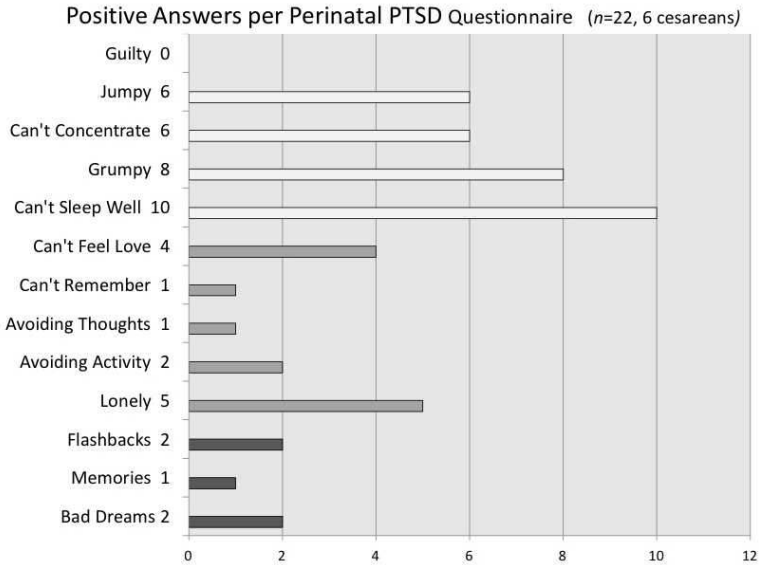

***fig. 1**:* Clustered symptoms of PTSD (adapted from Paul, 2008)

1) Hyperarousal includes "difficulty falling or staying asleep" (Paul, p. 22), being grumpy, having trouble concentrating, feeling jumpy. What healthy new mother escapes adjusting to the predictably unpredictable sleeping patterns of her nursing infant? The baby is not credited with keeping mother awake, nor is normal maternal wakefulness for the few days postpartum (Hunter, Rychnovsky & Yount, 2009). It is called pathological to actually respond to the new infant. Moreover, given this normal sleep deprivation, is it reasonable to frame the expected irritability or trouble concentrating as pathological?

2) Avoidance includes a "loss of interest in activities", "inability to remember" (Paul, 2008, p. 22), avoiding thoughts, and loneliness. Are postpartum women supposed to be interested in other activities? Aren't oxytocin and other hormones responsible for labor physiologically associated with amnesia (Brett & Baxendale, 2001)? Without control groups, how can studies assess women's loneliness if they are *not* institutionalized, isolated from family and friends, or separated from their babies? [10]

3) Unwanted intrusions include "bad dreams" (often associated with anesthesia[11]), "upsetting memories" and "flashbacks" (Paul, 2008, p. 20). The study does not establish memories of the birth as distinct from memories of the staff or the interventions, nor does it differentiate pleasant from unpleasant intrusions. Even if flashbacks are unpleasant, it is normal for humans to recall powerful emotional events to aid in integrating them and much psychological counseling utilizes this activity (Neiderhoffer & Pennebaker, 2002). Why this normally valuable remedy should suddenly be unhealthy postnatally is not discussed. Even distress at having to strip and be semi-naked in front of strangers is termed symptomatic of PTSD (Polachek et al., 2012); now modesty is symptomatic of a fulminating psychiatric disorder.

Research which claims high rates of PTSD (Paul, 2008; Polachek et. al., 2012) also replicates, and then mostly ignores, results correlating birth trauma more significantly with mothers being robbed of confidence (perhaps by having already endured an

[10] With respect to this cluster, tellingly, in Paul's study (2008) the same women who had trouble remembering, had "difficulty feeling loving". Initially this was thought to be attributable to experiencing pain, but these women did not report feeling much pain. Researchers overlooked the obvious confound that women interviewed five days post-cesarean are taking narcotics for pain, and likely have trouble feeling or thinking anything at all.

[11] e.g., Dobson, 2000; Maxwell, 2008; Taimoorazy, 2008.

embarrassing, interventionist birth before), being upset by what they perceive as hostile, incompetent or negligent treatment[12], miseducation leading to being traumatized by the mismatch between expectations and the birth experience, or most significantly, not having enough help postpartum.

In summary, mothers are labeled perinatally with a psychiatric disorder based on physiologically natural occurrences and traumatic births. These few examples demonstrate how exactly research which describes the reality of mothers' experience of maternity care and the reality of being a healthy new mother as pathology is profoundly misleading. The psycho-sociologically constructed meaning of postpartum, which posits psychological and sociological incompetence of new mothers, completely denies the real demand for appropriate support – adequate lying-in – because that would require changing the health system to allocate funds for valuable but minimally profitable measures. Instead, the rhetoric requires a battery of professionals to monitor the mother-baby dyad for months, if not years.

By reconstructing birth and now mothering as crisis through discursive manipulation, power is wrested and profit squeezed from mothers. As above, the changing discourse must be examined critically, in detail and as it relates to actual maternity care, in order to reveal which assumptions of health and illness, of power and powerlessness, are operating. It is crucial to avoid assessing such changes from a naïve perspective which presupposes that it is only value-free scientific research aimed at improving client health which determines professional practice.

[12] It is important to recognize that the research which associates PTSD with perceptions of dangerous or inadequate care (e.g., Creedy, Shochet & Horsfall, 2000), completely disregards whether these perceptions are objectively true, as if care is never sub-standard and many mothers are simply disposed to be paranoid.

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