

Best Be the Ties That Bind: The Medicalization of Mother Love

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Feminist scholars have argued that mothers have been subject to intensifying regimes of medicalization in our society. While many feminists have focused on the medicalization of reproduction and childbirth (Fox and Worts 1999; Lee 2003; Rothman 1982), other theorists have observed the ways in which medical expertise has attempted to regulate women's behavior in their roles as mothers (Apple 2006; Malacrida 2002; Rafalovich 2001). These perspectives have shed great light on the ways in which motherhood has become an experience that is dictated and regulated by external authorities.

This article contributes to the growing literature on the medicalization of motherhood by focusing on another facet of medicalized motherhood: the medicalization of maternal emotion or mother love itself. In the same way that some medical authorities have attempted to establish standards and guidelines for normal birth or infant feeding, this paper argues that other medical authorities have worked to normalize the maternal bond. A mother's love has become another object of scientific observation and intervention.

Given the centrality of maternal love for contemporary understandings of motherhood, this paper will examine the discursive processes by which maternal emotion came to be viewed as problematic in modern society. The purpose of this study is not to consider the truth or nature of maternal emotion. Instead, this study will identify the discursive techniques by which maternal emotion was constructed as threatened. Not only do these techniques reveal the social nature of truth-making but they also reflect the cultural anxieties underlying the social construction of mothering as threatened. In this paper, I will argue that our understandings of maternal love are shaped by intersecting discourses of biology, motherhood and modern society. Significantly, this paper will consider the social regulatory possibilities produced by the medicalization of maternal emotion. Using a Foucauldian perspective, I will argue that the

discovery of mothering disorders problematized the early relationships of mothers and their children and provided the justification for the surveillance of all new mothers. As mothering behavior was “normalized,” mothers became disciplined subjects whose behavior and thoughts were suspect, even to themselves.

In particular, this paper is a contribution to the literature on medicalization and motherhood in several ways. First of all, by building on prior work on the medicalization of pregnancy (Lupton 1999; Rapp 2000), childbirth (Rothman 1982; Fox and Worts 1999), and the postpartum period (Lee 2006), this paper argues that concerns about mothering extended maternal regulation to the realm of emotions. Maternal regulation was intensified as feelings became the subject of medical scrutiny and intervention. Additionally, this paper argues that it was the medicalization of children that was a powerful force in the emotional regulation of their mothers. In the case of the medicalization of maternal emotion, behavioral disorders and developmental delays in children were directly linked to deficits in the mothering they received. However, rather than viewing these mothers as bad, the medicalization of maternal emotion constructed these women as victims who required expert interventions in their lives. Finally, this paper emphasizes the importance of discourses of risk in the achievement and maintenance of medicalization. It is the successful claims of risk that gives constructions of threatened motherhood their regulatory power.

THEORETICAL PERSPECTIVE

Sociologists have argued that our society has been subject to increasing medicalization, the process by which medical definitions and frameworks are being applied to an expanding array of human problems and behaviors. Conditions that were previously viewed as natural or God’s will are now viewed through the lens of pathology. The growth in medicalization is

alarming because it is inextricably linked to social control. To submit to medicalization is to recognize the authority of experts, usually but not always medical personnel, to define the boundaries of normalcy, to classify individuals as well or sick, and to intervene in the lives of the ill or those believed to be at risk for illness.

Central to medicalization is a process of claimsmaking. As Conrad and Schneider (1980) argue, medicalization is a social accomplishment in which medical understandings of problems come to dominate. Drawing on the social constructionist theory of social problems, Conrad and Schneider argue that “illness is a social construction based on human judgments of some condition in the world” (Conrad and Schneider 1980:31). Medicalization is the consequence of the triumph of medical definitions of a problem with a resulting increase in power for medical professionals who now have legitimacy to diagnose and treat victims of the medical disorder. In their examination of why medicalization triumphs, Conrad and Schneider suggested that those in power are more able to impose their definitions. By contrast, Joel Best (1987) argued that the success of claimsmakers can also be attributed to their skill in rhetoric. In this perspective, medical professionals are viewed not as objective scientists who discover reality but instead as moral entrepreneurs who seek to persuade others. Medical claimsmaking can be witnessed in medical journals, academic conferences, and the mass media.

Critics of medicalization have noted that women have been particularly vulnerable to projects of medicalization. Historically, medicine often held the male body as the standard against which women were compared and often found failing (Lorber and Moore 2002). But more importantly, the medicalization of women was driven by their social role as mother. As mothering was linked to a growing array of social problems, such as infant mortality, juvenile delinquency, and poverty, mothers were held accountable (Hays 1996; Ladd-Taylor and

Umansky 1998). Medicalization offered the hope that previously nonmedicalized social problems could be solved through interventions in mothers' lives.

The regulation of mothers that results from medicalization exemplifies modern social control as conceived by Foucault. In writing about power, Foucault (1980) argued that we must move beyond negative understandings of power associated with the state that emphasize "refusal, limitation, obstruction, censorship" (p. 139). Power is also positive because it is productive through "mechanisms that shape and proliferate—rather than repress—desire, generate and focus our energies, construct our conceptions of normalcy and deviance" (Bordo 2003:167). In other words, power shapes us as modern subjects. The medicalization of mothers incorporates both understandings of power. At the extremes, the medicalization of mothers is consistent with negative power because failure to comply with medicalization can result in criminalization for neglect or abuse (Lupton 1999; Weir 2006). However, in most instances, the medicalization of mothers typifies positive power as women are persuaded to comply with medicalization in the interests of their health and the health of their children.

Nearly all facets of the role of mother have become medicalized. For most women, pregnancy and childbirth are experiences that are carefully monitored and administered by medical personnel (Lupton 1999). After birth, the medicalization of mothers, while less physically intrusive, continues as mothers' feeding and childrearing practices are monitored through well baby visits (Litt 2000). Other authors have noted that the mothers of disabled children are subject to even more extensive medicalization as their responsibility to their children continues to adulthood (Malacrida 2002; Rafalovich 2001).

This paper will contribute to this literature by examining the discursive processes through which the medicalization of maternal emotion was accomplished. This paper examines medical

and psychological literature on maternal emotion as these texts provide a location within which much discursive work was performed. Following Dorothy Smith (1987), I argue that studying these publications allows us to witness the operation of power as these texts represent a site for the accomplishment of truth. More importantly, these texts are significant because they form part of the “ideological apparatuses” of society which shape how we view ourselves and our society (Smith 1987, p. 17). Using a genealogical approach, I assume that examining claims will reveal the social interests underlying the medicalization of maternal emotion.

THE DISCOVERY OF PROBLEMATIC MOTHERING

Early Medicalization

In the Euro-American world, maternal love was promoted and idealized in the late 18th and 19th centuries (Lewis 1997). In the creation of separate spheres that occurred during this time, the home was defined as a haven of love and sentiment with mother at the center in contrast to the cold, materialistic world of men. With the construction of Victorian era gender roles, maternal love was understood as an extension of women’s inherent virtue. Good mothers were loving mothers while mothers who failed to love or dote on their children were condemned as selfish or unnatural (Badinter 1980.)

In the late 19th century and early 20th century, all aspects of motherhood, including maternal emotion, came under greater scrutiny with the rise of scientific motherhood (Apple 1995). Mothers were encouraged to look to science and childrearing experts to guide their mothering practices. Mothers’ instincts or advice from their own mothers or other women was considered inferior to the knowledge of scientific experts. Scientific motherhood can be viewed as the beginning of the medicalization of mothers as doctors played a prominent role in the ideology of scientific motherhood. Mothers were encouraged to look to their doctors for advice

and instruction in the care of their children. Initially, the medicalization of motherhood emphasized the physical health of children. But overtime, the mental health of children demanded that doctors scrutinize mother's emotions. The emergence and prominence of psychoanalytic thought in the 20th century was instrumental for the medicalization of maternal emotion. Freud's focus on the family in the early psychic history of the child facilitated the idea that early family experience was responsible for a host of later mental health problems in children. Such a view legitimated mother-blame as has been noted by many sources (Ehrenreich and English 1978; Ladd-Taylor and Umansky 1998). Much research of the early to mid-20th century attributed children's mental health problems to failures in mothering. The belief that what mothers did would have such permanent consequences for both the individual and the society legitimized the medicalization of mothers. Social problems became viewed as problems with mothers.

Initially the medicalization of maternal emotion focused on instructing mothers on appropriate behavior. John Watson (1928), in his *Psychological Care of Infant and Child*, expressed concern about "[t]he dangers of too much mother love" (p. 69). He argued that mothers were overly attentive and affectionate with their children and risked spoiling their children. Not surprisingly given his behaviorist approach, Watson understood the problem of excessive maternal attention as one of proper education of mothers. In his view, problematic mothers were ignorant at best and willfully resistant to science at worst, but he did believe that mothers could be reformed (Watson 1928). Ultimately, Watson viewed the practices of mothers as moral decisions. Good mothers chose to follow his advice and refrained from displaying too much maternal emotion while the mothers who loved too much were morally condemned for spoiling their children.

But the rise of psychoanalysis led to the view that perceived inadequacies in mothering and maternal emotion were indicative of a medical problem in the mother. Rather than being described as immoral or sinful, failing mothers came to be understood as sick. Maternal emotion played a central role in healthy motherhood as many texts on mothering discussed maternal love and maternal behavior interchangeably (see Levy 1943 for example). In the process of identifying the sources of maternal disorder, experts engaged in the construction of a normal and “natural” motherhood that would result in healthy, well adjusted children. Consequently, maternal emotion became worthy of medical scrutiny because it was viewed as the foundation of successful mothering and healthy children.

Early medicalizers drew from the discourse of psychoanalysis to account for disordered mothering. Those who were most closely affiliated with psychoanalysis tended to see mothering as inherently precarious due to a combination of biological and psychological processes. As Helene Deutsch (1945) stated in *The Psychology of Women: A Psychoanalytic Interpretation*, “. . . there is hardly a woman in whom the normal psychic conflicts do not result in a pathological distortion, at some point, of the biologic process of motherhood” (p. v). The psychological process of motherhood was considered even more precarious as psychoanalysts believed that the acquisition of femininity, necessary for motherhood, was particularly fraught with difficulty. As Freud (1933) explained, the psychological development of girls was more difficult (than for boys) because the acquisition of femininity required that girls transfer their attachments from their mothers to their fathers. The engine behind this process was a girl’s feelings of inferiority over her lack of penis. She blames her mother and “subjects the whole female sex to her utmost contempt (Brody 1956:379). When the girl transfers her desire for a penis to a desire for a baby, she has successfully achieved femininity. As a feminine woman, she has embraced passivity and

even masochism (Deutsch 1945). As Deutsch (1945) elaborated, “the highest stage of maternal love, motherliness, is achieved only when all masculine wishes have been given up or sublimated into other goals (pp. 306-307). Thus normal maternal emotion required that women successfully navigated the Oedipus complex.

However, not all women successfully achieve femininity and thus their ability to love suffered. According to Freud (1933), some women’s response to the castration complex was an exaggeration of masculinity. These “masculine” mothers’ resentment of the female role can be witnessed through disordered mothering. In the article “Maternal Conflicts,” Karen Horney ([1933] 1967) argued that these mothers were likely to be domineering, either being too controlling with their children or counter-intuitively, too lax or uninvolved in their children’s lives. Sometimes these mothers showed an over attachment to their daughters, alienating their daughter from the female role and thus repeating the cycle.

The psychoanalytic framework led to the creation of two new, sometimes indistinguishable disorders of mothers: maternal over-protection and maternal rejection. David Levy, the leading scholar of maternal over-protection, argued that one could identify maternal protection in the “excessive maternal care of children” (p. 37). However, maternal over-protection was ultimately a disorder of maternal emotion as he argued that maternal over-protection could either result from “exaggerated maternal love” or from a mother’s attempt to compensate for her underlying rejection of her child (Levy 1943:23). The identification of maternal rejection was similarly unclear since the emotional rejection of a child could be expressed through maternal over-protection, owing to a mother’s guilt over her rejection of the child or the actual neglect of the child (Figge 1932). Despite the lack of clarity in diagnosis of these disorders, their identification as maternal disorders demonstrate the concern that maternal

emotion can be problematic. More revealing were the attempts of researchers to account for the existence of these disorders of motherhood. Levy linked maternal overprotection to a long list of environmental factors, many of which could be linked to social class. In particular, Levy argued that poverty, being required to work from a young age, and premature responsibility due to the death of a parent was likely to contribute to maternal overprotection. While he did recognize situation specific factors like the illness of a child might contribute to a mother's intensive care of the child, Levy also argued that "primary affect hunger," a lack of love in one's own childhood, could also contribute to maternal over-protection. Other authors linked maternal rejection to a mother's dissatisfaction with her marriage (Newell 1934; Newell 1936) or her unhappy childhood (Figge 1932).

With the discovery of maternal over-protection or maternal rejection, the early medicalization of maternal emotion created an important role for doctors, psychotherapists, and social workers. The paradigm of maternal over-protection or maternal rejection guided the work of Child Guidance clinics. Levy (1943) recommended that mothers undergo psychotherapy designed to determine the source of her over-protection and provide her with insights of the harm she was causing in her child. In addition, Levy recommended environmental therapies intended to create distance between the child and the mother.

Underlying many of the discussions of disordered mothering was a belief that modern society was less supportive of mothers. Deutsch (1945) wondered "What is the psychology of a mother living in a social order in which there is no harmony between social custom and biologic factors (pg. 11)" In her work on the psychology of women, Deutsch noted the contradiction between the necessity for strong women in 19th century pioneer America and her biological inclinations. Symmonds (1939) attributed maternal rejection in part to women's frustrations at

not being able to achieve their own goals. In short, some early medicalizers of maternal emotion felt that modern society's emphasis on the individual contradicted the requirements of motherhood resulting in mothering disorders.

The writings on maternal emotion of the 1930s and 1940s established some key themes in the medicalization of maternal emotion. First of all, experts agreed that good mothering, which produced psychologically healthy children, required psychologically healthy mothers who were able to provide a healthy degree of love and attention for their children. As the writings on maternal over-protection and maternal rejection revealed, there was also a belief in an optimum level of maternal love which would produce the best results in children. Most importantly for the medicalization of mothers, maternal emotion was constructed as fragile or even precarious. Giving birth was no guarantee that a woman would fulfill her essential societal role. Consequently, doctors and mental health professionals claimed an important role for themselves in the identification and treatment of mothering disorders. Medical professionals were positioned as the defenders of maternal emotion, to whom the afflicted women could turn to for help.

Attachment Theory

The early medicalizers of maternal emotion tended to view maternal love as the culmination of a developmental process that began in childhood. As such, maternal love was viewed as precarious because there was much that could go wrong in a woman's psychological development. By contrast, later medicalizers of maternal emotion tended to view the development of maternal love as a nearly instantaneous process, related to pregnancy, birth, and the postpartum period. Because the time frame through which maternal love developed was shorter, the risks related to failure in maternal emotion were considered to be greater.

Ironically, unlike the earlier medicalization of maternal emotion which focused on mothers' interactions with their children, this new wave of medicalization of mothers emerged from a focus on troubled children who lacked mothers. The rise of attachment theory, which was based on research on children raised in the isolation of the institution, was very significant for the medicalization of maternal emotion. While attachment theory ostensibly focused on children, the behavior of mothers was invoked almost immediately.

For the early attachment researchers, attachment was synonymous with love (Ainsworth 1969). The main tenet of attachment theory was the belief that infants must form an emotional attachment with their caregiver as the foundation of future emotional and mental health (Karen 1994). John Bowlby (1951), in his review of the literature of institutionalized children, argued that the children were suffering from a malady he termed "maternal deprivation." While children of institutions may have enjoyed the best health care, Bowlby argued that these children suffered development delays and emotional disturbances because they lacked loving caregivers. Bowlby's work was buttressed by animal studies that showed that neglected animals also seemed to suffer from psychological and physical problems due to a lack of caregiver. As Diana Eyer notes in her critique, it is revealing that infants were diagnosed as suffering from maternal deprivation, as opposed to any other type of deprivation (Eyer 1992).

In Bowlby's later work on attachment, he viewed an attentive, loving mother as evolutionarily necessary for an infant's survival and mental health (1969). However, he did not assume that a mother's loving response was predestined or assured. In his view, an infant engaged in instinctual attachment behaviors designed to maintain proximity of the primary caregiver, usually the mother. Bowlby argued that a (biological) mother was predisposed to respond to her child, particularly due to hormones related to birth, but his theory did not insist

that mothers would necessarily mother. Rather, Bowlby (1969) viewed the mother's response to her child's attachment behaviors as an amalgam of "her own native endowment, but a long history of interpersonal relations with her family, as well as values and practices of her culture" (p. 342). What was important for Bowlby was that the mother's response to her child determined the quality of attachment of the child which in itself determined the child's future well being.

Mary Ainsworth's research which applied Bowlby's principles of attachment revealed that mothers did not always respond to their children in ways that promoted their children's attachment. Through the development of her famed "Strange Situation" test, she found that she could evaluate the degree of attachment a child had to its mother, and not surprisingly, found that a highly sensitive mother who was most aware and responsive of her infant's needs and most affectionate was most likely to have a securely attached child (Ainsworth 1979; Russel and Ainsworth 1981).

The work of attachment theory facilitated the medicalization of mothers in important ways. By relying on biological models of behavior, attachment theory suggested that there was indeed a natural and correct model of mothering and at the same time, attachment theory provided evidence that some mothers were failing to perform their biologically dictated roles. While attachment theory did not directly address the reasons for mother's failures (Bowlby cited previous research that found failing mothers to be suffering from unresolved conflicts (1951)), it did set the stage for the medicalization of mothers through highlighting the detrimental affects of such failures on children.

Bonding

In the wake of the discovery of child abuse (Pfohl 1977), researchers began to study the dynamics of maternal attachment. In a round table sponsored by the Johnson & Johnson Baby

Products Company, the failure of some mothers to properly attach to their children came to be understood as “mothering disorders” which could result in fail-to-thrive infants, child abuse and neglect (Klaus, Leger, and Trause 1975). Klaus and Kennell (1976a) described “the mother’s attachment to her child [a]s the strongest bond in the human” (p. 1). Maternal attachment was considered essential because it was believed to be both the source of a mother’s willingness to care for her dependent infant and the foundation of the infant’s future ability to form relationships (Klaus and Kennell 1976a).

As with the earlier medicalization of maternal emotion, bonding research constructed a normal motherhood which would result in psychologically healthy children. Because it was assumed that animals and humans shared a similar problem of assuring the care of dependent young, researchers argued for a common “evolution of similar patterns of maternal behavior in humans and other animals” (Trause, Klaus, and Kennell 1976:16). Researchers believed that animal mothers could provide useful insights to understanding human motherhood. Through field and laboratory studies of primates and other higher animals, researchers developed the understanding that it was a mother’s attachment for her child that resulted in her providing the necessary intensive child care. While Klaus and Kennel (1976a) argued that maternal attachment could be witnessed through a set of “behaviors such as fondling, kissing, cuddling, and prolonged gazing” (p. 2), attentive behavior wasn’t enough, because much like the over-protective mother who secretly rejects her child, a mother who went through the motions could still “put out these cues that she’s not aware of at all” (Fraiburg 1975:17). Maternal attachment required both an emotional bond and a set of behaviors that maintained proximity with one’s child.

Bonding researchers were keenly aware that maternal attachment could be a problematic process, with lasting consequences for mother and children. In research on animal attachment, it was found that animals failed to show mothering behavior if they were separated from their young. In fact, rats and goats would reject their young if separated from them immediately after birth (Trause, Klaus, and Kennell 1976). Researchers believed that postpartum hormones seemed to increase maternal responsiveness in an animal; in other words, her attachment to her young. If an animal was not introduced to her young during this critical period, it was believed that she was likely to reject her child or engage in troubled maternal behavior (these early studies were later criticized, see Eyer 1992). It was hypothesized that human mothers also shared a “critical period” for developing attachments to their babies.

The medicalization of human maternal emotion was accomplished through a process of domain expansion (Conrad and Potter 2000). Domain expansion refers to the process by which medicalization expands from a rather narrow illness or condition to encompass an expanding group of conditions or behaviors. In the case of the medicalization of maternal emotion, it was the risks to maternal attachment that expanded over time. Initially, medicalizers focused on the “critical period” immediately after birth by focusing on the risks to mothers of pre-mature infants, probably because the use of incubators and hospital procedures greatly reduced physical contact between mothers and their pre-mature infants. Barnett et al. (1970) published a pilot study in which mothers of pre-mature infants who were encouraged to interact with their children were compared to mothers whose interaction was minimal. While admitting that their study offered little basis for a conclusion, the authors suggested that there were differences in the mothers’ commitment to their children, confidence in their mothering skills, and stimulation of their infants based upon the amount of separation. Later research focused on the experimental

manipulation of early separation on the mothers of full term infants finding that mothers who were permitted more time with their infants after birth were more likely to provide prompt care for their children, less likely to go out without their child, and more likely to be affectionate (Klaus et al. 1972). While the initial findings of these studies were often weak (Klaus et al. 1972 reported non-statistically significant findings) and based on small samples (see Eyre 1992 for a critique), the research was significant for the medicalization of maternal emotion because it provided scientific evidence that initial separations of mothers from their infants might spawn mothering disorders.

Klaus and Kennell (1976b) expanded the domain of risks to maternal attachment through a rhetorical strategy that romanticized the past. Often through describing customs of other, often less developed cultures, they constructed modern cultural practices as threats to maternal emotion. Western birth practices were contrasted with those of other cultures in which childbirth occurred at home often in the presence of family. Implicit in these accounts was the belief that mothering disorders were a new problem linked to modern practices. Klaus and Kennell (1976b) argued that the increasing medicalization of Western childbirth was jeopardizing mothers' ability to bond with their children. The rise in Cesarean births, the use of anesthesia in labor, and common hospital practices that focused on inspecting and cleaning newborns were viewed as risks because they interfered with the critical period in which mothers were posited to be hormonally primed to bond with children (Klaus and Kennell 1976b). Even the clinical environment of a hospital was viewed as a threat to maternal emotion because it was impersonal and de-humanizing, hardly a basis for establishing emotional attachments.

But the risks to maternal attachment were not limited to the period immediately after birth. Bonding researchers also argued that modern family structure and changing gender roles

threatened maternal attachment. “One of the most tragic aspects of the nuclear family culture in the Western world is that many, if not most, young women are never exposed to caretaking of children before they have their own” (Brazelton as cited in Klaus and Kennell 1976b:40). In addition to this perceived lack of experience with children, the isolation of American mothers was constructed as a risk to maternal attachment. Because of a lack of extended family, it was argued that American mothers would not enjoy the needed time to focus on her infant after birth because she would need to perform household duties in the absence of social support (Klaus and Kennell 1976b). In addition, the changing gender roles of modern society were also viewed as threats to maternal attachment. Not surprisingly, working was constructed as a threat not only because this would entail physical separation between mother and child but also because it would result in a mental distance. In a more recent book, *Bonding*, Klaus, Kennel and Klaus (1995) argued that mothers who were planning to work might resist the bonding process for fear that it would be too hard to leave their children. Under these conditions, maternal bonding was viewed as particularly difficult in modern society.

THE NORMALIZATION OF MATERNAL LOVE

The medicalization of maternal emotion established a prominent role for doctors in the diagnosis, treatment and prevention of mothering disorders. The proper identification and treatment of mothering disorders required the medical practitioners receive instruction in observation and treatment of abnormal mothers. In the earlier medicalization of mothers, such observation and intervention had to occur when children were beyond infancy because this was when problems of over-protection or rejection could best be witnessed. It was only when children are capable of independence that one can see evidence of a mother’s over-protection. The later medicalization of maternal emotion greatly extended the monitoring of mothers.

During pregnancy, practitioners were instructed to watch for behaviors that would suggest a rejection of the pregnancy such as “a preoccupation with physical appearance or a negative self-perception, excessive emotional withdrawal or mood swings, unusual anxiety or feelings of depression, excessive physical complaints, absence of any response to quickening, or the lack of any preparatory behavior during the last trimester” (Klaus et al. 1995:8-9).

When there was evidence of mothering disorders, the earlier medicalization of maternal emotion placed great emphasis on treatment of mothering disorders through the use of psychotherapy. This is perhaps unsurprising given the psychoanalytic frameworks that seemed to assume that maternal emotion would always be somewhat problematic. Levy (1943) recommended that mothers undergo psychotherapy designed to determine the source of her over-protection and provide her with insights of the harm she was causing in her child. In addition, Levy recommended environmental therapies intended to create distance between the child and the mother. While the later medicalizers also embraced the use of psychotherapy once a mothering disorder was discovered, their greatest hopes and efforts centered on the prevention of mothering disorders. Their careful study of other cultures and animals allowed them to construct the boundaries of normal birth and mother-infant interaction. However, while their emphasis on normal mother-infant interaction developed in their attempt to identify and prevent mothering disorders, they also developed a maternal script which both constituted normal behavior but was also viewed as a way to prevent mothering disorders. Deviations from the script were both evidence of mothering disorders but also risk factors for the development of mothering disorders. Following the maternal script was believed to offer protection against mothering disorders.

The maternal script included birth practices, a women’s behavior after birth, as well as her underlying emotions. Because bonding was a process that was viewed as a “dangerous

opportunity” (Klaus et al. 1995:5) given belief in a critical or sensitive period, birth received great significance. Bonding researchers used the birthing and family practices of non-industrial cultures as models. Klaus and Kennell (1976b) argued for the importance of emotional support in labor and discouraged the use of anesthesia in childbirth. But it was in the moments immediately after birth that the script was the strongest. After birth, new mothers were instructed to look into the eyes of their infant, hold their naked child, preferably with skin to skin contact, and breastfeed for optimal bonding (Klaus et al. 1995). In the days after birth, Klaus et al. (1995) recommended that a mother be sheltered for “at least three or four weeks so she can establish a rewarding rhythmic interaction with her baby . . .” (p. 124). After birth, the mother needed to feel protected so she could devote herself almost completely to becoming acquainted with her new baby (Klaus et al. 1995). This stage required “primary maternal preoccupation” in which a mother must learn to put herself in the place of her infant so that she may sense the needs of her infant (Klaus et al. 1995).

DISCUSSION AND CONCLUSIONS

Feminist researchers have argued that the medicalization of mothers constitutes the implementation of patriarchal social control. As mothers are taught to follow (male) medical authority rather than relying on their own judgment, patriarchal authority comes to govern women’s lives. But most studies of the medicalization of mothers focus on the ways in which medical authorities attempt to guide childrearing practices. While it is the mother who is subject to medical authority, it is the child who is defined as sick. Failure for a mother to comply with the medical instruction can be perceived as a matter of ignorance at best or evidence of a “bad mother” who fails to consider her child’s needs. While an ignorant or “bad” mother may be subject to the intervention of social services, she is still treated as an active subject, capable of

making decisions related to her mothering. A mother may be condemned for making the wrong decisions, but at least she is constructed as being able to make decisions within the discourse of scientific motherhood.

By contrast, the medicalization of maternal emotion constitutes a different form of the regulation consistent with Foucault's concepts of disciplinary power. As maternal emotion was studied, it became normalized through the social measurement of what is typical and presumably healthy, and the creation of the abnormal, the discovery of those who deviate from the social norm. As Adams (2004) argues, the creation of scientific norms comes to include descriptive and proscriptive components. Through projects of medicalization, norms are linked to concepts of health and thus what is normal becomes desirable, even moral. The normalization of maternal love becomes a system of moral regulation because a mother's love is so obviously considered a social good. If love is required to meet the social good of happy and healthy children, and love is achieved through following the maternal script, then normalization defines the ways in which mothers experience their connections to their children.

In the medicalization of maternal emotion, it is mothers themselves who are the target of medical authority because it is mothers who are constructed as healthy or sick. Instead of being "bad" mothers, mothers are constructed as ill and are subject to a degree of medical scrutiny that greatly surpassed the social regulation that occurred as a result of scientific motherhood. Not only must mothers' behavior be monitored, as in scientific motherhood, but in the medicalization of maternal emotion, they are obligated to submit to medical treatment if their behavior does not conform to expected standards of mothering. While a mother is not condemned morally for not conforming to expected standards of mothering, she is subject to more intensive form of social control by being required to submit to medical treatment. The medicalization of maternal

emotion invokes an intensive and intimate form of medical regulation consistent with Foucault's understanding of the operation of modern power. By relying on a discourse of risk that constructs all mothers as potentially ill, the medicalization of maternal emotion enlarges the degree of medical surveillance necessary. Because all or most mothers are impacted by psychoanalytic factors, hospital practices, or changes in modern society, all mothers are subject to medical surveillance. More importantly, because underlying emotion can only be inferred by medical practitioners, it is mothers who in the end must monitor themselves for the appropriate emotion. In this way, mothers become disciplined subjects who are both monitored by medical professionals but also discipline themselves (Foucault 1977). Mothers conform to the image of maternal love because discourses of maternal love "inform individual behavior, they act as grids for the perception and evaluation of things" (Foucault 1991:81).

The Social Context of the Medicalization of Maternal Emotion

The medicalization of maternal emotion represents the intersection of several cultural trends. While traditional scholars of medicalization have attributed projects of medicalization to the expansion of the medical sphere into more and more aspects of life, an examination of the claims by which medicalization of maternal emotion was accomplished reveals that there were other contributing factors. While the medicalization of maternal emotion certainly represents an expansion of doctors' arena of expertise, the rhetorical strategies through which medicalization was accomplished suggests that it was as much a product of cultural anxiety as it was an example of medical imperialism. In particular, the medicalization of maternal emotion signifies the intersection of understandings of children, anxiety over changing women's roles, and a romanticization of the past.

First, it was closely affiliated with changes in the common understandings of the nature of children. In colonial times, the common image of children was that of sinners whose behavioral problems must be corrected with strict discipline, often applied by the father. However, in the mid 19th century to early 20th century, understandings of children changed dramatically. Children of the middle classes and eventually the working classes came to be viewed as innocent, vulnerable and in need of a mothers' full time care (Farrell 2003; Hays 1996). Since children were assumed to be morally pure, their behavioral problems were often attributed to the faults in the mothering they received. The rise of psychoanalysis gave credence to the idea both that mothering is greatly influential in a child's life but also that mothers themselves may have internal conflicts that interfere with successful mothering practices. The (re-)discovery of child abuse in the 1960's gave even greater urgency to the monitoring of mothers.

The growing belief that what happens in early childhood is determinative of a child's life facilitated the medicalization of mothers. Even a mother's problems with mothering were attributed to the mothering she had received. Since mothering itself was believed the result of childhood experience, psychotherapy was promoted as the solution both to immediate mothering problems but also as a way to prevent future problems. The medicalizing of maternal emotion tended to individualize social problems because it focused attention on individual mothers while drawing attention away from other factors that may have been impacting children and mothers such as poverty, a lack of parental leave, or decent child care. In addition, by emphasizing the importance of mothers, it contributed to the development of intensive, child-centered ideologies of motherhood.

It is very significant that much of the project of the normalization of motherhood was based on animal research and anthropological interpretations of pre-modern societies. The medicalization of maternal emotion was a conservative project that normalized the past. By explicitly comparing modern American families to families in the developing world or of the past, medicalizers assumed that mothering disorders were a relatively new problem of the modern social order. As such, there was a romantic aspect in the problematization of mothering. Medicalizers tended to idealize a past in which mothers could devote themselves to their children. Modern social practices that interfered with a mother's ability to exclusively focus on her children were condemned such as isolated nuclear families, because mothers would have to perform housework and serve husbands, overly technological childbirth practices that interfered with key bonding moments, and not surprisingly, women's careers which would physically remove mothers from the home.

Anxieties over the impact of changing family and gender roles can be witnessed in the medicalization of maternal emotion. In an era of rapid changes in family and gender roles, the normalization of maternal love can be viewed as an attempt to establish some permanence in a rapidly changing world. Ulrich Beck (1992) has argued that in the risk society, the only permanent relationship that remains is that between parent and child. The medical scrutiny of the mother child relationship suggests that there was also anxiety about this most basic of relationships. By normalizing love, medicalizers were attempting to ensure an enduring relationship in a rapidly changing world.

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