Pregnancy and pregnancy planning in the new parenting culture 22nd and 23rd June 2010, University of Kent

Welcome and introduction to the event
Dr. Ellie Lee welcomed participants to the event, and thanked the Centre for Law, Gender and Sexuality at Kent University and British Pregnancy Advisory Service (bpas) for their support. She also thanked the ESRC for their support of the whole seminar series. Ellie explained the background to the seminar series, and the talked briefly about the research network Parenting Culture Studies. She explained that PCS is an inter-disciplinary network, and people involved in it research diverse issues. What binds PCS together, however, is an interest in the construction of 'parenting' as a social problem, and the associated distinction between child-rearing and parenting, which has at its centre a belief that parenting is both too important and too difficult to be left to parents themselves. The idea behind this event is such ideas around parenting are now being extended backwards into pregnancy and even pre-conception. Ellie noted how public discussion of this development was very apparent in 2006, when Tony Blair argued that measures should be taken to identify children at risk of behaving anti-socially pre-birth (the so-called 'foetal ASBO'). The idea that what a child will be like is profoundly influenced by maternal (and paternal) behaviour during (and even before) pregnancy has become growing theme in many spheres of society. It is hoped this seminar can mark the beginning of a process through which this development can be explored and its probelms illuminated.

Session 1: Extending parenting backwards? Pregnancy and pre-pregnancy in contemporary context
Chair: Jan Macvarish, Research Associate, CHSS, University of Kent
Papers: Elizabeth (Betsy) Mitchell Armstrong, Associate Professor of Sociology and Public Affairs, Princeton University, 'Do happier pregnancies make healthier babies? Stress and the medicalization of maternal emotion'; Cynthia Daniels, Professor of Political Science, Rutgers University, 'Policing pregnancy'.
Discussants: Frank Furedi, Professor of Sociology University of Kent and Janet Golden, Professor of History, Rutgers University

Betsy opened by showing a video from Medscape, featuring a doctor saying 'don't ask me how or why, but psychological stress kills the fetus'. She gave a list of a range of adverse effects associated with stress in the mother, including: pre-term birth, still-birth, fetal behaviour, impaired fetal development, higher infant stress reactivity, sleep disturbance, excessive crying, apgar score, colic, and even into childhood autism, ADHD, language delay, problem behaviour, schizophrenia, cancer in adults and even sexual orientation. What is stress though, Betsy asked? She defined it as the physiologic response to psychological and physical demands and threats ('stressors'). This involves a person-environment interaction; we all respond to this in different ways. It has been linked to disease – both in terms of sudden shocks causing disease responses, but also in a 'weathering' way, over a long-period. It is noted in the literature that stress is adaptive in acute situations; this can become mal-adaptive in light of constant stress. Stress in pregnancy was largely explored first in 1950s/60s, in the form of animal studies. It wasn't until 60s/70s that stress in pregnancy was looked at formally, particularly with respect to the relationship between stress and the workplace. There is a broad range of ways in which stress is conceptualised by

people. Such as – anxiety, daily hassles, work etc. It is characterised in a variety of different ways. Sometimes seen as a state, and other times as a trait (reaction).

How might stress effect the fetus? asked Betsy. There are many hypothesised mechanisms – is it hormonal? Via immune system functioning? Via indirect pathways? (e.g., if stressed, one might be more likely to use drink/drugs) Is the fetal programming altered? What is the evidence for the effect on the fetus? In fact, Betsy revealed, not much! The one outcome that is compelling is pre-term birth, and possibly therefore low-birth weight. All of the other effects appear rely on very murky, weak evidence. Yet, the idea that stress is bad for the baby has permeated public discourse. Yet the logic here is slightly flawed - all stress is linked under the same banner. Whilst it might be that a lot of stress is bad for the developing fetus, this does not necessarily mean that a little is bad. Nevertheless, Betsy noted that the responsibility for reducing stress is squarely on women's shoulders.

In historical perspective, it's not new that we worry about women being stressed in pregnancy. There has long been a notion of maternal impressions: the idea that something the woman sees/tastes etc can leave a direct effect on the fetus. ('Strawberry marks' on children were understood as a result of a mother's craving). These beliefs continue today – one recent project looked at relationship between consumption of chocolate in pregnancy and infant behaviour at 6 months.

Cynthia presented her paper next, and opened by listing 3 related phenomena:

1) Public pregnancy (warnings)
2) Policing pregnancy (prosecutions)
3) Invisible fathers (paternal-fetal harm)

She argued that:

1) helps to create a culture which make 2) possible, and both lead to 3).

Explaining, she said that traditional reproductive politics in the US has focussed on abortion. Recently, this has shifted to the management and control of the pregnant body. This is not simply at the level of drugs and alcohol but a long list of considerations around a range of foodstuffs: fish, meats, hot dogs, cheeses and even herbal supplements and teas. She argued that this perpetuated the idea that pregnant women are vulnerable to risks and hazards. The most visible campaigns around pregnancy have been on alcohol use such as the 'a pregnant woman never drinks alone' slogan. Yet what we are now seeing is how 'information' about fetal development extends is backwards to even the point where 'sexually active women who are not using contraception' need to be thinking about how their behaviour might affect potential children. Cynthia noted that smoking messages appear to be less intense than alcohol/drugs ones. This is curious as actually evidence about smoking being detrimental to fetal development is more direct than evidence for alcohol use (since it reduces oxygen levels).

She also noted that there have been 200 prosecutions of pregnant women since 1980 (in the US). 15 states, for example, consider substance abuse in pregnancy as child abuse. 33 states requite health care professionals to report to welfare authorities the suspected use of alcohol or drugs in pregnancy. In some cases where women have suffered stillbirth, they have been convicted of homicide by child abuse for using cocaine in pregnancy. One woman was sentenced to 12 years in prison for this crime,

despite a failure to prove causation between drug-use and still-birth. (She was released after 5 years). In conclusion, Cynthia argued that there was a presumed exclusive responsibility of women for fetal health/harm. Yet the male reproductive system is highly sensitive to physical/heat/toxins etc. For example, it takes 72 days from start to finish in the cycle of sperm creation, and there is considerable scope for drugs, smoking etc to have an effect on this.

Frank responded first to the papers, and noted that he was interested in the distinctive features of the moralising imperative towards pregnancy. These new features, or at least features that are distinct now, include:

a) An ambiguity in the discourse about pregnancy. Pregnancy is both celebrated yet problematised to the extent of caricature. Every problem can be associated with pregnancy if you want. In pregnancy there is now joined up fear-mongering: cigarettes, alcohol, stress etc all lumped together in pregnancy. From a sociological perspective, pregnant women operate as a symbol for wider society, in that we are recasting social problems as early as possible. Problems are also increasingly seen as behavioural problems, not structural ones (with respect to anti-social behaviour, and so on)
b) That pregnancy is interpreted as an opportunity for social intervention – good time to talk about everything from vitamins to smoking. This is an extended form of socialisation. The meaning of adulthood changes, to the extent that women become a conduit for educating the whole family. The way one would once have educated children, is now foisted on pregnant women.

Frank had one question for Cynthia: He said that there was a danger of making male reproduction the mirror-image of female reproduction. Is there not a danger in medicalising male reproduction in the same way as female reproduction?

Janet opened her response by saying that she would be offering a history frame to the debates. From this perspective you could look at the effects of stress – e.g. spontaneous abortion – as something that would once have been seen very differently as positive, in that in a eugenic frame it was weeding out the weaker individuals. She made 4 points: 1. Why is it so important to have happy babies? It's a very modern secular view – used to want fearful babies, trembling before God? When did we create the notion of happy babies? 2. In terms of the anti-abortion literature, we don't say 'ok, well, if you're stressed by pregnancy, why don't you have an abortion?' Not an option. 3. Men work but women have 'lifestyle choices' – implication that they can more easily change their habits. 4. We should be nervous about animal studies: huge danger here in making bad social policies with animal analogies.

Discussion

Ann Furedi The historical specificity of what we're talking about: It seems that there is such a focus on the fragility of fetuses. Until Thalidomide in 1960s, there was no idea that things could cross the placenta. Very historically and culturally specific

Ruth Cain How much of a connection is there with abortion and the Intensive Mothering idiom? There appears to be a mirroring of the science on each side of the birth.

Jennie Bristow Noting the trend towards commercial surrogacy in India, where women are kept in confinement (and kept healthy). Stress concerns seems to be about relational factors; notion that women should live in a very confined, isolated bubble. The ideal pregnant woman is now one that does not have relationships.
Jennifer Howze Women being refused alcohol in pregnancy. Linked to abortion politics? Women being 'too selfish' to bear a baby/restrain from drink
Tom Pengelly Sexual orientation and stress. Is there a homophobic aspect to this?

Responses
CD: Yes – this movement towards regulating pregnancy does seem to have grown out of the anti-abortion movement. Child as victim.
BA: It's not necessarily the case that there is a relationship between the two (pro-life and regulation of pregnancy movements). In fact, it's a much deeper shift around how we see the fetus, which drives both movements. Discourses about the rights of the unborn child begin early 20th C.
To Ann Furedi: The duality of pregnancy – both sacred and profane, that we revere and are revolted by. Both fragile and hard to achieve, and in other instances hard to get rid of.
CD: The strength of the evidence to assess risk – totally disproportional; some stories more compelling than others.
Sally Sheldon: to CD. Idea of fetal harm being the result of life-style choices for women, work for men. In UK we don't have criminal prosecution, but civil liability, so child can later sue parents. You can sue your father, but not your mother. Because men will be exposed at work (therefore suing the employer) and seen as 'unseemly' for children to sue mothers.

Summing up
FF: Relationship between rights of fetus and abortion discussion – assumption that what happens in childhood determines what will happen later on. Based on notion that as soon as you elevate rights of the fetus you flatten out human subjectivity; consciousness and experience. Ratified culturally through brain research – which is increasingly deterministic.
BA: I am also a demographer – relationship between human fertility and offspring. Shift from quantity to quality of children.
CD: There seems to be a historical tension here: how do you put reproductive needs on the agenda without extending the power of state surveillance? Ended up with the idea of the public pregnancy. We need to push back against that.

Session 2: Fatherhood and parenting culture
Chair: Sally Sheldon, Professor of Law, University of Kent
Papers: Tina Miller, Reader in Sociology, Oxford Brookes University, 'Men and 'bonding': fathers' expectations in the antenatal period'; Jonathan Ives, Lecturer in Behavioural Science and Heather Draper, Reader in Biomedical Ethics, Centre for Biomedical Ethics, The University of Birmingham, 'Should we strive to involve men in a meaningful way during pregnancy? Rethinking men's involvement in antenatal care'
Discussant: Mary Ann Kanieski, Assistant Professor of Sociology, St.Mary's College, Notre Dame

Tina presented her findings from a recent study exploring fatherhood: Small in-depth study; qualitative and longitudinal; White, heterosexual, employed, professional men; Interviewed in late antenatal period, early postnatally and late postntally. Findings were that fathers were seen as 'detached', but willing learners. They emphasised 'being there' for their children. They wanted it to be different to what they had experienced with their own fathers (emotional, not economic). They wanted to 'fit fathering in' to the rest of their lives – which Tina noted was something that mothers would not be able to say! She said that there were clearly dominant discourses about ideal fathering, which also shape what can and can't be said. The 'Possible story lines' are not so open to mothers as to fathers – parenthood is not so morally inscribed for men. So, whilst men are subject to new discourse of 'involved fatherhood' it is not expected of them to know what to do, unlike women. Much more 'uncertain' in this terrain – able to position selves as willing learners: social and political images. All fathers spoke about preparing appropriately – accessing information, classes etc. Yet there was a tension in wanting to be involved, but recognising that they don't have the same emotional involvement as mothers. How do these changes shift the boundaries around how we see motherhood, if we are changing the role of fatherhood? Men have a wider repertoire of story lines than women, but ambiguities remain too.

Jonathan and Heather opned by saying men's involvement in antenatal care is part of a wider narrative around the modern father; physical and emotional presence, overlying an economic and social responsibility. There are tensions here: implicit breadwinner role is always the bottom line. Fatherhood has extended back – men are expected to attend consultations/classes etc (95% now do, NHS) Similarly, the Child Health Strategy (2009) talks about very important role that father plays. This may be an encouraging, but what does 'involvement' in antenatal care mean in practice? How is it justified? Jon and Heather suggested three kinds of involvement: 1. Man's interest in shaping his own responsibilities as father. Yet even in this, it is mother who has final say – her bodily integrity oughtweighs his intentions to be a father. (Easy when mother and father are together, not so much if acrimonious). 2. As an advocate for mother – pregnant women can easily be isolated. The father then acts a means of padding out the numbers; he is an extension of the person he is representing (not as person in his own right). Involvement justified only as far as he is being an effective advocate – probably not as effective as e.g. a doula. Men can't put their own interests forward. This, in turn may erode their confidence/lack of respect. 3. Role as father to protect child's interests: Women have an equal obligation to allow men to do this. Problems: Parents may not agree about best interests. Also, unclear what it means to be a father to a fetus, as it is future oriented.

Maybe, then, there's little men can do, though they can have feelings of fatherly concern. Not clear though that through ante-natal classes that this is the best way to proceed in fostering them. Thus the policy to encourage paternal engagement requires a distinction between future children in general, and specific future children. There is no one-size-fits-all policy. Certainly, failure to engage with atenatal services is not indicative of failure of responsibility. There are a variety of ways men can prepare for fatherhood (e.g. preparing home/giving up smoking). These are forms of involvement. Idea that both parents should be equally 'involved' in the same sort of labour overlooks quality of labour and character of people involved. Overt attempts to 'involve' men may run risk of creating him as a passive bystander and it is potentially

disastrous if man's first experience of fathering is of being surplus to requirements. Women are also disadvantaged – they feel obliged to engage a partner, even if they don't want to.

Mary Ann opening her response to this paper by stating that in the continuing process of the medicalisation of parenting one of the most pervasive trends is the intensification of fatherhood. Jon and Heather are attempting to integrate public and private here. The State has an interest in involved fatherhood (e.g. economic benefits in later life). Will attempts on the part of the State to influence private life have the right effects though? Why do we construct fatherhood in relation to child well-being? Why can't it just be for fun and enjoyable? We need to re-think the concept of interests – we are missing the concept of family; interests of all members must be balanced. Fathers are problematically presented in much of the discussion of this issue as having separate interests, which replaces the family with a collection of individuals with opposing interests. Of Tina's paper, she asked, Why is involved fatherhood being idealised? Why is this emerging in this period of time? Which groups of fathers are we talking about? Is it linked to the fact that the breadwinning role is harder to sustain individually? Both papers, said Mary Ann, point to the fact that a new form of fatherhood is emerging. Tensions between work and family continue in our time.

Discussion

Jan Macvarish Do men ever complain about being dragged into the banality of domestic life?

Ann Furedi The idea of family being absent is very true. But we have to admit that there *is* an alienation of fathers – is it not a product of the social constructionist way of looking at fathers? Men ARE excluded. They cannot conceive, birth etc. Does this mean they are excluded from fatherhood? No, absolutely not! It's like we're trying to construct them into this birthing process, when we really can't.

Jennie Bristow What is the father involved in? It's with an ideology, not actually with their partners or children. It's about tasks, not emotions. Secondly – idea that men don't talk to each other the way women do. If this is true; how do men absorb and resist attempts to involve them in good fathering? A lot of it is coming through their partner – makes them the enemy. Quite disruptive of couple relationship.

Ellie Lee We should pursue the rise of Male PND as a social phenomenon; any kind of curiosity about the idea a man CAN have male PND seems to be absent; it sems the idea of any link between biology and PND has been set aide. We should also ne very concerned about recent materials from the DH on engaging fathers – leaflets about what men should do about breastfeeding, smoking and alcohol in pregnancy. No sensitivity about how destructive it can be to treat parents as separate units; idea that there can be a spontaneous intimate relationship is threatened. Trying to get the father to change what the mother does in the interests of the child is destructive.

Responses

TM: My study set out to look at men's fatherhood experiences, not involved fatherhood per se. Gender and masculinities.

JI: Seems to be an ideal; roles fathers are expected to play seem impossible (e.g., making the decision about when to go in to hospital for birth). Symbolic act of fathers cutting the cord – driving a wedge between mother and child.

Discussion

Vivienne Brady Do antenatal classes perpetuate medicalised discourses? To JI: Where is the midwife in all of this?
Pam Lowe What is often overlooked is how in a lot of policy developments we have a very classed agenda. The NCT model of what pregnancy and parenting should be has enormous power in policy circles. Their idealised view is what gets rolled out in policy. Overlooks issues around power and control. The more involved fathers are in pregnancy, the more violence against women gets disguised (as women have less space to speak out). Involvement is a double-edged sword.

Session 3: Pregnancy, drugs and alcohol in contemporary parenting culture
Chair: Ellie Lee, Kent University
Papers: Janet Golden, Professor of History, Rutgers University Alcohol, pregnancy and harm-reduction: a review of the American experience; Pam Lowe, Lecturer in Sociology, Aston University Under the influence? The construction of Foetal Alcohol Syndrome in the UK ; Polly Radcliffe, Research Associate, University of Kent Substance misusing women and pregnancy. Problematised mothers and the management of spoiled identities
Discussants: Elizabeth Mitchell Armstrong, Associate Professor of Sociology and Public Affairs, Princeton University and Pat O'Brien, Consultant & Honorary Senior Lecturer in Obstetrics and Gynaecology University College Hospital London and spokesperson, RCOG

Janet focussed on the history of the construction of Fetal Alcohol Syndrome (FAS). May 31st 1977 – 1st child with FAS met the media who was mentally retarded with other defects. The next day, the National Council on Alcoholism announced that women who had more than two drinks a day in pregnancy had a risk of giving birth to damaged babies.
Phase 1 1973-77. Discovering the offspring of alcoholic women. Medical literature detailing association between alcohol and damaged fetal development emerged. Coincided with visibility of female alcoholism. There was a correlation with legalised abortion – if a woman is an alcoholic, should she have an abortion? Becomes rapidly politicsed and medicalised.
Phase 2: 1977-1986. The crusade to warn. Conflicting logics between teratology and epidemiology (former – all react differently, hence must take utmost caution, latter works on a percentage logic). Again recommendation from authorities is to limit self to two drinks per day. In 1981 a new warning was issued– pregnant women and those trying to become so should avoid alcohol.
Phase 3: 1986-1990. The discourse of law and responsibility. Debates about fetal rights, and FAS shifts from from individual tragedy to evidence of misconduct by women. Labels on bottles warning women about the risks of drinking in pregnancy were introduced. This concern was specifically linked to ethnic minorities
Phase 4: Since 1990. The death row debates. Inmates seeking leniency on grounds of FAS. Janet noted that it is interesting that alcoholism is seen as a disease, until one is pregnant and then it's a woman's fault. But what sort of accountability for the 'victim' of FAS?

Pam's paper was designed to trace the 'why now'? question of British policy. She noted that images of pregnant women are almost always of woman with a glass of wine – middle class model or pregnancy. There has been an 'FASD migration': FAS identified in alcoholic women in the US… but now quickly caught up in Europe. We

have gone straight into the idea that it's all women who are 'at risk' of it; a democratised threat from the start. Also, arrived as FASD; not FAS but a range of disorders. This has really taken off since about 2000, previously very little attention. Linked to arrival of claimsmakers such as the organisation NoFAS. Little wide-spread support to begin with but there was a peaking of interest in FAS in 2007. DH and NICE producing recommendations which were counter to each other, despite meaning to be evidence based. For example, the advice to pregnant women has changed to promote abstinence, despite there being no evidence for this as more beneficial to the fetus than light to moderate drinking. The consumption of alcohol is now considered a social problem – in terms of anti-social behaviour, and it is young women in particular who are focused on as problematic binge drinkers. Classed arguments; specifically young women as risk to fetuses. There is an idea that educated middle class women don't need to be told. There is a trend towards the public fetus – motherhood screened out. There is a neo-liberal agenda of public health and surveillance under which we are all meant to comply with these regimes, not only for our own good, but for wider public society.

Polly reported on her ESRC funded study, of 24 women using drugs whilst pregnant. On average aged 30, opiate users (methadone), all smokers, no problem drinkers, engaged with services, half pregnant, half given birth. Polly focused on the management of identity these mothers felt – may saying that they were 'leading a double life'. But pregnancy and childbirth curtail women's ability to keep information secret - having to lie to medical staff and other mothers. These women felt angry that there was no distinction between chaotic drug use and stable drug use. Women with a history of substance misuse have to present themselves as worthy of motherhood

Betsy Armstrong responded to the papers first, and said she thought was the globalisation of public health policy, especially around drinking during pregnancy. In the US we see glimmers of resistance to the abstinence message, but here seems to be a bit stronger. Janet pointed out the role of scientific uncertainty in policies around drinking during pregnancy. This is about the individualisation of responsibility – not about providing community level solutions, but about convincing individuals to act in a particular way: tendency to obscure other risks (eg. Power plants are a much bigger source of mercury than eating fish); makes it imperative for women to perform their moral fitness as mothers; paradox here as this framework constructs woman herself as ultimate protector of fetus, yet, constructs her and her body as the greatest threat to fetal well-being. Pat argued there are many debates that need to be teased out. FAS and FASD are not the same thing. FAS is a very definite diagnosis but FASD is so woolly and so uncertain; very poor quality studies. People who are searching for reasons for misfortune can use FASD, as it fits the bill with a range of symptoms.

Only about 9 per cent of women will go above the guidelines on drinking. So the question is, is, will these messages about abstinence reduce FAS? No. Mothers who give birth to FAS babies will all be alcoholics – e.g. 1 bottle of gin per day. Only 128 FAS babies are born per year. Should all women be told not to drink at all? Alcoholics will drink anyway and abstinence advocacy makes them even more reluctant to seek help if you say abstinence is the only solution. Since 1981 – US authorities have said that women shouldn't drink at all in pregnancy. In spite of advice, moderate drinking increased from 1 to 3 per cent. Why did advice in UK change? There had been an increase in binge drinking – felt it would lead to an

increase in drinking in pregnancy. But there is no evidence for this. As soon as most women find out they are pregnant they cut down. Also here is the idea that people don't understand what a unit is, so it is easier to advise them not to drink at all. Surely that's our problem not women's problem? Is there any harm in advising women not to drink at all? Yes, there is, because 1. If you make a statement like this in such a firm way on lame evidence, you loose the trust of people, crying wolf. Makes it difficult next time and 2. there are many good mothers who have drunk in previous pregnancies according to prior guidelines; when this changes makes them feel terrible. There is a difference between the States and here: here fetus has no rights at all over those of the mother.

Discussion
Jan Macvarish Individualisation of risk. But there is a notion of a dysfunctional culture. Individual is not trusted to be a risk manager.
Jennie Bristow The resistance to the abstinence advice this was largely middle-class. Not motivated by a concern with binge drinking and anti-social behaviour alone.

Responses
JG: It seems we will never be able to talk about whether alcohol is beneficial in pregnancy. Why do the British adopt this FASD? Bad science diagnosis is advantageous for some people. One can claim disability benefits etc. Also, if child is having problems in school and you have a 'disorder' to draw on, can access services.
EL: A very small group of individuals have managed to be very influential in changing DH policy.
PL: Now entire livelihoods and careers based on FASD. Diagnosis can bring benefits. Class – if you read policy documents etc, it is about the broader problem of alcohol. Need to restrict the middle classes to prevent the rest of us drinking.
POB: Medical profession – paternalism seems to be still there, just below the surface. Rather than giving people the information, we make the decision for them about how much to drink (none!) Also, doctors find it hard to say 'I don't know'. Almost always impossible to prevent medics writing some sort of 'expert opinion' despite lack of evidence.

Discussion
Danielle Bessett Women who are asked to stop smoking; by quitting entirely it would be too stressful, but they're aware they ought to.
Ruth Cain Anti-depressants similar thing – better for women to take drugs than to be stressed

Responses
POB: Cross-cultural differences in interpretation of same policy (in the US women get refused when ordering wine in bars, French will insist!)
BA: French do not consider wine alcohol whereas the US is a very puritanical society.

Session 4: Motherhood, abortion and parenting culture
Chair Ann Furedi, CEO bpas
Papers Rachel Jones, Senior Research Associate, Guttmacher Institute, New York, 'Abortion decision making in a culture of 'intensive motherhood''; Danielle Bessett, PhD, Charlotte Ellertson Social Science Postdoctoral Fellow, Ibis Reproductive Health, Cambridge, MA, USA, 'Pregnancy after Abortion: women's experiences of a

stigmatized reproductive career'; Evelyn Mahon, Senior Lecturer in Sociology at the School of Social Work and Social Policy, Trinity College Dublin, 'Is there ever a good time to have a child?'

Rachel Jones gave a presentation based on qualitative data about abortion decision-making in a culture of 'intensive motherhood'. First of all, however, she provided some contextual information about the USA. Recent data indicates that women who have abortions are often poor or on low income. Race and ethnicity is significant – black and Hispanic groups are over-represented. Most women who have abortions are not married, but over one in four are cohabiting. Jones discussed repeat abortion: half of those women who had abortions in 2008 had had a prior abortion. Noting that the stereotype in the USA is that adolescents are getting pregnant and having abortions, only 18% of those having abortions are under 20 years of age, and the majority are in their twenties. 89 per cent of those who had abortions did so at under 12 weeks' gestation. Moving on to talk about motherhood and abortion, Jones noted the assumption that women have abortions because they don't want children. She also discussed the 'pro-choice assumption' – that the woman having an abortion and the woman carrying a pregnancy to term is 'the same woman at a different stage in her life'. But, she argued, 61 per cent of those having abortions in the USA already have at least one child. Twenty-three per cent of those under 20 years of age are mothers, and 10 per cent had a baby in the past 12 months. Jones cited research by some colleagues indicating that the most common reason given for abortion was that children 'would dramatically change my life'.

The Guttmacher Institute study that Jones presented was a qualitative study of 38 women at four different abortion providers in the USA. Three quarters were mothers, and about half were at or below the poverty line. Almost half were in the second trimester of pregnancy: this, she acknowledged, is not representative of the population, and reflects the process by which interviewees were recruited at abortion clinics. When discussing their reasons for seeking abortion, women talked about a number of issues. *Caring for their other children* emerged as a strong theme: one woman had severe morning sickness, which she had never experienced before and she felt impeded her ability to play the mothering role she wanted to in relation to her other children. One 19-year-old respondent already had three children and lacked the financial resources to have a fourth child. Mothers also discussed *health* – their own, and that of their children – and how this related to their maternal obligations. Four women had children with serious health problems, and five women had health issues themselves. Jones remarked upon how, even when women talked about their own health problems, it was in the context of bringing up the children they already had. Women talked about the *ideal conditions of motherhood* as framing their decision. Jones noted that this included both the 'real and perceived' disadvantages of having a child in their situation. For example, one unmarried woman with no children said that she couldn't give her child 'everything in the world' – expressing the idea that total devotion to motherhood is necessary before embarking on the process. Respondents to the Guttmacher study also raised *maternal and fetal health* concerns – they talked about drugs, smoking, or failing to take prenatal vitamins to express concerns that they were not ideally positioned to carry this pregnancy to term. Adoption was an issue brought up, unprompted, by nearly one in four interviewees, but in the context that to adopt would be unrealistic. Jones suggested that this expressed the idea that if you have a child, it is your responsibility to take care of it – how would you know that

somebody else could do that? Some women discussed the bonds developed *in utero* as reasons against adoption.

In conclusion, Jones noted that most women who have abortions are mothers, and that motherhood influences women's abortion decisions. The issues she discussed in her presentation were not the main reasons that respondents brought up for having abortions, but were some of the issues they raised. Some women used 'anti-choice' language to discuss their abortions, and were sad about the decision – but they nonetheless thought that they and their families would be better off as a result of the abortion. Jones suggested that pro-choice advocates need to work to achieve better social supports for motherhood, and for parents, and to use language that speaks to women's experiences. She also suggested that attempts to increase adoption are not going to impact upon the abortion rate.

Danielle Bessett began by observing that this event was the first time she has shared a panel with somebody who looks at the mix of abortion and parenting, she noted the difficulty in doing research based on this 'mix' when women's care is split across different sectors. The context of her research is one in which 52% of US women who have abortions plan to have children in the future, and one in three women have abortions. She noted that neither of the notation systems for recording women's obstetric history - GPA (gravida/para/abortus), and TPAL (term births, preterm births, abortions, living children) – separates between the sequence of events. Past reproductive events often re-emerge in prenatal care, and Bessett argued for a more dynamic approach to understanding this.

Bessett discussed women's reproductive careers in terms of the way that women's relationship to reproductive experiences change over time, and in relation to previous and anticipated reproductive events. She said she had been struck by the way that women talked about previous abortions while they were carrying a wanted pregnancy, and discussed her research: a longitudinal study with 64 pregnant women in the greater New York metropolitan area. One third of women interviewed reported having terminated a previous pregnancy, and women described their abortions differently at different stages. Those who experienced problems with getting pregnant reported concerns about the effect of the abortion upon their fertility; as Bessett noted, even those who said they were familiar with the very small odds of such an effect said that it had crossed their minds that 'something had gone wrong'. Others discussed being prevented from having children by a vengeful God. Bessett suggested that there was a need to pay more attention to those who continue to experience difficulties in becoming pregnant.

Abortion emerged as quite distinct from the current pregnancy. Bessett noted that some of the women may have even forgotten about a previous abortion, and that it was sometimes thought of in terms of a lifestyle choice rather than a medical problem. For some women, the experience of abortion contrasted with the experience of miscarriage, where the worry was that something was wrong with them to bring about a miscarriage. Some women articulated feelings of regret and fear about the repercussions of abortion upon their current pregnancy – for example, illness or disability of the fetus – in terms that Bessett described as religious or 'supernatural'. However, she stressed that these responses were not consistent with what has sometimes been described as 'post abortion syndrome' – the women weren't

exhibiting signs of mental illness, but they were describing their experiences in a discourse of religiosity. Across both patterns of responses – those women who appeared to regret previous abortions, and those who did not – disclosure of a prior abortion was understood by women to affect their treatment in prenatal care and during the birth, leading to a question over the extent to which abortion carried a 'stigma' in women's reproductive careers. Bessett concluded that women's reproductive histories can shape their experiences and how they feel they are treated by others. The concept of the reproductive career better conceptualises the experience of women across their life span. It may be that women are not articulating a stigma attached to abortion but something else – but, she said, we don't know what this 'something else' is until we interrogate it.

Evelyn Mahon's paper emerged from three different studies she has conducted over the past 20 years. She noted that Irish reproductive history and discussion has been very influenced by American groups, and noted that though there is no right to abortion in Ireland, contraception was legalised in 1979 and women travel to the UK to have abortions. Mahon discussed her research on women and 'crisis pregnancy', which examined factors that influenced women to have abortions. Part of the aim of this research, she said, was an effort to make abortion visible, and seen as part of everyday life. The data showed that a crisis pregnancy was socially constructed – that women who had abortions tended to be young, single and unemployed. Adoption was a major policy until the 1970s, she explained, and most illegitimate births were adopted. The sociological question this raised was, if everybody is doing one thing and abortion is seen as so awful, why do people do it? The major findings of Mahon's study included the experience and meaning of stigma. Stigma is about a lot of things, she explained: the negativity attached to premarital sex and single motherhood meant that the parent and child would be stigmatised. She noted that when women gave babies up for adoption, the effect was the same as that of abortion: namely, the idea that the baby was gone. In addition to stigma, Mahon talked about women's unreadiness to have a child, which included financially not being able to cope. Mahon went on to discuss some of the social shifts that have taken place over recent years, particularly in relation to Ireland's economic development. Irish women have internalised ideas about the importance of education and work, and also certain ideas about the needs of the child. For example, the two-parent family has become an internalised model, and those women seeking abortion couldn't conceive of adoption. There are new patterns of reproduction emerging, around ideas about the age at which women should have their first birth, the importance of first establishing a relationship with a sexual partner, and women's attempts to define their own lives.

Discussion

Ann Furedi Rachel's data is very similar to the breakdown of abortion statistics in the UK.

Frank Furedi to Rachel Jones: Did the researchers look at what women meant as well as what they said?

Charlotte Faircloth to Danielle Bassett: Could you clarify why health professionals need to know about women's reproductive history?

Ellie Lee to Danielle Bessett: Could you say more about the concept of stigma?

Responses

DB: Stigma relates to the concept of the tainted self. Miscarriage also carries stigma but in a different way.

Discussion
Jan Macvarish We need to problematise the concept of stigma.
Pam Lowe Most women don't regret having an abortion: they feel justified in what they do but worry that other people might judge them harshly.
Polly Radcliffe The discussion relates to competing identities of motherhood.
Lesley Hoggart Looking at stigma in relation to how individual women respond to abortion, and some women do feel regret.
Offra Koffman Did anything come out of the research in terms of women's relationships with their partners?
Frank Furedi Stigma is a conceptually unsustainable term because it requires moral certainty. This points to a methodological problem, in that people are engaged in a moral performance: what they say is not necessarily what they mean. Their responses tell you what the cultural script is: the challenge is to unpick the meanings.
Sally George I work with women who see themselves as women who wouldn't have an abortion – then they have a diagnosis of fetal abnormality, and it requires a change in their identity.
Rachel Jones Sometimes women don't report abortion to researchers. We talk about stigma but sometimes women forget they've had an abortion.
Danielle Bessett With stigma, all you need is a belief that someone is judging you. There is some concern about abortion discrimination.
Evelyn Mahon Reproductive life has completely changed. Frank's point might be a bit dismissive of the ethnographic work that has gone on.
Ann Furedi Some observations from working in abortion provision. It is astonishing that women come to abortion clinics and are shocked that there are so many other women there. Women are often desperate to make people understand that abortion is wrong but right for them.

Session 5: Abortion and the politics of motherhood
Chair Ann Furedi, CEO bpas
Paper Professor Kristin Luker, Elizabeth Josselyn Boalt Professor of Law and Professor of Sociology, University of California, Berkeley, 'Abortion and the politics of motherhood revisited'
Discussant Ruth Fletcher, Senior Lecturer in Law, Keele University

Kristin Luker's presentation focused on what she called a 'paradox' of macrosocial forces and the individual. The right to abortion in the USA came about partly because the right people were in the right places at the right time, but abortion is now legal and available across Europe. Referring to the insight that women are always mothers or potential mothers, she pointed out that discussion about the rights of the individual person tend to be discussions about young men. Abortion held together the gender and sexual regime – but since 1964 it changed dramatically. This represented the end of the first demographic revolution, where fertility became increasingly marital, investing more in smaller numbers of children, and there was strong disapproval of pre-marital sex. Nine years later, abortion and contraception was legal and accepted, and there was widespread change in attitudes towards pre-marital sex. She stressed that the significant change happened before the *Roe v Wade* judgement of 1973.

The shift came about because of a combination of factors: technological change, with the Pill becoming the most popular contraceptive; ideological change, coming from the civil rights, women's, and the student movement; and legal change. The Griswald case about contraceptive provision in 1964 was key: she stated that while *Roe v Wade* got all the publicity, *Griswald* had done much of the heavy work. *Griswald* found a 'hidden right to privacy' in the constitution and that was extended in *Roe v Wade* to 'bear' and well as 'beget' a child. Luker argued that this was the day the pro-life movement was born. What mobilised people was not really abortion, so much as the idea that the unborn child is not really a person.

Luker discussed the dramatic changes to women's lives brought about by *Roe v Wade* – illustrated by the increase of women into the professions. This changed the context in which decisions were made, and public opinion started to question the idea that women should leave running the country to men. However, while some women were positioned to take advantages of the changes, others were not. The option of abortion immiserated women for whom motherhood was the best job they could do. Luker suggested that women who were less educated or positioned to take advantage of equality are likely to appreciate a gendered world – a housewife has control over her own timed, and a certain status. In 1985, noted Luker, she had argued that abortion destablised motherhood. In fact, it destablised *marital motherhood.* Abortion divided women along lines of the meaning of motherhood – but she acknowlged not having appreciated the extent to which the postponing of motherhood was also sdignificant. Luker discussed what has been termed the 'second demographic revolution', with the decoupling of marriage and motherhood – the two are no longer seen as sequential. She noted the increase in the proportion of births out of wedlock, and raised issues to do with Hochschild's concerns about the care deficit and the role of neo-liberalism. In conclusion, she argued that we need to pull back and think of the larger social and demographic contours of this discussion.

Ruth Fletcher's response centred on emphasising how the significance of change is indicated by a lot of feminist work on reproductive rights, which shows the diversity of reasons for women having abortions.

Discussion
Jan Macvarish Is the problem only experienced by the poor? How do we account for the rise in college educated women remaining single and childless?

Responses
KL: There is an idea that the issue is not discrimination against women, but against those who don't want to spend 20 hours a day at work. There are seen to be three possible solutions to the care deficit: 1) to reinforce typical gender roles; 2) to hire a person to provide care; 3) to seek social democratic solutions. The fourth is what we don't know yet.

Discussion
Ellie Lee: The bifurcation is less apparent now, shown in the literature of work-life balance and the way women look at career progression. Many of these issues need a lot of unpacking, in terms of the lack of moral certainties on one side or another.

Responses

KL: Abortion has lowered the entrance point to premarital sex. Individuals seem to be muddling around and all moving in the same direction.

Discussion
Jennie Bristow Compelled by the link between abortion and the move away from marriage, but is that the whole story? The literature suggests a broader cultural move away from commitment to intimate relationships in general.
Frank Furedi As the cost of intimacy is lowered, Western society has become uncomfortable with intimate relations. Agrees with Luker about the 1970s and 1980s, but the thesis seems more questionable as time goes on. Eg Scandinavian societies provide good care standards through the state – and there are more single mothers. There is a balance between the cultural, sociological and economic. But abortion and contraception are the foundation on which these changes are happening.

Responses
KL: We need to synthesise better the shift from the material to the post-material, and conceptualise human rights in relation to social and economic justice.

Discussion
Janet Golden In the 1950s/60s, the greatest amount of cultural resources went to the middle classes – now we are seeing a welfare revolution amongst the upper classes. Underlying this is a new aspiration that does create a fundamentalist response.
Cynthia Daniels We need to reintroduce political economy into the discussion.
Evelyn Mahon The feminisation of the labour force was the big thing that changed in Ireland.
Lesley Hoggart People might be in a relationship but living separately.

Responses
RF: It's interesting that the theme of self-reliance comes up, and the way this works with ideas about neo-liberalism.
KL: There are many points to think about. Marriage, when the employability of men is going down, and the feminisation of the labour force. Also the cultural change – women don't put up with men in the way they used to.

Session 6: Reproductive technology in an age of intensive parenthood
Chair: Emily Jackson, Professor of Law, LSE
Papers: Martin Richards, Emeritus Professor of Family Research, Cambridge University, 'Choice or eugenics? Present practice and future developments in the culture of choice'; Julie McCandless, lecturer in law, Oxford Brookes University, 'What is 'supportive parenting'? The new 'Welfare of the Child' clause in the Human Fertilisation and Embryology Act (2008)'

Martin Richards noted that antenatal care is a very unusual public health campaign because it has almost universal uptake, and described the history of antenatal screening. The first genetic clinic was established in 1946, and dealt with couples who had a child with a genetic disorder – the main issue was 'recurrence', and couples would often decide to have no further children. The clinic's aims were described in a study at the time as providing a service to individual couples, and reducing the proportion of children born with a disability. This study pointed to developing technology to point to carriers of genetic diseases, and prenatal diagnosis of such

disorders. Richards argued that the culture in which the clinic operated was one of reform eugenics, and its aims were not controversial at the time. Richards went on to explain that with the end of eugenics in the 1970s, such ideas became unmentionable. There was a shift from the belief in self-sacrifice for the common reproductive good to individualistic reproductive autonomy. Health professionals stopped giving advice in this area and instead provided information and 'non-directive counselling'. He posed the question of whether this represented an end of the genetic clinic, or its rebirth in a culture of choice?

Moving on to antenatal screening today, Richards discussed the recent attempt to repeat Ann Oakley's study of maternity care in the mid-1970s, when two-thirds of scans were dating scans. The 2009 study found that all women had scans at 11 weeks and an anomaly scan at 22 weeks. One third of women also had private scans, for a variety of reasons – both medical and to gain a clear image of the fetus. He pointed out that women are seeking antenatal scans – they are not being imposed upon them. Richards discussed other screening programmes that are available today, including those which are directed towards specific groups at particular risk of certain disorders. There are many new diagnostic tests, including non-invasive tests that use blood samples to look at Free Fetal DNA. At the moment, argued Richards, the main use of this latter test is marketed as a home kit to test the sex of the baby. Richards argued that the move towards SNPs (single nucleotide polymorphisms), which are a common variation in a genome, and genome sequencing will be hugely significant in terms of what the tests can tell you about the fetus. On the limits to choice, Richards posed the question: 'Is this a new eugenics?' He argued that many of the ideas are similar to the 40s and 50s model, but different in that it is not state-sponsored sterilisation. Richards discussed a study of families with intellectual disorders, which found that they wanted a diagnostic and genetic test; and also sex selection, which is not permitted in the UK but people do it, through buying genetic test kits from the internet or travelling to countries that do permit PGD for sex selection. The lesson from history, Richards argued, is that 'people do what they can do'. He concluded by noting that there are more and more opportunities for testing, and only four possible ways to exercise choice: choice of sexual partner, termination of pregnancy, IVF and embryo selection, or gene therapy.

The presentation by Julie McCandless was based on work she has conducted with Professor Sally Sheldon on the legislative backdrop to the HFE Act 2008 – a flagship piece of legislation passed by the New Labour government. McCandless noted that this legislation raised a number of controversial issues, the foremost of which was the removal of the 'need for a father' in the provision of fertility treatment, and the replacement of this clause with the need for 'supportive parenting'. McCandless discussed the media reportage of this shift, which focused on the idea that 'no fathers are required', and asked why it excited so much attention. Although this was represented as a major change, it was not necessarily so significant in terms of clinical practice – the Human Fertilisation and Embryology Authority (HFEA)'s code of practice has been interpreted increasingly liberally. 'All the fuss' can be explained, argued McCandless, through 'a number of conflations'.This is a clause with a long history, and the 'need for a father' initially represented a compromise with Conservative MPs who wanted to restrict ARTs to married couples. Also significant was how agendas were set in the process of legal reform. McCandless noted that the House of Commons Science and Technology Committee had recommended the

removal of the 'welfare of the child' clause – initially, the issue was the clause itself. By the time the debate came to Parliament, some compromise was needed again. The simplicity of the phrase, and the way the deletion of the 'need for a father' clause became the focus of societal anxieties was another issue – the discussion of the need to have an explicit mention of fatherhood relates to broader anxieties around fatherhood. The clause was seen to send a symbolic message – to fathers, and to children without fathers. Finally she mentioned the broader debate about parentage, and the idea that a child has a right to know their biological father. The debate was thus a snapshot of views about the family. McCandless concluded by raising the question of what this change would mean in practice, and whether the 'welfare clause' would be interpreted differently. She indicated some potentially controversial cases in ART – including older women (and men), transgender persons, and platonic 'couples' and non-dyadic partnerships.

Discussion
Ellie Lee The use of ARTs in practice seems to be moving in the direction of an assumption that people are 'supportive parents' unless there is a good reason to think otherwise.

Responses
EJ: Part of the story is the role played by equalities legislation, which means you can't discriminate against people. Although there are issues raised by the restrictions on treating couples with health or disability problems.

Discussion
Ann Furedi There is a world of difference between public policy now, which enables individuals to make choices for themselves, and the eugenic movement at the start of the 20th century. On the disability side, we need to pick apart these differences. There is a much stronger eugenic application in the discussion of teenage pregnancy, or the neo-Malthusian debate about population reduction.

Responses
JM: Family law still contains a hierarchy of relationships.
MR: There was no state eugenics in the UK after legislation – so the Eugenics Society was in favour of voluntary policies. These are the same people who set up early eugenics.

Discussion
Pam Lowe We need to unpack the concept of choice. What about the right not to choose?
Janet Golden People are engaged in privatised eugenics – for example over height, in the USA you can't be a sperm donor if you're under 5'11".
Lesley Hoggart On teenage pregnancy, the research shows that adverse outcomes are because of poverty, not age – yet that group is picked out on the basis of age.

Responses
EJ: There are also issues to do with older mothers – a narrowing of the age in which pregnancy is permitted.